

An Organisation-wide Policy for the Management of Incidents

Including the Management of Serious Untoward Incidents

To be used in conjunction with associated policies listed within this policy

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Contents

Section		Page
1	Introduction	5
2	Purpose	5
2.1	Fair Blame Philosophy	5
2.2	Aims and objectives of the policy	6
3	Definitions	7
4	Duties	8
4.1	Role of affected/involved staff member/ person in charge at time of incident	8
4.2	Role of line manager/ senior manager	9
4.3	Role of risk manager/equivalent	9
4.4	Role of nominated director(s)	10
4.5	Role of chief executive	10
4.6	Role of the board	10
4.7	Role of the committee with overarching responsibility for risk management	10
4.8	Role of any other committees/groups with responsibilities for incident management	11
4.9	Role of Head of Communications/ Trust Communication Department	11
5	Reportable incidents and reporting processes	11
5.1	Reportable incidents	11
5.1.1	Incidents relating to breach of confidentiality and data loss	12
5.2	Reporting all incidents	13
5.3	Reporting SUIs	13
5.3.1	Reporting SUIs – Arrangements during office hours	14
5.3.2	Reporting SUIs – Arrangements out of hours	14
6	Communication and Notification processes for all incidents	14

6.1	Patient/relative/visitor/contractor communication & support	14
6.2	Communication with staff	15
6.3	Internal communication	15
6.4	External stakeholder notification and/or involvement	15
6.5	Media involvement	16
6.6	Principle of confidentiality and data protection	16
7	Incident Investigation	16
7.1	Incident grading and appropriate levels of investigations	16
7.2	Responsibility for investigation	17
7.3	Root cause analysis	17
7.4	Recommendations and action planning	17
7.5	Monitoring of action plans	17
7.6	Process of ensuring continual risk reduction following the implementation of action plans	17
7.7	Sharing of lessons learnt	17
8	Incident & Causal Factor Analysis	18
8.1	Responsibility for incident analysis	18
8.2	Responsibility for causal factor analysis post investigation	18
9	Hotline Arrangements	18
10	Process for monitoring the effectiveness of Policy	18
11	Dissemination, implementation and access to this policy	19
11.1	Dissemination and access	19
11.2	Implementation and training	19
12	Review, updating and archiving of this document	19
13	Policy Development	19
14	References	20

Tables

Table 1	Grid for assessing breach of confidentiality or data loss incidents	12
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Appendices

Appendix A	Incident reporting forms	21
Appendix A1	IR1 Form	21
Appendix A2	Medication incident report form	23
Appendix B	Guidance notes for completing the incident forms	25
Appendix B1	Guidance note for IR1 form	25
Appendix B2	Guidance note for medication incident form	26
Appendix C	Incident reporting procedure and flow chart	28
Appendix D	Risk Matrix – Decision Support Tool for Risk Analysis	29
Appendix E	List of reportable incidents (including those which will be deemed serious)	32
Appendix F	RIDDOR Guidelines and RIDDOR Reportable Incidents	34
Appendix G	List of internal and external stakeholders	37
Appendix H	List of associated document and policies	38
Appendix I	Checklist for the review and approval of procedural document	39
Appendix J	Plan for consultation and dissemination of procedural documents	42
Appendix K	Equality impact assessment tool	44
Appendix L	Version control sheet	46

1 Introduction

The PCT places high value on the importance of establishing a safety culture within the organisation; a reporting culture, which appreciates the significance of effective incident management. Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly managed, they may result in a loss of public confidence in the organisation and a loss of assets.

Reporting of incidents is more likely to take place in an organisation where there is a well developed safety culture and where there is strong leadership. The chief executive and directors (including the non executives) have made their support for patient and staff safety transparent by their actions and it is clearly understood throughout the organisation that it is unacceptable to reach other objectives at the expense of safety.

The PCT has a legal responsibility to report SUI's, adverse incidents and near misses, to monitor and investigate immediate and underlying causes of accidents and incidents to staff, patients and visitors and to report their findings and learn from them. The PCT will take corrective action to ensure the health, safety and wellbeing of its employees, patients, contractors and any other persons affected by its services. Additionally, the requirements associated with Controls Assurance, Clinical Governance, the NHS Litigation Authority Scheme for Trusts, Health Care Commission Investigations, NPSA, COSHH and RIDDOR standards require reporting, recording and monitoring systems to be in place.

The PCT has a **common reporting** system, **report form** and a centrally maintained database for **all** types of incidents (clinical and non-clinical). Reporting of all incidents and near misses, regardless of severity, is **mandatory**.

This policy should be read in conjunction with the Major Incident Plan and other associated policies as appropriate.

2 Purpose

The organisation intends to ensure that all incidents, whether they have caused actual harm, or were a near miss, are reported by staff in a timely manner. The PCT will appropriately manage and investigate incidents, based on their severity, and to ultimately learn and make changes as a result of incidents, complaints and claims in order to improve safety, for patients, staff, visitors and contractors, and the services which we commission. Qualitative and quantitative data analysis will be used to highlight any trends which may be occurring and uncover any further need for intervention.

2.1 'Fair Blame' Philosophy

The PCT is committed to being honest and open in the way it conducts its business and encourages staff to be similarly honest and open in promptly reporting incidents.

Although an incident may have been directly caused by an individual, the PCT recognises that the genuine mistakes and errors of judgement which are made from time to time are likely to be due to a multiplicity of factors and system failures. A detailed, sensitive enquiry, carrying out a **root cause analysis** will look at contributory factors and underlying causes, which may have compounded the situation as deemed appropriate for the adverse incident.

The 'Fair Blame' philosophy promotes a culture that as far as is reasonable ensures that staff, who report their genuine mistakes promptly, are not subsequently punished for doing so. Exceptions to this will be where reporting is inappropriately delayed or misleading, or where there is personal or professional misconduct or gross negligence or if there was malicious intent. The NPSAs *Incident Decision Tree* is tool that will be used as an aid to determine course of action following an adverse incident and the Trust disciplinary policy may be consulted if required.

The PCT encourages staff to report concerns about services or individuals; where staff feel unable to do this in the usual way, **the whistle blowing policy** can be used.

The National Patient Safety Agency (NPSA) Seven Steps to Patient Safety (April 2004) is a key tool in building a safety culture and is referenced in this document.

All other relevant organisations to Hounslow PCT including commissioned services, social services departments and private sector providers are required to adhere to this Organisation wide policy for the management of incidents including serious untoward incidents and its associated policies.

Above all the PCT wishes to prevent incidents occurring and to learn where errors may occur

2.2 Aims and Objectives of the Policy are:

- To ensure that systems are in place to protect the safety and wellbeing of staff, patients and visitors against all forms of hazards.
- To meet the statutory requirements for reporting incidents, accidents and disease under RIDDOR to the Health and Safety Executive, COSHH, NPSA, and NHS London
- To comply with directions to NHS bodies on measures to deal with violence against NHS staff (Secretary of State Directions, sections 16d, 17 and 126(4) of the NHS Act 1977 & 1983
- To improve patient outcomes and quality of care in clinical organisations, situations through investigation and audit of incidents and near misses, education of staff and the updating of protocols and guidelines.
- To establish early identification and notification of incidents so that any adverse effects resulting from the incident can be addressed promptly by a senior member of staff.
- To gather and record timely, accurate information on incidents in order to facilitate a quick response to complaints and to enable a claim to be defended in cases of litigation.

- To record information on incidents on the Datix database, and by analysing this data, monitor performance and trends across the Trust and benchmark against other trusts and national standards.

The above process will be monitored by the Integrated Governance Committee or in the near future for Provided Services by the Clinical Governance and Risk Management Committee which will report quarterly to the appropriate PCT Board.

3 Definitions

Definitions of some terms used within the context of this document are as follows:

- **An incident** is defined as *“any event, which has given or may give rise to actual or possible personal injury, to patient dissatisfaction or to property loss or damage”*. This definition covers all areas including patient or client injury, fire, theft, assault, employee accident & complaints.
- **A clinical incident** can be defined as *“any incident directly related to patient treatment or care, which did or could have resulted in an adverse outcome (e.g. treatment error, medical equipment failure, medication error)”* or ‘An event or omission arising during clinical care and causing physical or psychological injury to a patient’ (DOH, 2000).
- **A Serious Untoward Incident** is *in general terms something out of the ordinary or unexpected with the potential to cause serious harm, and/or likely to attract public or media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service (NHS London, 2007)*. This guidance is available from the Quality and Healthcare Transformation team or the Organisational Risk Manager for reference if required. The types of incidents to be reported to the Strategic Health Authority (SHA) as SUI’s is appended to this policy.
- **Patient safety incident** is *‘any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare. This is also referred to as an adverse event/incident or clinical error and includes near misses’ (NPSA 2004).*
- **Patient safety** is *‘the process by which an organisation makes patient care safer. This should involve risk assessment; the identification & management of patient related risks; the reporting & analysis of incidents; and the capacity to learn from and follow up on incidents and implement solutions to minimise the risk of them recurring’ (NPSA 2004).*
- **Root cause analysis (RCA)** is a technique to explore the root cause of incidents and to improve safety by learning lessons and taking action following incidents.

4 Duties

Below is a detailed overview of the individual and departmental roles and levels of responsibility for incident management within the organisation including: the board, trust committees/groups and also individuals such as the chief executive, directors, managers and all staff.

4.1 Role of affected/involved staff member

Any staff member involved in an incident or who becomes aware of an incident should report this immediately or as soon as is reasonably practicable to the immediate line manager and then centrally to the organisational risk manager using the relevant incident reporting forms. It is important that the incident is graded and any immediate actions taken documented. Relevant forms and guidance on how to do this are appended to this policy.

Any PCT employee who is involved in or becomes aware of an incident is responsible for:

- Taking any necessary **immediate** emergency action. This may include stopping the procedure or medication, stabilising the patient or calling the resus team.
- Informing the person in charge of the department at the time (by **direct personal** contact with them or by telephone), if the incident is serious, affects staffing, running of the service or falls within or likely to fall within the SUI category.
- Filling in the Incident Record (IR1 form) using the guidance notes on the pad and the flow chart appended to this policy. A contemporaneous (at the time) record of the incident must be made and kept securely. This must include the time, date of incident and legible signed statements and sequence of events.

The person in charge of the department team at the time is responsible for:

- Grading and assessing the seriousness of the incident and the level of response and action required. If an SUI, the SUI process is activated.
- Providing all necessary assistance in dealing with the immediate situation and ensuring remedial action is taken.
- This may include the following:
 - Making the area safe e.g., preventing staff/patient entry, ventilate area.
 - Wear protective clothing.
 - Remove similar items of equipment involved.
 - Changing any clinical procedures.
- **Immediately** informing the Director on Call of all serious and potential serious untoward incidents.
- Ensuring that relevant information is filled in on the IR1 form.
- Sending the pink copy of the IR1 form to the organisational risk manager in a sealed envelope marked private and confidential and passing the remaining two copies (blue and white) to the departmental manager or acting manager or senior clinician for investigation same day or as soon as possible.

4.2 Role of line manager/ senior manager

The departmental manager or service head is responsible for:

- Commencing an immediate investigation (where the incident is an SUI, a Root Cause Analysis must be carried out)
- Dealing with ongoing issues from the incident and ensuring that all necessary action has been taken.
- Ensuring IR1 form is accurately completed and filling in their response.
- Passing the blue copy of the IR1 form to the Organisational Risk Manager once investigation is completed and retaining the white copy in the department.
- Monitoring incidents within his/her own department.
- Ensuring that feed back and learning outcomes are communicated to staff.
- Ensuring that staff within their department are trained in incident reporting and use of appropriate forms as well as local implementation of the incident system.

If serious incident or SUI,

- Liaising with relevant clinical staff who have clinical, supervisory or managerial responsibility
- Within 3 working days a three Day Report to be completed and within 60 working days final report with a root cause analysis. See Trust policy on Investigation of incidents, complaints and claims for guidance on RCA technique.
- Suspension of a member of staff for gross misconduct if necessary, in consultation with HR. In all cases, it is essential that the NPSAs *Incident Decision Tree (IDT)* should be used to determine appropriate course of action for staff involved in an adverse incident. Refer to the trust policy on investigation incidents, complaints and claims for further guidance on use of the IDT.
- Establishing all the facts by questioning staff/patients/relatives; requesting further information from other sources/departments.
- Ensuring that all-immediate corrective action has been taken.
- Keeping relevant consultant staff with clinical, supervisory or managerial responsibility informed if appropriate.
- Ensuring the incident is re-graded after review or root cause analysis if necessary
- Giving feedback to the staff/patients/relatives as appropriate following guidance in the Trusts *Being Open* policy. Any information given to staff, patients, relatives or public must be copied and documented.
- Completing section E to K of the IR1 form when appropriate
- Providing updated information to the Risk Manager when appropriate e.g. lost time information and liaising with them to ensure that the incident is dealt with efficiently and effectively.
- Ensuring that each site has a site safety supervisor and a site fire marshall.

4.3 Role of risk manager/equivalent

The Organisational Risk Manager is responsible for

- Data analysis and for providing reports to the Board and

- Reporting SUI's via STEIS after consultation with the Director of Quality and Healthcare Transformation or the appropriate lead director for Provided Services once Arms Length.
- Responsible for auditing the reporting system and periodically reviewing and advising on updates to the policy.

4.4 Role of nominated director(s) including the non executive directors.

Director of Quality & Healthcare Transformation

- Lead for clinical and non-clinical risk management in the organisation.
- Responsible for signing off an incident as SUI before reporting to the SHA via STEIS.
- Approves involvement of external stakeholders as appropriate.

Director of Public Health

- Lead for outbreak of an infectious disease or contamination incident and lead for emergency planning and major incident plan.

Director of Procurement

- Lead for incidents occurring to patients whom we commission care.

Director of Finance

- Lead for Financial risk and the reporting of fraud.

Associate Director of Corporate Affairs

- Lead for Media enquiries and engagement of legal support and corporate governance

4.5 Role of chief executive

The chief executive is the accountable officer and as such will be informed of all SUIs with regard to patient and staff safety, and reiterates the non-punitive stance of the PCT

The Chief Executive must also be made aware of all SUIs involving gross breaches of health & safety, children, fatalities and any event likely to attract media interest..

4.6 Role of board

The PCT board will receive a quarterly anonymised incident report, giving details of numbers of incidents of all types, trends, progress and lessons learnt.

The PCT Board may also discuss SUI's in Part II of the Board for fuller discussion.

4.7 Role of committee with the overarching responsibility for risk management

The Integrated Governance Committee has overarching responsibility for risk management, delegated by the Board.

- The committee's role is to ensure actions are taken as a result of trend analysis, and the cascading of information throughout the organisation.
- Responsibility for monitoring the completion of the action plans and the subsequent effectiveness of any risk reduction measures introduced are included within this remit.

This is reflected in the Terms of Reference (TOR) for this committee which is reviewed annually and is available on request. The APO Clinical Governance and Risk Management Committee may in the near future take over this role for the provided services.

4.8 Role of other committees/groups with responsibilities for incident management

Other groups/committees in the trust that may have a role in the management of incidents includes the Learning & Development group, Health and Safety committee, Infection Control Committee and Provider services Clinical Governance groups. Departments may have other locally based groups, which are responsible for ensuring the lessons learnt organisationally are introduced in the service areas/departments.

4.9 Role of the Head of Communications/ Trust Communication Department

- Responsible for leading and responding to any press or media enquiries
- Where incident is likely to result in adverse media coverage, the trusts communication department should contact the SHA's communication team to agree a strategy for handling the media.

5 Reportable incidents and Reporting processes

Whenever an incident occurs, it is important that staff should act immediately in accordance with processes laid out in this policy. A flow chart of the reporting processes is appended to this policy.

5.1 Reportable Incidents

A reportable incident is an event that contains one or more of the following components

- It is contrary to the specified or expected standard of patients care or services
- It places patient, staff members, visitors, contractors at unnecessary risks
- It puts the trust in an adverse legal or media position with potential loss of reputation
- It puts trusts property or assets in an adverse position or at risk of loss or damage

A further list of reportable incidents, SUI reportable incidents and RIDDOR reportable incidents are appended to this policy.

5.1.1 Incidents relating to breach of confidentiality and data loss.

All incidents relating to actual or potential breaches of confidentiality involving person identifiable data that could lead to identity fraud or have other significant impact on individuals, including actual or potential data loss should be reported immediately to a senior member of staff.

The incident should be risk assessed using the grid below to determine its severity. All incidents rated between 1-5 should be reported as an SUI through the trusts SUI process.

Table 1 – Grid for assessing breach of confidentiality or data loss incidents

0	1	2	3	4	5
No significant reflection on any individual or body. Media interest unlikely	Damage to an individual's reputation. Possible media interest e.g. celebrity involved	Damage to a team's reputation. Some local media interest that may not go public	Damage to a services reputation, low key local media coverage	Damage to an organisations reputation/ local media coverage	Damage to NHS reputation/ National media coverage.
Minor breach of confidentiality. Only a single individual affected.	Potential serious breach. Less than 5 people affected or risk assessed as low, e.g. files were encrypted	Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. up to 100 people affected	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

Note1: any incident involving the cervical screening programme should be reported to the London Quality Assurance Reference Centre, and individuals should adhere to the guidelines in the NHS CSP publication No 11 “ Guidelines for Managing Incidents in the Cervical Screening programme”, November 1999.

Note 2: any incident that relates to the contracting of an infection should be regarded as a serious untoward incident and should be subject to a root cause analysis investigation.

Please remember: - the more incidents we report on, the safer an organisation we are.

5.2 Reporting all incidents

After an incident, staff are required to completed an incident form.

The Trust uses two types of form for the reporting and recording of information about all incidents.

5.2.1 The first type, IR1 form is in two parts;

- The first part of the form, sections A to D is completed for all incidents, including SUIs.
- The second part of the form, sections E to K, is completed following an investigation of the incident, by the manager as appropriate.
- Each IR1 form is in triplicate, a pink, blue and white copy.

All departments and centres should have an Incident Recording and Information System (IRIS) pad of number controlled IR1 forms.

A separate form should be filled in for each person directly affected by the incident. Guidance on completing the forms is appended. Guidance is also included in the IRIS pad.

Once filled in for each person affected by the incident, the pink copy is sent onwards to the Organisational risk manager by the person reporting the incident while the blue and white copies of the form is to be reviewed and signed by the line manager who will follow up any required action to ensure the incident or near miss does not occur again. The line Manager or Investigating Officer is required to undertake a Root Cause Analysis (RCA) of the incident where indicated, following the NPSA guidance using an appropriate tool. Guidance on conducting a RCA should be sought from the Organisational Risk Manager if the manager is not trained in using the technique. Further guidance on investigation and use of the RCA is contained in the trust policy on investigation of incidents, complaints and claims.

Once the investigation is completed, the manager should then send the completed blue copy of the IR1 form and any other associated documents to the Organisational Risk Manager who can be contacted on Phone: 020 8630 1072 or Fax: 020 8630 1035 whilst retaining the white copy in the department or service.

5.2.2 The second type is the PCT Medication Incident Report Form: this should be used for reporting all incidents involving medications. Guidance on completing this form is also appended.

5.3 Reporting SUIs

Where an incident is suspected to be an SUI, staff are required to act immediately and inform the organisational risk manager by phone. If it is not clear if incident is an SUI, this should be discussed immediately with the Director of Quality and Healthcare Transformation or the Organisational Risk Manager during office hours who will clarify the situation.

5.3.1 Reporting SUIs – Arrangements during office hours

- Suspected SUIs should be reported immediately to a senior member of staff who will contact the Organisational Risk Manager or directly if no senior staff available.
- Organisational Risk Manager will liaise with the Director of Quality and Healthcare Transformation (lead director) to confirm if SUI.
- Once confirmed, the Organisational Risk Manager will report to the SHA within 24 hours.
- Reporting will be done using the Department of Health's online STEIS system and follow up call is made by the risk manager
- Relevant internal stakeholders such as the Chief Executive, AD Corporate Governance or AD Communications are notified of event by the lead director.
- An initial report is submitted to the SHA 3 days after the event by the Risk Manager
- The final investigation report is submitted within 60 working days from date of incident.
- SUIs should not be reported to the SHA without the approval of the Director of Quality and Healthcare Transformation or other nominated director if unavailable.

5.3.2 Reporting SUIs – Arrangements out of hours

- Suspected SUIs should be reported to the Director on call. There is a single pager number for 'on call'.

Dial **08700 555500**, ask for pager number **865544**, then dictate your message – give your name, brief details of incident and location.

- The on call director may need to confer with the lead director for risk to confirm incident is an SUI.
- The on call director will oversee any immediate actions that need to be taken regarding patient care if applicable.
- Relevant internal stakeholders such as the Chief Executive, AD Corporate Governance or AD Communications are notified of event by the on call director/ lead director the next day.
- The organisational risk manager reports SUI to SHA within 24 hours after approval from lead director using the STEIS system.
- An initial report is submitted to the SHA 3 days after the event by the Risk Manager
- The final investigation report is submitted within 60 working days from date of incident.

6 Communication and Notification Processes for all incidents

6.1 Patient/relative/visitor/contractor communication & support

Communication with the patients and/or the relatives, visitors or contractors may need to be both pre and post investigation. This communication should follow the principles of 'being open' (NPSA, 2005) and the trust policy on *Being open* which staff should refer to.

Within the organisation, the Lead Director for risk management or designated manager will be responsible for all verbal/written communication with the patient, relative or any affected persons and/or their families.

Information regarding any support systems available should also be made known to patients/relatives/visitor/contractors.

6.2 Communication with Staff

Communication with staff may need to be both pre and post investigation. The trust has a duty to ensure that staff involved in a patient safety incident or other adverse incidents are well supported and potential impact of these incidents on staff are minimised.

- The line manager or other designated senior manager will be responsible for keeping staff informed of progress or outcome of investigation. It might also be necessary to interview staff as part of the investigation. This communication should take place on a regular basis and should be done in a supportive and sensitive manner. Statements from staff should be dated and signed and interviews with staff should be documented, dated and signed by all involved. Guidance on writing statements and conducting investigations is contained in the trusts policy on the investigation of incidents, complaints or claims.
- Staff should be informed of support available including access to the free counselling services available from the Dialogue Consultancy to all PCT staff.
- Staff should also be reminded that there are ways of raising concerns about practice, services, incidents and near misses or other occurrences within the trust and this can be done through the incident reporting process, identifying risks and bringing these to the attention of management for placement on the risk register, speaking directly with any manager/Director or via the PCT whistle blowing policy available on the intranet.

6.3 Internal communication

A list of those internally and externally who may need to be informed of an incident is appended.

NB: Any SUI (Initial report) must also be copied to the PCT Communications lead, who will advise the Chief Executive as necessary. PCT Communications will lead on any press /media enquiries.

6.4 External stakeholder notification and/or involvement

There may be need to notify and/or involve external stakeholders of an incident for a number of reasons. It might be that they were involved in the incident and their input is required as part of the investigation process, to facilitate learning and sharing of lessons, it might be required by legislation or they may be needed to help investigate

certain incidents which may be outside the expertise of those within the PCT. These may include contractors, neighbouring trusts, the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS), the Health & Safety Executive (HSE) if the incident is Reporting of Injuries Diseases or Dangerous Occurrences Regulations (RIDDOR) reportable, the Strategic Health Authority (NHS London) if a SUI, the Medicines and Healthcare products Regulatory Agency (MHRA), the Police or Environmental Health Agency (EHA) etc. It will be the responsibility of the appropriate Director and/or the Chief Executive to contact these agencies, and decide when their involvement may be requested.

6.5 Media Involvement

The PCT has a requirement to inform patient/staff/relatives and other persons (i.e. contractors involved in or affected by an adverse event) before the media. The trusts *Being open* policy describes how this communication should take place and who should be communicating with them. This in most cases will be the lead director or senior manager within the department or service involved in the incident.

The trusts communication department is responsible for all communication with the media and staff should not on any occasion issue statements to the press on behalf of the trust unless cleared to do so by the communications department. Recent guidance on handling SUIs involving breaches of confidentiality and where incident is likely to result in adverse media coverage admonishes the trusts communication department to contact the SHA's communication team to agree a strategy for handling the media. Where necessary, the SHA communications team will brief the Department of Health Media Centre.

6.6 Principle of confidentiality and data protection

It is essential that all staff should comply with the trusts code of practice on information sharing, confidentiality and security. The confidentiality of staff or patients should not be breached during the management of incidents and communication with internal and external stakeholders.

7 Incident investigation

An investigation should commence as soon as practicable after the event, and for an SUI, the next working day. This should be initiated by the Head of Service/Director as appropriate.

Staff should refer to the Trusts policy for the investigation of incidents, complaints and claims for detailed guidance on investigating incidents.

7.1 Incident grading and appropriate levels of investigations

Different grades of incidents will require different depths of investigation, and various levels of management may undertake them. There may be a need for re-grading the incident post investigation (higher or lower). Significant risks uncovered must be entered onto the trust risk register and local risk registers. Refer to the appended risk matrix for guidance on grading incidents. For incidents graded moderate to serious

or SUIs, staff should refer to the Trusts Being Open policy for guidance on initiating the *Being open* process and communicating with patients, families and/or carers.

7.2 Responsibility for investigation

The relevant senior manager within the department or other appointed personnel with relevant required skills will take the lead for the investigation of incidents. Staff should contact the organisational risk manager for guidance as necessary and refer to the Trusts policy for the investigation of incidents, complaints or claims for further guidance.

7.3 Root Cause Analysis

This should be undertaken for all SUIs and serious incidents as appropriate by the lead manager for the affected service and with an RCA trained PCT staff member using the NPSA RCA toolkit. Refer to the Trusts policy for the investigation of incidents, complaints and claims for further guidance.

7.4 Recommendations and action planning

Recommendations are to be made post investigation, and for a detailed action plan to be produced. For all SUI's Action plans must include persons responsible, and the date for completion. Any learning from the incident investigation should be anonymised and shared with the rest of the organisation.

7.5 Monitoring of action plans

Action plans will be monitored by Directors/Heads of Service of the relevant department involved in the incident, by the Health & Safety Committee and the Integrated Governance Committee. The APO Clinical Governance and Risk Management Committee will in future also take up this role for provided services.

SUI Action plans may be provided to Part II of the PCT Board.

7.6 Process of ensuring continual risk reduction following the implementation of action plans

Any identified risk as part of managing incidents will be placed on the risk register and following any risk reductions, the PCT risk register will be reviewed quarterly to track progress in reduced severity and to ensure that risk transfer does not take place or is mitigated.

7.7 Sharing of lessons learnt

The sharing of the lessons learnt post investigation is a critical part of incident management. Lessons learnt may be shared through team briefs, quarterly incident reports, alerts, clinical governance meetings and web based folders throughout the PCT. Managers are also responsible for disseminating lessons learned to staff in their areas. For external organisations that may be involved in or affected by incidents, lessons learned should be shared through the relevant cross

organisational committees. The organisation has agreed a document, an adaptation of the NPSAs Seven Steps for Patient Safety, with West London Mental Health Trust and the London borough of Hounslow on how to deal with incidents involving the mental health of patients.

8 Incident & Causal Factor Analysis

8.1 Responsibility for incident analysis

This analysis is undertaken by the Organisational Risk Manager on a quarterly basis and report produced is disseminated to Executive Directors, Managers and all relevant members of staff, Integrated Governance Committee, Health & Safety Committee, and also the Board. This analysis should be both qualitative and quantitative in nature, and should discuss any trends that have been identified.

8.2 Responsibility for causal factor analysis post investigation

The organisation may uncover a number of causal factors during an investigation, which will undoubtedly lead to the identification of trends. For example: communication, training, equipment etc. The organisational risk manager is responsible for collating this information from all relevant incident investigations regularly and the report disseminated to relevant managers and committees.

9 Hotline Arrangements

The organisation may need to manage an incident which has affected a large number of individuals who may need, either to be contacted by, or who may need to contact, the organisation. Where it is deemed necessary to establish a hotline, the Director on call may declare it as an internal Major Incident and this should then follow arrangements as laid out in the Major Incident Plan. Staff should contact the Director on call immediately out of hours or contact the Organisational risk manager during office hours.

During office hours:

- Contact the Organisational Risk Manager immediately on 02086301072

Out of hours:

- Contact the Director on call (Brief details to be notified e.g. name, date, time and type of incident and to forward details to the Organisational Risk Manager)

Dial **08700 555500**, ask for pager number **865544**, then dictate your message – give your name, brief details of incident and location.

10 Process for monitoring the effectiveness of policy

The trust expects that the effectiveness of this policy will be monitored on a regular basis. This is included as a key performance indicator included within the PCT Risk Management Strategy.

This document will be monitored and reviewed using levels 1-3 of the NHSLA Risk Management Standards for PCT and relevant standards of Standards for Better Health.

The Organisational Risk Manager will be responsible for auditing the reporting system. The effectiveness of the reporting system will be audited on an annual basis by assessing staff awareness of the system, the quality of the information recorded and the number of incidents reported against the number expected. Quarterly reports are made to the PCT Health & Safety Committee; the Integrated Governance Committee, the Arms-Length Provider Organisation (APO) Clinical Governance and Risk Management Committee and to the PCT Board.

11 Dissemination, Implementation and Access to this Document

11.1 Dissemination and access

This document is disseminated through the Integrated Governance Committee, Health & Safety Committee, APO Clinical Governance and Risk Management Committee and other relevant committees as well as the PCT intranet and other relevant external organisations. The PCT Intranet should be the source of the most up to date version.

11.2 Implementation and Training

The requirements of this policy are also included in Corporate Induction and Mandatory Training policies.

All staff in post are trained in identifying reportable incidents, reporting them appropriately to a line manager and filling in the IR1 forms correctly. Training for new staff is incorporated into the induction programmes. Reporting incidents is now part of the PCT Mandatory Training Policy (2004 and as amended)), and attendance at Incident reporting is also mandatory.

Each Line Manager/Team Leader will receive guidance and support specific to their service, responsibilities and position in the PCT. The Service Directors, Director of Quality & Healthcare Transformation and the Health & Safety Advisor, are available to provide such advice.

Specific training/advice is available on Root Cause Analysis and staff are advised to contact the Organisational Risk Manager or Assistant Director for Quality Standards if needed.

12 Review, Updating and Archiving of this Document

The Organisational Risk Manager will be responsible for auditing the reporting system and periodically reviewing and advising on updates to the policy. Older versions of the policy will be removed from the intranet and replaced with the current version while the older version is archived by corporate affairs.

13 Policy Development

This policy was developed by the Trusts clinical governance team covering both the corporate and provided services.

- Sue Jeffers – Director of Quality & Healthcare Transformation
- Harry Clarke – Former Assistant Director Quality Standards
- Oyejumoke Okubadejo – Assistant Director Quality Standards
- Bally Virdi – Organisational Risk Manager

14 References

1. *National Patient Safety Agency (NPSA) Seven Steps to Patient Safety. The full reference guide. Available at www.npsa.nhs.uk/sevensteps April 2004*
2. *Health and Safety Executive (HSE) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), HSE Books.*
3. *NHS London, 2007, The revised NHS London Serious Untoward Incident Reporting Guidance (15th October 2007)*
4. Gateway ref: 9571, Annex B Reporting Serious Untoward Incidents (SUIs) Relating to actual or potential breaches of confidentiality involving person identifiable data (PID), including data loss., Matthew Swindells, 29 February 2008
5. NHSLA Template document for Policy for the Management of Incidents
6. *Department of Health, 2000, An organisation with a memory*

As a minimum, the following information on the form must be completed as appropriate:

- *Incident description*
- *Location of incident*
- *Name of person recording incident*
- *Name of person / persons involved directly with the incident*
- *Name and contact details of any witnesses*
- *Any equipment involved*
- *Date and time of incident*
- *Incident grade*
- *Near miss*
- *Fact not opinion*
- *Serious incidents to be reported immediately*

The Health and Safety at Work Act 1974 places responsibilities on Employees as well as Employers to take reasonable care of themselves and others. Reporting incidents forms part of that responsibility and will help to improve safety throughout the PCT. Incident reporting should not be seen as a means of management identifying breaches of policy, procedure or national guidance, rather, it should be viewed as a means of improving safety standards for all.

The timely completion of Incident Report forms (IR1s) in the workplace is essential. Failure to complete and submit a report could result in repeats thereof, increases in injury severity, probability rates and costs to the organisation. In a recent comparison of Trusts of similar size, geographical spread and service provision, it is evident that there is a significant degree of under reporting of incidents in the PCT. A high volume of reported incidents does not in general terms detract from the services delivered by an organisation. Instead, it shows that there is a willingness to identify problems and accept that standards should be constantly under review.

Please take time to complete form IR1 after any incident. In doing so you will be contributing to the positive safety culture that the CEO and Chairman want to engender throughout the PCT, helping to identify the areas of concern, and create a safer environment for all.

A2. HPCT Medications Incident Reporting form

Hounslow Primary Care Trust

MEDICATION INCIDENT REPORT FORM

Base:	Team Number:
-------	--------------

Patient's Name:

Computer number:

Address:

Date of Birth:

or Age years

G.P.

Type of error:

Wrong medication

Wrong dosage

Wrong patient

Wrong time

Wrong route

Omission

Other (please describe)

Reason for error:

Incomplete / confusing prescription

Misread prescription (including dose)

Misread medication label

Miscalculated dose

Failed to check identity

Forgot to give medication

Other (please describe)

Description of the incident (to be completed by the investigating manager)

Medicine Involved:

Name and Grade of Person(s) involved:

Name and grade of person reporting incident:

Signature:

Date and time:

Appendix B - Guidance notes for completing the Incident forms.

B1. HPCT Incident form IR1

Section A to D to be completed by person reporting the incident.

Section A. *If the incident relates to more than one of the categories, tick more than one box. For example: If a patient is abusive and complains about their treatment, tick both the 'Violence, Abuse or Harassment' box, AND the 'Informal Complaint' box.*

Section B. *For 'Site', please enter the NHS site that the incident occurred at. If the incident occurred elsewhere, please state where, for example: Patient's Home etc.*

For 'Location Type' please state the form of the location, for example: GP's Office, Treatment Room, Ward, Corridor, Stairway, Trust Car Park, Public Car Park, etc.

Section C. *The individual affected by the incident is the person who suffers, or potentially suffers, injury, ill health, or loss, including theft and any other property damage or loss. Complete separate IR1 Forms for each person involved. If the person is a patient, please state what kind, e.g.: In-Patient, Resident etc. If the person is a staff member, simply state Staff and fill in the details in the following boxes. Ethnicity Codes as follows.*

Ethnicity Code	Description
01	White British
02	White Irish
03	White Other White
04	Mixed White and Black Caribbean
05	Mixed White and Black African
06	Mixed White and Asian
07	Other Mixed
08	Indian

Section D. *Please complete this section as clearly as possible. Give a summary of the key events and people. If you are reporting a near miss, please tick the box provided and give details.*

If detailing injuries, include the side of the body (where applicable), the part of the body affected, and the nature of the injury. For example: Right forearm bruised etc. Continue on a separate sheet if necessary. Include ALL the relevant parties informed, stating both names and job titles.

The Following Sections are to be Completed by a Manager

Section E. *Give the name of the chief investigator and include a contact number if not in the Hounslow PCT Telephone Directory.*

Section F. *The purpose of this section is to ascertain the underlying causes of each incident. Where human error has been a factor, please explain accordingly. Moreover, please include any details that could have led to that error: for example, if a mistake has been made due to stress, or an excessive workload, we would like to know.*

Completion of an IR1 form does not constitute an admission of liability of any kind on any person

*The information collected will be entered into a database which will be used to assess general trends and problems that can be tackled, or highlight procedures that can be improved, **not** to lay blame on individual parties. The more incidents that are reported, the more effective and beneficial the response will be.*

Section G. *Please detail any remedial action taken, no matter how small.*

Section H. *Specify the time absent from work in both total days and total hours. If six eight hour shifts have been missed, state 48 in the hour's box.*

Section I. *See Appendix F to clarify what Incidents are RIDDOR reportable.*

Section J. *Assess and evaluate the risk. A simple approach to quantifying risk is to define qualitative measures of consequences and likelihood. This allows construction of a risk matrix which can be used as the basis of identifying acceptable and unacceptable risk. See Appendix D - Risk Matrix, for further guidance.*

Section K. *The manager who has completed sections E. – K. of the form should sign here and include a contact telephone number.*

B2. HPCT Medication Incidents Report Form

Medicines incidents may occur for a variety of reasons. As part of the PCTs' policy on providing high quality care and managing risk, it is essential that all medicines incidents are reported.

The accurate reporting of incidents will aid the detection of patterns or types of errors to which their may be an easy solution. An annual report of incidents will be prepared for the PCT Board.

The person identifying the incident should:

1. Immediately report it to a senior member of staff (if appropriate).

The senior member of staff should:

2. Identify the nature of the incident.
3. Identify possible adverse effects.
4. Take all immediate action necessary to ensure the patient's safety is maintained.
5. Complete a PCT medication incident report form and forward to the Team Leader within 24 hours.

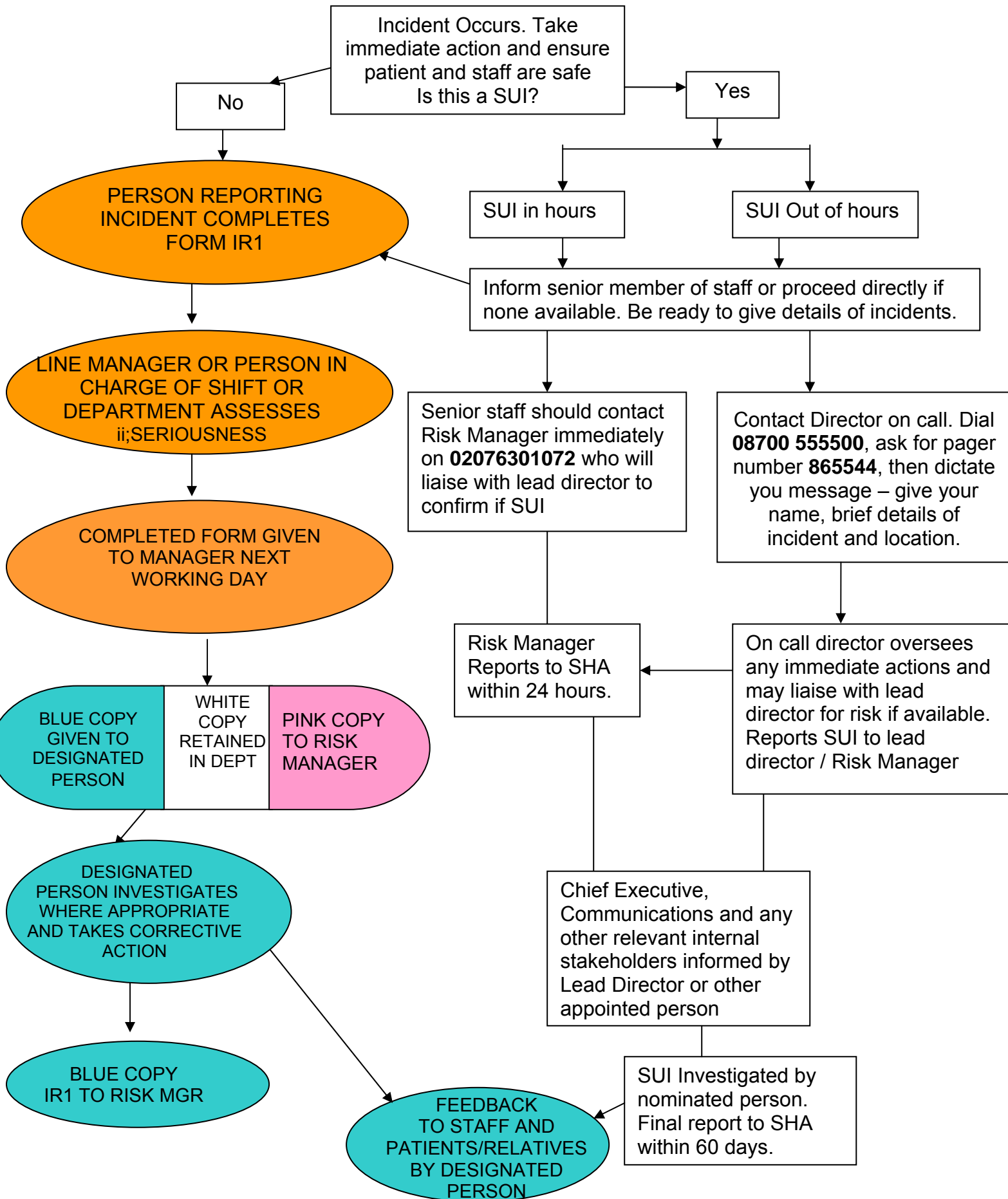
This will include

- ◇ A description of the incident.
- ◇ Details of the medicine involved.
- ◇ The name and grade of person(s) involved in the incident.
- ◇ The name and grade of person reporting the incident including date and time.
- ◇ Details of corrective action taken including medical orders, observations, specific antidotes etc.
- ◇ Name of person(s) taking corrective action.
- ◇ Name and grade of team leader notified.
- ◇ Name of doctor notified.
- ◇ Name of PCT Pharmacist notified
- ◇ Name of the Lead Nurse notified
- ◇ If patient was informed of incident and by whom.
- ◇ If the patient was not informed the name of carer or relative notified and relationship to the patient.

6. The Team Leader will investigate the incident further (if appropriate) and report to the Service Manager.

7. The Service Manager will report to the PCT Risk Manager.

Appendix C - Incident reporting Procedure & flow chart



Appendix D - Risk matrix - Decision Support Tool for Risk Analysis

SIMPLE RISK QUANTIFICATION MATRIX

AS/NZS 4360: 1999 Risk management defines risk as “The chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood”.

<u>Risk = Consequences x likelihood</u>

A simple approach to quantifying risk is to define qualitative measures of consequences and likelihood such as the exemplars given below. This allows construction of a risk matrix which can be used as the basis of identifying acceptable and unacceptable risk.

MEASURES OF CONSEQUENCE

LEVEL	DESCRIPTION	DESCRIPTION (Not exhaustive)
1	Insignificant	No injuries. Low financial loss (<£10)
2	Minor	First-aid treatment. Moderate financial loss. (>£100) Inconvenience or minor injury requiring subsequent treatment.
3	Moderate	Medical treatment required. Moderate environmental implications. High financial loss. (>£1000) Moderate loss of reputation. Moderate business interruption. Short term disability or impairment of health (mental or physical). Potential claim for damages. Breach of legislation.
4	Major	Excessive injuries. High environmental implications. Major financial loss (>£5000). Major loss of reputation. Major business interruption. Long term disability or impairment of health (mental or physical)
5	Catastrophic	Fatalities, huge financial loss. Major environmental implications with detrimental effect.

MEASURES OF LIKELIHOOD

LEVEL	DESCRIPTION	DESCRIPTION
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time.
3	Possible	The event should occur at some time.
4	Likely	The event will occur in most circumstances
5	Certain	The event is expected to occur in most circumstances.

RISK RATING

Consequence X Likelihood

	<u>Potential Consequences</u>				
Likelihood	5 Catastrophic	4 Major	3 Moderate	2 Minor	1 Insignificant
Certain - 5	25 High	20 High	15 Significant	10 Significant	5 Moderate
Likely - 4	20 High	16 High	12 Significant	8 Moderate	4 Moderate
Possible - 3	15 High	12 Significant	9 Significant	6 Moderate	3 Low
Unlikely - 2	10 Significant	8 Significant	6 Moderate	4 Low	2 Low
Rare - 1	5 Moderate	4 Moderate	3 Low	2 Low	1 Low

RISK RATE LEGEND

High Risk	Immediate action required by a Director who must be informed immediately
Significant Risk	Urgent senior management attention required with action planned within the month
Moderate Risk	Responsibility for assessment and action planning allocated to a named individual
Low Risk	Routine risks which can be managed by routine procedures

Appendix E - List of reportable incidents (including those which will be deemed serious)

The list below are examples of what is covered by the term incident include

- Accidental injuries
- Accidents
- Ill health that is work related
- Unusual or dangerous occurrences such as fire or electrical malfunction
- Medication incidents including blood transfusion incidents
- Adverse drug reactions
- Security and incidents involving violence or damage to property, plant or people
- Equipment failure/ misuse involving both clinical and non clinical equipment and data security incidents
- Racial harassment

Physical assault:

In the event of physical assault on a member of staff the nominated Director must be :

- *Informed of the incident*
- *The police contacted immediately by the person assaulted or by an appropriate manager or colleague and that full cooperation is given to the police in any investigation*
- *The Counterfraud and Security Management Service is informed of the incident and that full cooperation is given to it in any investigation or subsequent action which it considers appropriate*
- *The details are recorded in accordance with the PCT Incident reporting procedure*
- *The victim of the assault is informed of the investigations progress and offered such support as is necessary or desirable in the circumstances.*

Non Physical Assault:

- *The nominated Director must be informed of the incident*
- *In appropriate cases assessed by reference to their nature and seriousness, the police are contacted as soon as reasonably practicable and that full cooperation is given to the police in any subsequent investigation*

[extract from Secretary of State Directions to NHS bodies on measures to deal with violence against NHS staff; NHS Act 1977]

Types of Incidents to be reported to the SHA as SUIs include:

Child: Significant harm to a child

Cluster: A number of low level incidents which aggregate to suggest a potentially more serious problem

Infection: known or suspected cases of health care associated infection and those which are deemed a significant outbreak

Look back: Infected healthcare workers /patient incidents that necessitate consideration of a look back exercise

Vulnerable adult: Significant cases involving vulnerable adults

Vulnerable child: Significant cases involving children

Serious: significant cases of a specified nature

Death: Cluster, Maternal, Unexpected, MRSA/C.Diff

Error: serious complaint; equipment (risk of injury harm or danger to the life of a patient; staff suspicion of serious error

Events: Confidentiality Criminal; Major event; Maternity; Suicide

Faulty: Equipment, Instruments, Look back, Procedures, Criminal, HSE

Death: Secure settings; service user; community setting

Events: absconsion; Homicide; admission

Data and confidentiality issues: It involves actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals.

Appendix F - RIDDOR GUIDELINES AND RIDDOR REPORTABLE INCIDENTS

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) requires the reporting of certain work-related accidents (including an act of physical violence), diseases and dangerous occurrences that are contained in the 8 schedules of the RIDDOR Regulations. Reportable incidents, where a person is off work for 3 or more days (see basic guidance below), SHALL be reported to the HSE. RIDDOR reportable incidents require an additional reporting procedure. Fatalities shall be reported within 24 hours, by the responsible person(s)

Sue Jeffers – Director of Quality and Healthcare Transformation

Tel: 0208 630 3016 email: sue.jeffers@hounslowpct.nhs.uk

Bally Viridi – Organisational Risk Manager

Tel: 0208 630 1072 email: bally.virdi@hounslowpct.nhs.uk

OVER-THREE-DAY INJURY

If there is an accident connected with work (including any act of physical violence) and your employee, or self employed person working on your premises, suffers an over-three-day injury you must notify the Organisational Risk Manager or Director of Quality & Healthcare Transformation immediately by telephone & email. An over-three-day injury is one which is not major but results in the injured person being away from work or unable to do their normal work for more than three days (including non working days, e.g weekends). This must be followed up by completing form IR1. Outside office hours you should contact the Director on call who will report to the RIDDOR Centre

INJURY INVOLVING PATIENTS , CONTRACTORS OR VISITORS

Any injury which involves a patient, contractor or visitor will be reported as an adverse incident. Any incident which involves patients, visitors or contractors being taken away from the site to Hospital for treatment is RIDDOR reportable in the same way as for staff. This applies to residents at the Mulberries, Sandbanks or the Berkely Centre.

DISEASE

If a doctor notifies you that one of your employees suffers from a reportable work-related disease, you must notify the Organisational Risk Manager and a completed disease report form (F2508A) must be sent to the enforcing authority. This is done by the PCT.-Organisational Risk Manager. A summary of the reportable diseases is given below. A full list is included in the full RIDDOR Regulations.

DANGEROUS OCCURRENCE

If something happens which does not result in a reportable injury, but which clearly could have done, then it may be a dangerous occurrence, which must be reported immediately (e.g. by telephone). A summary of dangerous occurrences is given below. Within ten days you must follow up with a completed accident report form (F2508) which is available on the RIDDOR website.

EXAMPLES OF RIDDOR REPORTABLE MAJOR INJURIES, DANGEROUS OCCURRENCES AND DISEASES

Reportable major injuries are:

- Fracture other than to fingers, thumbs or toes;
- Amputation
- Dislocation of the shoulder, hip, knee or spine;
- Loss of sight (temporary or permanent)
- Chemical or hot metal burn to the eye or penetrating injury to the eye;
- Injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- Any other injury: leading to hypothermia, heat-induced illness or unconsciousness; or
- Requiring resuscitation or admittance to hospital for more than 24 hours;
- Unconsciousness caused by asphyxia or exposure to harmful substance or biological agent;
- Acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin;
- Acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material

Reportable dangerous occurrences are:

- Collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
- Explosion, collapse or bursting of any closed vessel or associated pipework;
- Failure of any freight container in any of its load-bearing parts;
- Plant or equipment coming into contact with overhead power lines;
- Electrical short circuit or overload causing fire or explosion;
- Any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;

- Accidental release of biological agent likely to cause severe human illness;
- Failure of industrial radiography or irradiation equipment to de-energise or return to its safe after the intended exposure period;
- Malfunction of breathing apparatus while in use or during testing immediately before use;
- Collapse or partial collapse of a scaffold over five meters high, or erected near water where there could be a risk of drowning after a fall;
- Unintended collapse of any building or structure under construction, alteration or demolition where over five tonnes of material falls; a wall or floor in a place of work, or any false-work;
- Explosion or fire causing suspension of normal work for over 24 hours;
- Accidental release of any substance, which may damage health.

Reportable diseases include:

- Certain poisonings;
- Some skin diseases such as occupational dermatitis, skin cancer, chrome ulcer, oil folliculitis, acne;
- Lung diseases including: occupational asthma, farmer's lung, pneumoconiosis, asbestosis, mesothelioma;
- Infections such as: Leptospirosis, hepatitis, tuberculosis, anthrax, legionellosis and tetanus;
- Other conditions such as: occupational cancer, certain musculo-skeletal disorders,
- Decompression illness and hand-arm vibration syndrome.

If in doubt, ask the Organisational Risk Manager.

In summary:

In the event of a RIDDOR reportable incident

During office hours:

- Contact the Organisational Risk Manager immediately on 02086301072

Out of hours:

- Contact the Director on call (Brief details to be notified e.g. name, date, time and type of incident and to forward details to the Organisational Risk Manager)
- Leave a phone message for the Organisational Risk Manager
- You will be advised of the steps to take

Appendix G - List of internal and external stakeholders

This list is not exhaustive.

Internal Stakeholders

- Chief Executive
- Communications Department
- Corporate Affairs Department
- Human resources Department
- Provided services Directorate

External Stakeholders

- Other NHS Organisations
- NHS Directorate of Health and Social care
- Strategic Health Authorities
- NHS Litigation Authority
- The Police
- HM Coroner
- Social Services
- Medicines and Healthcare Products Regulatory Agency (MHRA)
- Health and Safety Executive (HSE)
- Area Child Protection Committee
- Health Protection Agencies
- Environmental Health
- Legal Advisors
- National Patient Safety Agency
- Local Representative Committees
- Medical Defence Organisations

Appendix H - List of associated document and policies

This list is not exhaustive:

- Major incident Plan
- Claims Policy
- Complaints Policy
- Whistle-blowing Policy
- Disciplinary Policy
- Medical Equipment & Devices Policy
- Medicines Management Policy
- COSHH Regulations Policy
- Display Screen Regulations Policy
- Child Protection Guidelines
- PCT Zero Tolerance Policy
- Secretary of State Security Directions
- Safeguarding Adults Policy
- Counter Fraud Policy
- Policy for the investigation of incidents, complaints and claims
- Health and Safety Policy
- Infection control Policy
- Risk Strategy and Policy
- Being Open Policy
- NHS London, SUI Reporting Guidance, October 2007
- HPCT Confidentiality and Security Code of Practice, May 2008
- Seven Steps to Safety A guide for organisations working with Mental Health Service Users in Hounslow (WLMH Trust, HPCT and London Borough of Hounslow)

Appendix I - Checklist for the Review and Approval of Procedural Document

To be completed (by author/reviewer) and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	Rationale		
	Are reasons for development of the document stated?	Yes	
3.	Development Process		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	Content		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
6.	Approval		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	Dissemination and Implementation		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	Document Control		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	Process to Monitor Compliance and Effectiveness		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	Review Date		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	Overall Responsibility for the Document		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Yes	

Individual Approval (Author/ Reviewer)

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

Name	Oyejumoke Okubadejo	Date	20 th June 2008
Signature	O.Okubadejo		

Committee Approval:

If the committee is happy to approve this document, please sign and date it and follow the Trust Committee Approval/ Ratification flowchart. If the committee has the powers to ratify on behalf of the Trust Board, then forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents. Otherwise, forward the document onto the next phase of the flow chart and await final ratification before dissemination.

Name of Committee: Integrated Governance Committee

Name of Chair		Date Approved	9 th July 2008
Signature			

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

Appendix J - Plan for Consultation and Dissemination of Procedural Documents

To be completed and attached to any document which guides practice during consultation with stakeholders and when submitted to the appropriate committee for consideration and approval.

Acknowledgement: Document modified and based on University Hospitals of Leicester NHS Trust template

Consultation Record – To be used during the consultation process with stakeholders

Title of document:	Policy for the Mangement of Incidents including SUIs		
Date finalised:	19th June 2008	Consultation/ Dissemination Lead: Print name and contact details	Oyejumoke Okubadejo
Previous document already being used?	Yes / No (Please delete as appropriate)		
If yes, in what format and where?	Electronic		
Proposed action to retrieve out-of-date copies of the document:	Replace with new version on intranet		
Groups/ Stakeholders consulted	Date circulated/ presented	Paper or Electronic	Comments
Director Quality & Healthcare Transformation	19th & 20th June 2008	Electronic	
AD Corporate Affairs	19th & 20th June 2008	Electronic	
AD Communications	19th & 20th June 2008	Electronic	
Organisational Risk Manager	19th & 20th June 2008	Electronic	
AD Human Resources	19th & 20th June 2008	Electronic	
AD Clinical Governance	19th & 20th June 2008	Electronic	

Dissemination Record - to be used once document is ratified.

Date ratified		Date due to be reviewed	
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Disseminated to: (either directly or via meetings, etc)	Format (i.e. paper or electronic)	Date Disseminated	No. of Copies Sent	Contact Details / Comments

Appendix K - Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

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

If you have identified a potential discriminatory impact of this procedural document, please refer to the HPCT Equalities Impact Assessment for a description of how to conduct a full assessment or contact Annette Tagoe, the inclusion advisor for HPCT and Hounslow Borough for advice and suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Annette Tagoe.

