Incident Reporting and Investigating Policy

Dudley Integrated Health and Care NHS Trust

Document no.	Version	Issue date	Planned review date
PPOL-CORP-007	1.0	28 March 2022	28 March 2023
Document type	Policy ☐	Procedure ☐	Policy & Procedure ✓
	Corporate ✓	Local ☐	Quality & Safety Assurance
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Related Trust documents	
PROC-CORP-004	Datix Level 1 Training Guide
PROC-CORP-005	Standard Operating Process 1 - Reviewing and Investigating an Incident
PROC-CORP-006	Standard Operating Process 2 - Investigating a Serious Incident
POL-CORP-053	Safeguarding Children and Adults Policy
POL-CORP-007	Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
POL-CORP-015	Being Open/Duty of Candour Policy
POL-CORP-019	Health and Safety Policy
POL-CORP-073	Removable Media Policy
PPOL-CORP-006	Claims Management Policy
PPOL-CORP-019	Managing Complaints, Concerns and Compliments Policy
POL-CORP-064	Investigating Deaths Policy
POL-CORP-034	Clinical Record & Note-Keeping Policy

Overview & purpose

This policy aims to provide guidance and support for the reporting, investigation and closure process in both clinical and non-clinical areas to ensure all incidents and near misses are appropriately reported and investigated, maximising the Trusts opportunity to learn from such events.

CONTENTS

1 KEY PRINCIPLES

1.1 Introduction

The Trust acknowledges that the delivery of healthcare is complex and sometimes things can go wrong. The organisational response across the Trust at all levels will be to minimise the reoccurrence of similar incidents in the future with the over-riding principle that incidents and near misses are not in themselves evidence of neglect, carelessness, or dereliction of duty, and that the best way to reduce incidents and near misses is to learn from underlying system failures rather than to take action against individual members of staff ('fair blame'). The Trust is committed to developing a just culture, encouraging a willingness to admit mistakes without fear of punitive measures. Every incident report is seen as a learning and quality improvement opportunity.

1.2 Objectives

- To ensure incidents and near misses are investigated appropriately, thoroughly and in line with local and national policy and timescales
- To make clear the incident reporting requirements for clinical and non-clinical services
- To ensure incidents involving data breaches are reviewed and reported in line with the Data Security and Protection Toolkit incident reporting guidance (NHS Digital)
- To increase awareness of the need to ensure the immediate and future safety of patients, staff, carers and the public
- To establish and enhance a patient safety and learning culture
- To ensure collection of information that is timely, accurate and relevant and that enables analysis of incident trends and identification of areas for investigation
- To provide accurate reporting practices to support the provision of assurance to external agencies
- To ensure lessons learnt from investigations are appropriately disseminated and actioned

1.3 Counter Fraud Statement

In creating this policy, the authors, reviewers, and Committee have considered and minimised any risk which might arise from discharging its duties in relations to fraud, theft, bribery, or other illegal acts and are ensured that the terms of reference are robust enough to withstand evidential scrutiny in the event of a criminal investigation. Where appropriate, they have sought advice from the Trust's Local Counter Fraud Specialist.

1.4 Fair Blame statement

The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

1.5 Alternative Options to Reporting Incidents

In circumstances, where staff feel unable or are reluctant to report an incident using the incident reporting procedures, alternative options are available to ensure that staff have the ability to report what they need to.

For example, individuals or teams could report directly to or through one of the following in accordance with the Trust's Whistleblowing Policy:

- Non-Executive Directors
- Staff Side Representative
- Associate Director of Quality and Governance
- Director of Nursing, AHPs and Quality
- Chief Executive
- Service Manager
- Governance Manager
- HR Team
- Freedom to speak up Guardian

1.6 Staff Support

When being notified of an incident the Trust should ensure that staff are kept informed of any investigations or outcomes and appropriate guidance and support is made available. Staff support may include immediate or ongoing emotional support, team debriefs facilitated by the relevant manager, 1:1 or supervision support, professional and/or legal support. In all cases, staff should be made aware of how to access Staff Support Counselling Services. Leaflets are also available where required. Offers of support and staff response must always be fully documented. Copies of Return-to-Work interviews, where the level of support is documented, attendance records and occupational health referrals/ medical reports need to be retained on personal files.

2 PROCESS

2.1 Reporting Process

All incidents and near misses should be reported via Datix at the earliest opportunity and no later than 1 working day after the event.

Once an incident has been reported, the Datix system will notify the relevant people through its notification system. Furthermore, additional staff will be notified via the Quality & Safety team. For example, incidents where the harm is rated as *Severe* or *Death* should also be immediately notified to the relevant Service Manager, Associate Director of Quality & Governance, and potentially the on-call manager if out of hours.

If you are reporting an actual data breach incident which is ongoing, i.e., the data remains with an unauthorised or incorrect individual, or the data is accessible or still being released to incorrect individuals, you must also notify the Information Governance Team at the point of reporting the incident. this is to ensure that the IG Team can support immediately in relation to containing the data breach.

Personal identifiable data (PID) must not be recorded in any 'free text' or 'description' spaces on the DATIX form.

Incidents involving patients must be recorded in the health records, if the reporter has access to them, in accordance with the Clinical Record & Note-Keeping Policy. Entries in patient notes must detail the DATIX number and where applicable police log number etc.

All injuries must be noted using anatomical terms and appropriate medical action sought. Any equipment/items, including ligature knots, involved in an incident/accident must be retained in safekeeping for examination if required, until the investigation is complete.

Where there are several low-level incidents of a similar nature e.g., involving the same patient or repeated low-level verbal/racial non- physical aggression, during a shift, staff members may report these as one overall incident. This is to prevent staff members having to fill out multiple incident forms across a short time period and to encourage reporting. This report should include details on the numbers of incidents that have taken place across the shift as well as the details of all individuals involved.

2.2 Investigation Process

Once reported, the Quality & Safety team will carry out an initial review of the incident to ensure that it is correctly allocated for investigation and a level of investigation will be assigned.

All Information Governance incidents will be reviewed by a member of the IG Team and where applicable any actions/recommendations will be raised with the allocated handler.

The incident must then be reviewed by the allocated handler (usually the team manager for the area under which the incident has been reported) in line with the timescales provided in **Standard Operating Process 1 Reviewing and Investigating an Incident**.

Incidents will then be scrutinised at the weekly review panel. This will confirm the level of investigation required and ensure that, if required, the relevant external bodies have been contacted. All incidents are treated on a case-by-case basis, however, below are three broad areas to determine the different levels of investigation.

Level 1:

- No obvious implication for learning for other teams
- May have external input to the investigation
- To be completed within 10 working days
- Closure approval of incident may be internal to the team

Level 2:

- More complex investigation required
- Level of harm is moderate or above
- Evidence of learning for wider organisation
- May take longer than 10 days to investigate
- Closure approval required external to team

Level 3:

- Externally reportable incidents
- Investigation process overseen by the Quality, Safety & Assurance Team
- Approval of incident will be by nominated Executive Lead

The investigation of incidents at any level should include the relevant members of staff and specialist teams/external advisors when required.

In relation to IG incidents where the incident meets the external reporting threshold an initial investigation review must be completed and forward to the Information Governance Team within 72 hours of the incident being identified. Please refer to section 2.3.10.

2.3 Reporting and Investigation Considerations

2.3.1 Serious Incidents

The Quality & Safety team will notify the Executive Team and appropriate Service Manager that an incident has been reported which meets the criteria for reporting to the commissioners on StEIS. The Quality, Safety & Assurance Team will then report the serious incidents on StEIS. The process for the investigation of serious incidents is detailed in **Standard Operating Process 2 Investigating Serious Incidents.**

2.3.2 Duty of Candour

Duty of Candour is a legal requirement for all care organisations to be open and honest with its patients and/or their representatives when things go wrong. Duty of Candour applies to all notifiable safety incidents[1] and requires an NHS body to:

- Make sure it acts in an open and transparent way with the relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity
- Tell the relevant person in person as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification
- Provide an account of the incident which, to the best of the health service body's knowledge, is true of all the facts the body knows about the incident as at the date of the notification
- Advise the relevant person what further enquiries the health service body believes are appropriate
- Offer an apology
- Follow this up by giving the same information in writing, and providing an update on the enquiries
- Keep a written record of all communication with the relevant person

All information relating to compliance with Duty of Candour requirements must be recorded on Datix and copies of letters sent attached to the incident record. Further information on Being Open/Duty of Candour is available in the Trust's Being Open/Duty of Candour Policy.

2.3.3 Incidents linked with Complaints or Claims

There can be occasions where a complaint, or claim, is reported alongside an incident. Depending on the level of investigation that is required, for example if it were to be a Serious Incident, a discussion should be had to ascertain an appropriate and agreeable way forward with all parties including families.

However, it is important that the SI Investigating Officer is aware of the complainant's concerns and that these are included in their deliberations and final report. This is in line with the Department of Health's document *A Guide to Better Customer Care, 2009* which supported the 2009 Complaints Regulations.

2.3.4 Never Events

Never Events will always be considered serious incidents as described in the ***NHS England (2015) Never Events Policy and Framework Revised January 2018.***

2.3.5 Incidents Involving Medicines

All incidents involving medication errors, including issues such as storage, disposal, administration, prescribing errors must be reported in accordance with the Medicines Management Policy. The Pharmaceutical Specialist will be responsible for notifying the MHRA where required. In cases of other incidents involving medication e.g., overdose or self- harm, the details of any medication involved must be recorded.

2.3.6 Child Death Notifications

All child deaths will be reported on DATIX by the relevant Lead for Safeguarding under the team with whom the child had most contact with i.e., School Nursing speech & language etc. and investigated in line with National Child Death investigation processes i.e., rapid response, Child Death Overview Panel (CDOP) processes.

2.3.7 Incidents Involving Adult or Child Safeguarding Concerns

In the event of any incident involving either/both adult and/or child Safeguarding concerns, the relevant safeguarding referral form should be completed in accordance with local Safeguarding Board Policy and Procure and submitted to the relevant Local Authority in line with their reporting timescales. Referral forms should be uploaded to the Datix report once submitted- either by attaching the completed form at the point of reporting or by emailing the completed form to the Governance Team to attach if the Datix has already been submitted.

It is the responsibility of the staff member submitting the Datix form to liaise with the relevant Local Authority to identify any actions as a result of the referral being made and the Nurse in Charge/Team Manager receiving the notification and believes the vulnerable adult/child may still be at risk as a result of the incident to take immediate action to ensure the patients/child's safety.

Incidents where safeguarding concerns have been noted may be subject to Safeguarding Investigation processes such as Serious Case Reviews (SCR), Domestic Homicide Reviews (DHR) etc. Decisions on levels of safeguarding led investigations are made by the Local Authority and the Trust may be asked to assist with these investigations. In these circumstances, support and advice can be sought from the Trust Safeguarding Leads.

2.3.8 Process for Recording Incidents in Health Records

Incidents involving patients should be fully recorded in their health records. The most senior person on duty at the time of the incident must ensure an accurate, up-to-date chronological record of events, decisions and actions taken is clearly and legibly recorded in the health care records; signatures, names, dates, times, as well as clear references to care plans, risk assessments, incident form numbers, police log numbers etc. must be included.

The records should indicate what happened; what effects were noted on the service user's condition including any psychological or emotional harm; what actions were taken to minimise adverse effects and what changes, if any, were implemented in the care plan as a result of the incident.

If the incident resulted in specific clinical interventions or the death of the service user, notes recorded will be used for investigation purposes and, in cases where death occurred, for use by the coroner or police. Information/discussions given to relatives/carers at the time of the incident are to be recorded in the notes. However, investigation processes, reports, Duty of Candour/ Being Open meeting notes are to be kept separately to the healthcare records.

2.3.9 Securing Notes in the Event of Death

In the event of the death of a service user or child, the patients' notes should be secured by the most senior member of staff on duty. They should then inform the Quality, Safety & Assurance Team and Service Manager. In the case of a child death, the Lead/Named Nurse for Safeguarding should also be informed.

2.3.10 Information Governance Incidents

A data breach means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.

There are three types of data breach:

- Confidentiality breach - unauthorised or accidental disclosure of, or access to personal data
- Availability breach - unauthorised or accidental loss of access to, or destruction of, personal data
- Integrity breach - unauthorised or accidental alteration of personal

All data breaches should be reported via the Data Security and Protection Toolkit, the severity of the incident must be graded according to the severity of the breach and the likelihood of those serious consequences occurring; both are scored on a scale of 1–5 (see below grid).

Severity (Impact)	Catastrophic	5	5	10	15	20	25
	Serious	4	4	8	12	16	20
	Adverse	3	3	6	9	12	15
	Minor	2	2	4	6	8	10
	No adverse effect	1	1	2	3	4	5
			1	2	3	4	5
			Not Occurred	Not Likely	Likely	Highly Likely	Occurred
			Likelihood that citizens' rights have been affected (harm)				

DHSC & ICO

ICO

Incidents where the grading is in yellow and red must be notified to the ICO within 24 hours of discovery of the incident, the section in red also must be notified to the Department of Health and Social Care (DHSC) within 24 hours.

Where the incident is assessed that it is the incident is reportable and full details will be automatically emailed to the ICO and the NHS Digital Data Security Centre via the Trust's Data Security and Protection Toolkit (DSPT).

The DHSC will also be notified automatically via the DSPT where it is (at least) likely that harm has occurred, and the impact is at least serious.

The ICO may request further updates or identify actions to be taken in relation to the incident, the ICO will liaise directly with the Trust's Data Protection Officer who will liaise directly with the incident leads and Governance in relation to the management of the incident. Where incidents are externally reported the Data Protection Officer must be kept informed about the incident investigation and lessons learnt process in order to update the ICO.

2.4 External Reporting Considerations

Incidents that impact on the quality and care of patients must be reported to the CQC. For the majority of incidents this happens via the routine uploading of DATIX data into the national Learning from Patient Safety Events (LPSE) database.

There are some incidents that require reporting to the CQC on an individual basis using their notification form as follows:

- Deaths and unauthorised absences of people detained or liable to be detained under the Mental Health Act 1983
- The admission of a child or young person under the age of 18 to an adult psychiatric unit or ward
- Applications to deprive a person of their liberty under the Mental Health Capacity Act 2005, and their outcomes

Notification forms should be discussed with the Service Manager in the first instance before informing the Governance Team who will liaise with the relevant persons to ensure the incident is reported to the CQC.

For more information regarding notification forms contact the Governance Team or visit the CQC website at http://www.cqc.org.uk/content/notifications-nhs-trusts.

2.4.1 Scenes of Crime Considerations

Where suspicions or unknown circumstances arise in any incident the potential exists for the location of the incident to be classified as a 'scene of crime'. Therefore, there should be no disturbance to the scene or removal of items. Access to the scene must be restricted. This is particularly important where sudden or unexpected death has occurred, or where arson is suspected. In such cases, the area should be sealed off from all staff and patients until the police have attended and have given permission to access the scene. The body should not be moved or touched other than for resuscitation attempts, and the immediate location should not be disturbed more than is essential to facilitate first aid attempts.

2.4.2 Media Interest

Any incidents that may generate public or media interest must be discussed with the Communications Department by the relevant manager. The Quality, Safety & Assurance Team must also be informed.

The Communications Department will prepare media statements, work closely with managers as the post-incident actions progress, and provide support for managers. Depending on the circumstances, joint statements may be prepared and issued with Emergency Services, Social Services or the Clinical Commissioning Group (CCG).

Wherever possible, individuals and/or their families should be fully informed of any circumstances which involve them before any information is released to the media. The Executive Team should agree the most appropriate staff member to contact the family regarding this.

For severe or serial incidents that are likely to generate high levels of interest, the Trust will establish a Communications Strategy for dealing with multiple enquiries.

2.5 Closure & post closure activities

The closure of incidents will be approved depending on the aforementioned level of investigation. The Quality and Safety team can be contacted at any point of the investigation for support and advice, including advice on the closure of incidents.

All incidents graded with a harm severity of moderate or above may require a 72-hour incident assurance report (IAR). The 72-hour report template is available from the Quality & Safety team upon request. Completed reports must be approved by the Service Manager and submitted to the Quality, Safety & Assurance Team for review and approval within 3 working days. The approved report must be attached to Datix.

Standard Operating Process 1: Reviewing and Investigating an Incident should be followed to identify the level and timescales of further investigation(s) required.

2.6 Oversight and monitoring

As confirmed within Appendix 7, incidents will be reviewed as part of the weekly review panel meeting. In addition, quality assurance will also be conducted by the Quality, Safety & Assurance Team on a proportion of closed cases as well as a proportion of incidents recently logged. As part of the patient safety framework, the Quality, Safety & Assurance Team will implement best guidance for incident management. Themes, trends & lessons learned.

The Quality & Safety Team will monitor reported incidents and subsequent investigations to identify themes and trends within service areas and across the wider organisation. The learning from investigations will be reviewed and disseminated via the Learning Lessons process.

2.6.1 National Confidential Inquiry into Suicides and Homicides (NCISH)

NCISH examines all incidences of suicide and homicide that occur within mental health services in the UK. The NCISH requires the assistance of the relevant consultant in completing a questionnaire about the deceased. In all cases, the manager should alert the Quality & Safety team upon receipt of a questionnaire.

2.6.2 Coroner's Office

All unexpected or suspicious deaths are referred to the coroner. If further investigation is required by the coroner, they may contact the Trust for a report of the care and treatment to be provided to aid in the investigation. In cases where individual staff members (regardless of profession) are contacted directly by the coroner, they must inform the Quality, Safety & Assurance Team.

A template for a coroner's report is available from the Quality, Safety & Assurance Team. Completed reports must be approved by the Service Manager prior to their submission to the Quality, Safety & Assurance Team, who will then submit to the Coroner's Office.

2.6.3 General Practitioner

The appropriate GP will need to be informed of the death of any service user. This should be done on the next working day if out of hours.

3 REFERENCES

Health and Social Care 2008 (Regulates Activities) Regulation 2014: Regulation 20: Duty of Candour

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Health and Social Care 2008 (Regulates Activities) Regulation 2014: Regulation 13: Safeguarding Patients from Abuse and Improper Treatment

The intention of this regulation is to safeguard patients from suffering any form of abuse or improper treatment, such as discrimination or unlawful restraint, while receiving care and treatment. This would include inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

Where any form of abuse is suspected, occurs, is discovered, or reported by a third party (which may be external to the provider) the provider must take timely and appropriate action, including investigation and/or referral to an appropriate body.

NHS England (2015) Serious Incident Framework: Supporting Learning to Prevent Recurrence

The Framework seeks to support the NHS to ensure that robust systems are in place for reporting, investigating and responding to serious incidents so that lessons are learned, and appropriate action taken to prevent future harm.

NHS England (2015) Never Events Policy and Framework Revised January 2018

Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes and so this policy and framework provides the NHS with an essential lever for improving patient safety. Regardless of the outcome of an individual Never Event, Never Events are always considered serious incidents as described in the Serious Incident Framework.

APPENDIX 1: Responsibilities

Title	Responsibilities
Chief Executive	Ensuring this policy is implemented and operational responsibility has been delegated within the Trust.
Director of Nursing, AHPs and Governance	• Ensure that appropriate and robust systems, processes and procedures are in place for incident reporting and associated risk issues • Lead on strategies and innovations to reduce the number of incidents relating to risk within both care and support services • Ensure that any serious concerns regarding the implementation of this policy are brought to the attention of the Trust Board
Associate Director for Quality and Governance	• Manage and co-ordinate the assurance processes including healthcare governance and manage incidents within the Trust • Lead in supporting development of an effective patient safety agenda, within the context of integrated governance, ensuring that the Trust provides clinical care of the highest quality
Trust Board	Strategic overview and final responsibility for overseeing there are appropriate and robust systems, processes and procedures in place for incident reporting and associated risk across the Trust.
Quality and Safety Scrutiny Group	• Oversee the implementation of a systematic and consistent approach towards incident reporting and associated risk issues • Discuss and review incidents, claims and complaints and review data within the monthly Quality & Safety report
Service Leads/Managers	• Monitor incident reporting and associated risk issues across all areas within their group • Monitor action plans from completed incidents and subsequent clinical audits to ensure changes are implemented to current practice
Quality & Safety Team	• Monitor incidents on Datix and action and escalate in line with this policy • Escalate any areas of non-compliance with the process outlined in this policy to the relevant manager • Allocate Root Cause Analysis (RCA) Lead Investigators and monitor compliance with submission dates
Head of Quality & Governance	• Update this policy as necessary for approval by the Quality and Safety Steering Group • Lead responsibility for the day-to-day implementation of this policy • Co-ordinate risk and safety management within the Trust including investigation of incidents • Lead for risk management within the Trust and responsible for the provision of clinical risk management advice, guidance and support
Clinical Directors	• Ensure appropriate and robust systems, processes and procedures are in place for incident reporting and associated risk issues for all areas within their group • Oversee the completion of reports, audits and subsequent action plans in respect of incidents • Lead discussions on reports, audits and data received at Group Quality and Safety Groups • Provide updates on incidents reported and associated risk issues within their Group to the Quality and Safety Steering Group

Title	Responsibilities
Service Managers	• Ensure they are familiar with this policy and adhere to the procedures referred to • Ensure staff attend training applicable to their role and implement the guidance across their areas of responsibility • Ensure all incidents are reported promptly • Investigation and monitoring of incidents associated with their services/teams • Approval of incident reports, including 72-hour and RCA reports as required • Implementation and monitoring of action plans resulting from incidents
All staff	• Respond to the immediate needs of the patient and/or others, including colleagues, in the event of an incident and to re- establish a safe environment • Ensure incidents are reported as soon as possible to allow managers to act swiftly and appropriately • Clearly document all actions taken following an incident to minimise the risk of future occurrences • Act only within their professional capacity and remit at all times whilst undertaking duties for the Trust

APPENDIX 2: Glossary

Incident	Any event or circumstance arising from or during Trust activities that could have or did lead to, unintended or unexpected harm, injury, distress, loss or damage to a person or property. This includes suspected suicides or homicides (both victim and assailant) involving current patients of the Trust and of individuals who were patients of the Trust within the 6 months prior to their death
Near Miss	An unplanned event or circumstance which has the potential to result in injury/harm to a person and or damage to property but was avoided
DATIX	Name of the Trust's electronic Incident Reporting System
Serious Incident	'Events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisation are so significant, that they warrant using additional resource to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare' (NHS Serious Incident Framework, 2015)
Staff Members	All staff employed by the Trust which includes allied health professionals, contractors, visitors, temporary workers, bank and agency staff, secondments and any other individuals providing services on behalf of the Trust

Duty of Candour	The Legal duty for Trust to be open and transparent with patients and/or their representatives in relation to care and treatment. The Health and Social Care 2008 (Regulated Activities) Regulation 2014: Regulation 20 sets out the legal requirements for Trusts to provide an appropriate notification, apology, support and information when incidents have occurred during healthcare that have caused harm
Patient Safety Incident	Any incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in harm
Personal Identifiable Data (PID)	Any data that can be used to identify an individual, for example, names, NHS numbers, date of birth, address etc.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).	The regulation provides a requirement for certain incidents to be reported to the Health and Safety Executive to ensure that "risks to people's health and safety from work activities are properly controlled.
Strategic Executive Information System (StEIS)	A system which enables electronic logging, tracking and reporting of Serious Incidents between Trusts and Commissioners
National Reporting and Learning System (NRLS)	A national system which collects, reviews, analyses and feeds back data, learning, and action relating to patient safety incidents and risks
72-hour incident assurance report (IAR)	An information gathering tool used to provide further information on an incident after the initial report has been made. This is used to provide assurances of the immediate actions taken following an incident to make the situation safe and identify any initial thoughts of factors that may have caused the incident, and any lessons that can be learnt
Root Cause Analysis (RCA)	A set of investigative techniques used by NHS Trusts to uncover the underlying, or 'root' cause(s) for an incident occurring to identify areas of learning that may prevent the incident from reoccurring.

APPENDIX 3: Equality Impact Statement

DIHC is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available upon request. If you require this policy in a different format e.g., larger print, Braille, different languages or audio tape, please contact the HR Team or the Equality and Diversity lead.

APPENDIX 4: Sustainability Impact Statement

DIHC is committed to ensuring that the way we provide services is responsible and minimises the impact on the environment e.g., zero waste to landfill, recycling and reuse percentages, commuting and starts to support the reporting of the Trust's annual carbon footprint and progress against Climate Change Act and NHS targets, and on progress against the Green Government Commitments and carbon reduction targets where applicable.

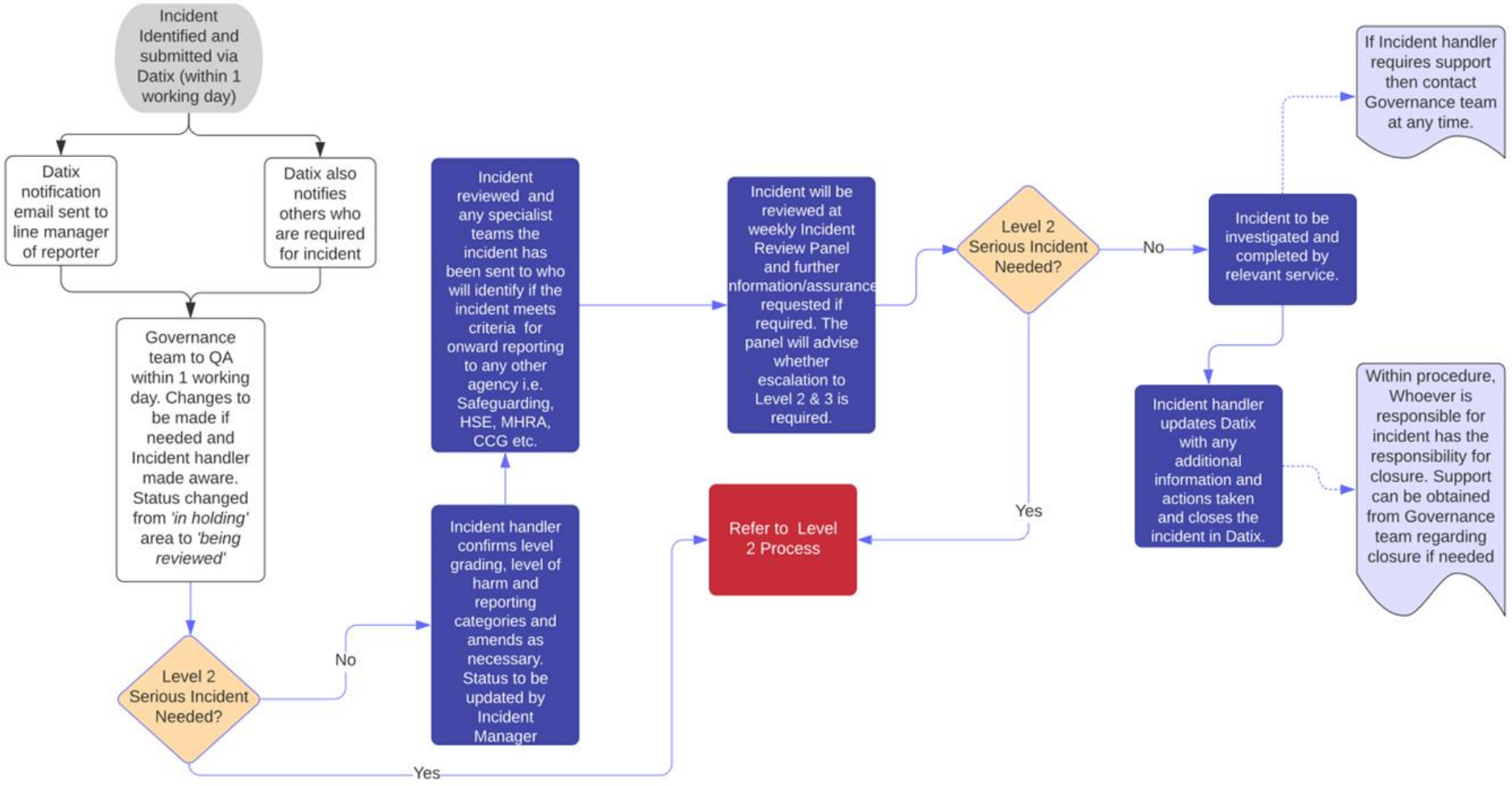
APPENDIX 5: Data Protection and Freedom of Information Statement

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g., use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

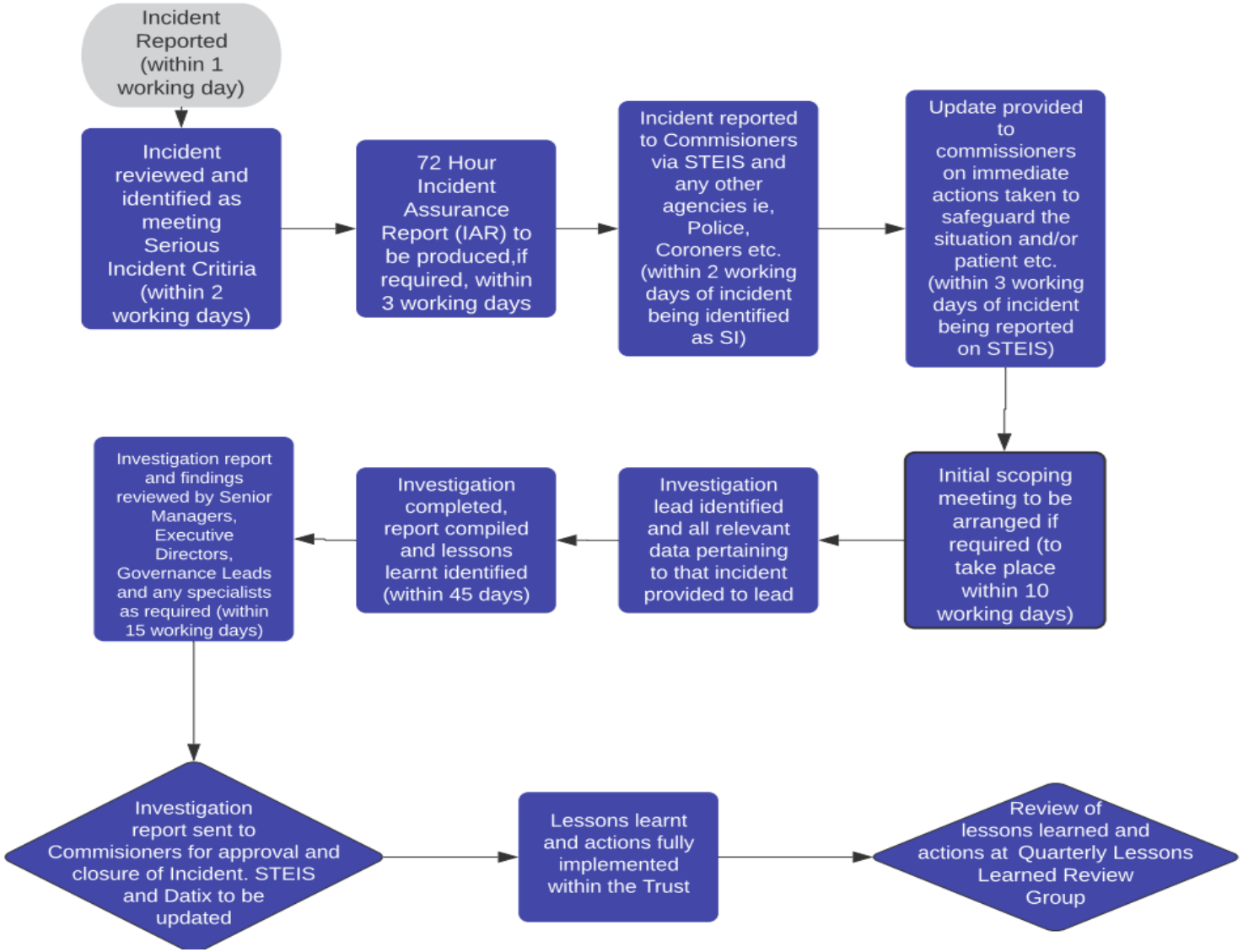
APPENDIX 6: Monitoring effectiveness of this policy

Incidents Management – Monitoring Framework		
Auditable standard / KPI	**Frequency / Method / Person Responsible**	**Where results and any associated action plan will be reported to and monitored**
Incident reporting and management	Monthly - Governance Assurance Unit will review progress of all moderate and above graded incidents. All incidents are managed locally by Quality and Safety team and escalated to Group Head Nurse	Monthly Group Assurance Reports
How all incidents and near misses involving staff, patients and others are reported	Quality and Safety Team will review progress of all moderate and above graded incidents. All incidents are managed locally by Quality and Safety Team	Monthly Group Assurance Reports
How the organisation reports incidents to external agencies	Monthly - Local Clinical Quality Review Meetings with commissioners	Minutes of Clinical Quality Review Meetings

APPENDIX 7: Standard Operating Process 1 – Reviewing and Investigating an Incident



APPENDIX 8: Standard Operating Process 2 – Investigating a Serious Incident (SI) Level 3



APPENDIX 9: Amendment history

Version	Date approved	Approved by	Date issued	Summary of change
1.0	28/01/2022	PPDG	28/03/2022	New Document for DIHC (formerly DWMHT)