Morecambe Bay

Primary Care Collaborative

Incident Investigation and Management Policy

Document Reference	POL008
Purpose	The procedures detailed in this policy provide practical guidance on how to investigate and manage incidents
Author	Federation Support
Application/Scope	Organisation-wide
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Review Date (N.B: Review dates may alter if any significant changes are made)	21/09/2024
Version	V2.3
Status	APPROVED

Morecambe Bay Primary Care Collaborative

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1. INTRODUCTION

1.1 Summary

An Incident is defined as an untoward event which causes or has the potential to cause any of the following:

- Harm to an individual including failure to protect
- Financial loss to an individual or the Organisation
- Damage to the property of an individual or the Organisation
- Loss or potential loss of personal data
- Disruption to services provided by the Organisation
- Damage to the reputation of the Organisation

This definition also encompasses all prevented incidents i.e. where none of the above occurred either by good fortune or due to the intervention of employees. These can also be referred to as "near miss" incidents.

Morecambe Bay Primary Care Collaborative (MBPCC) takes the management of incidents very seriously, and this policy outlines the approach to the investigation and Management of them.

Incident management is the reactive arm of MBPCC approach to Risk Management, where proactive management is handled through risk assessment and mitigation, incident management occurs if the risk management approach has not fully mitigated a risk, which has occurred.

Please refer to the Risk Management Policy for further details on proactive management of risk, and the management and reporting of risks.

1.2 Purpose

It is our policy to ensure that any incident be managed professionally and in line with best practice

1.3 Scope

This policy applies to all MBPCC employees and directors.

From time to time MBPCC may utilise the resources of sub-contractors to deliver contractual obligations. For avoidance of doubt, where a sub-contractor is providing care to patients, as laid out in the contracts between MBPCC and subcontractors, they are solely responsible for delivery of the regulated activity they are providing, and must ensure all their employees operate under their own policies which must meet the relevant CQC standards. MBPCC will seek assurance from all sub-contractors that suitable policies are in place, and may at their discretion request copies of any relevant policies for review and for verification. In such cases this policy document does not apply.

2. PROCEDURE

2.1 Reporting

In the event of an incident occurring employees will:

a) Complete an online incident report form or an IR1 form (see appendix) in the event of the online system being unavailable.
b) Include details of the remedial actions taken on the incident form.

c) Document, on the incident form, events from the time the incident occurs to ensure that details surrounding the incident are accurate.
d) Where a reportable incident has occurred, these should be reported through to StEIS, as primary care does not have direct access to this platform it must be carried out via the Primary Care Quality Team (see appendix 6)
e) Where the incident involves safeguarding, an alert should be raised as appropriate, please refer to the adult and child safeguarding polices for further information

2.2 Management

a) Take appropriate remedial actions at the time of the incident to prevent further harm to the patient, member of the team or to the general public.
b) Carry out incident investigations according to the severity of the event
c) Who should complete the form?

Any person who is employed by MBPCC on a permanent or temporary basis may complete an incident form. Ideally the person who was directly involved in the incident should complete the incident form as soon as possible after the event. Where this is not possible a witness or supervisor may complete the form.

2.3 Raising concerns

All team members have a right, and a duty, to raise with their employer any matters of concern they may have about health service issues associated with the organisation and delivery of care.

The MBPCC Whistle Blowing Policy and procedure should be used by any employee who wishes to express concerns about malpractice/wrongdoing, alongside the Freedom to Speak up process where appropriate.

Any related incidents should be reported in the usual way.

If an employee is aggrieved about their personal position, they should refer to the Grievance Procedure.

2.4 External Reporting

MBPCC has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Act 1974 and in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

It is also a requirement to report certain incidents to other national organisations, as outlined below:

Incident Type	Organisation	Responsible	Timing
RIDDOR reportable incidents	Health and Safety Executive (HSE)	Service/Line Manager	As appropriate, but within 10 days of the incident occurring
Medical negligence incidents	Clinical Negligence Scheme for General Practice (CNSGP)	Service Manager	See NHS Resolution process for latest details (HERE)
Medical device incidents	Medicines and Healthcare products	Service Manager	As appropriate

	Regulatory Agency (MHRA)		
Incident involving fraud or potential fraud	NHS Protect	Service Manager (in discussion with local security rep)	As appropriate
Incident involving data security	Information Commissioners Office (ICO)	Senior Information Risk Owner (SIRO) – this is included within the Data Security and Protection (DSP) Toolkit Incident reporting tool)	As appropriate (https://ico.org.uk/for-organisations/report-a-breach/)

The following process is to be followed:

- Incident is reported via MBPCC incident reporting system
- Relevant manager (as per table above) is notified of the incident
- Relevant manager (as outlined in table above) is responsible for informing the relevant agency as per external agencies own notification arrangements
- Incidents should also be reported to the CCG – see appendix 6

2.5 Process for following up action plans

Formal action plans, as a result of incidents, will not always be required. If action plans are developed they must be monitored by the service manager to ensure the actions are implemented and minimise the potential of reoccurrence.

Action plans for some incidents that would be considered severe if they were to reoccur will be reported to Board as part of the mitigation of risks, as outlined in the risk management policy by the service manager.

2.6 Fair Blame

MBPCC is committed to the fair management of incidents, and will take a fair blame approach to investigating and resolving issues and incidents. Incidents will be managed in line with the presumption that employees do not deliberately cause issues or incidents, and that systemic and process issues often lie at the heart of errors – in this way we will support our teams to work through issues and incidents without unduly blaming individuals, except where misconduct or a lack of professionalism is discovered to be a contributing factor.

2.7 Responsibilities

All employees must report any accident or incidents to their line manager or to the person in charge of the service at the time. If an incident relates directly to the performance of a colleague, team members should also consider implementing the MBPCC Whistle Blowing Policy, which is available on the Intranet/shared drive.

All employees will be expected to fully support the investigation of an incidents or near misses, and participate in delivery of any actions plans to address and prevent future occurrences.

The Chief Executive has overall responsibility for the implementation of this policy and the ultimate oversight of all incidents.

The Medical Director will be made aware of all incidents pertaining to service delivery and patient care, and will be responsible for supporting improvements to clinical quality through clinical leadership.

The Director for Governance will have oversight of the incident management approach and will share them with the board as appropriate, as well as support development of a learning culture. This would include a review of incidents for further learning and for theme identification and enabling improved patient care and safety.

Service/Line managers have the responsibility to complete the relevant forms with their team and escalate incidents as required by law/process, and for embedding any relevant learning from incidents within teams.

The Board is responsible for ensuring that appropriate systems are in place to enable the organisation to deliver its objectives in relation to this policy.

2.8 Training

All employees must complete mandatory training in line with the employee handbook and induction, within which reporting in relation to incidents and near misses are covered, employees retrain mandatory elements on an annual basis.

2.9 Learning

As a small organisation, the level of incidents will likely remain low, and so the reporting of incidents to the board as appropriate will support the process of assessing incidents for patterns and failed mitigations, by mapping outputs of incidents into the mitigation of risks, the monthly risk management process will highlight risks, mitigations and issues, as well as the quarterly board deep dive into risks management to assess issues/incidents and maintain a link between optimising front line services and an engaged board.

2.10 Duty of Candour

THE DUTY OF CANDOUR is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

MBPCC is committed to the management of incidents with this duty at the heart of any interaction with patients. We will always be open and honest with patients in handling an incident which has or may have caused significant harm. This duty does not extended to low level (actual or potential) harm, in which case it may alarm patients unnecessarily or make them feel uncomfortable with little practicable benefit. However, for all other incidents it does apply.

3. DEFINITIONS/GLOSSARY OF TERMS

Abbreviation or Term	Definition
CNSGP	Clinical Negligence Scheme for General Practice

DSP	Data Security and Protection (Toolkit)
HSE	Health and Safety Executive
ICO	Information Commissioners Office
MBPCC	Morecambe Bay Primary Care Collaborative
MHRA	Medicines and Healthcare products Regulatory Agency
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SIRO	Senior Information Risk Owner
StEIS	Strategic Executive Information System
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
RCA	Risk cause analysis

4. CONSULTATION WITH STAFF, PRACTICES AND PATIENTS

Name	Job Title	Date Consulted
Jane Jones	CCG Head of Safeguarding	27/08/2020
Louise Wilkinson	Safeguarding and Quality Practitioner	15/09/2020

5. DISSEMINATION/TRAINING PLAN

Action by	Action Required	Implementation Date
Jo Knight/Boyana Konar	Upload policy to MBPCC website	Following approval of V1.1 end Sept 2020
Jo Knight	Delete out of date copies and host current copy on Federation G Drive (supporting induction process), updating Policy tracker	Following approval of V1.1 end Sept 2020
Andrew Giles	Ensure all employees are aware of the policy and are asked to read and understand it	MBPCC Board Meeting 22/09/20
Andrew Giles	IR1 form to be added to TeamsNet	15/10/20
Liz Stedman	Upload to TeamNet	Jan 2021
Liz Stedman	Upload Policy and IR1 form to TeamNet and website	Sept 2021

6. AMENDMENT HISTORY

Version No.	Date of Issue	Section/Page changed	Description of change	Review Date
V1.0	27/07/2020	Approved Policy	New policy	27/01/2023
V1.1	20/09/2020	All	New format	27/01/2023
		1.1 Page 4	Addition of failure to protect	
		2.1d Page 4 & Appendix 6 Pages 18-21	Serious Incidents and StEIS reporting additional guidance included	
		2.4 Page 6	Reporting to the CCG included	
V2.0	22/09/2020	N/A	Approval at MBPCC Board	22/09/2023
V2.1	19/01/2021	Page 7	Additional Definitions/Glossary of Terms added	

V2.2	25/08/21	Appendix 4	Updated IR1 form in relation to medication incidents	
V.2.3	19/09/21	Various	CCG feedback regarding safeguarding links, learning, STEIS reporting and Freedom to Speak up inclusion	21/09/2024
V2.3	21/09/21	Review	Policy approved by the Board	21/09/2024

7. APPENDICES

Appendix 1: Process for Reporting a Risk

All incidents, whether clinical or non-clinical must be reported online reporting form or the manual paper form (see appendix). Employees are required to input the incident details on the form. The incident report will then be quality assured by the Service manager or senior manager designated for this purpose, who will add extra further details to the incident report.

All incidents graded red will be alerted to Chief Executive via email, who can confirm whether it is a red incident and instigate the Serious Untoward Incident policy if appropriate.

	CONSEQUENCE SCORE				
LIKELIHOOD SCORE	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 – Rare	1	2	3	4	5
2 – Unlikely	2	4	6	8	10
3 – Possible	3	6	9	12	15
4 – Likely	4	8	12	16	20
5 – Certain	5	10	15	20	25

The incident score will be graded as a colour, as shown in the grading matrix, Incident scores above 15 are graded as Red incidents and are potential Serious Untoward Incidents.

Consequence X Likelihood = Incident Score

1 – 3	Low
4 - 8	Moderate
9 – 14	Significant
15 – 25	High

Appendix 2: RIDDOR Reportable Incidents

Death or major injury

If there is an accident connected with work and: an employee or a self-employed person working on MBPCC premises is killed or suffers a major injury (including as a result of physical violence); or a member of the public is killed or taken to hospital; you must notify the Service Manager without delay.

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 any 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 requiring 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.

Over-three-day injury

If there is an accident connected with work (including an act of physical violence) and an employee, or a self-employed person working on your premises, suffers an over-three-day injury you must report it to the service manager immediately.

An over-3-day injury is one which is not "major" but results in the injured person being away from work OR unable to do their full range of their normal duties for more than three days.

Disease

If a doctor notifies you that an employee suffers from a reportable work-related disease then you must report it to the Service Manager immediately.

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 musculoskeletal disorders; decompression illness and hand-arm vibration syndrome.

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 to the Service manager.

Reportable dangerous occurrences are:

1. collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
2. explosion, collapse or bursting of any closed vessel or associated pipework;
3. failure of any freight container in any of its load-bearing parts;

4. plant or equipment coming into contact with overhead power lines;
5. electrical short circuit or overload causing fire or explosion;
6. any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;
7. accidental release of a biological agent likely to cause severe human illness;
8. failure of industrial radiography or irradiation equipment to de-energise or return to its safe position after the intended exposure period;
9. malfunction of breathing apparatus while in use or during testing immediately before use; 10. Failure or endangering of diving equipment, the trapping of a diver, an explosion near a diver, or an uncontrolled ascent;
10. Collapse or partial collapse of a scaffold over five metres high, or erected near water where there could be a risk of drowning after a fall;
11. Unintended collision of a train with any vehicle;
12. Dangerous occurrence at a well (other than a water well);
13. Dangerous occurrence at a pipeline;
14. Failure of any load-bearing fairground equipment, or derailment or unintended collision of cars or trains;
15. A road tanker carrying a dangerous substance overturns, suffers serious damage, catches fire or the substance is released;
16. A dangerous substance being conveyed by road is involved in a fire or released;
17. The following dangerous occurrences are reportable except in relation to offshore workplaces: unintended collapse of: any building or structure under construction, alteration or demolition where over five tonnes of material falls; a wall or floor in a place of work; any false-work;
18. Explosion or fire causing suspension of normal work for over 24 hours;
19. sudden, uncontrolled release in a building of: 100 kg or more of flammable liquid; 10 kg of flammable liquid above its boiling point; 10 kg or more of flammable gas; or of 500 kg of these substances if the release is in the open air;
20. Accidental release of any substance which may damage health.

Responsibilities

In all cases where a RIDDOR reportable incident has occurred, these must be reported in line with the law, and done so by the service manager, the service manager should carry out this notification after discussing the matter with the Chief Executive where the incident will be discussed and the organisations response can be agreed, however, for the avoidance of doubt, irrespective of the ability of the service manager to discuss with the Chief Executive, the matter must be reported externally in line with the legal time frames.

Appendix 3: Procedure for management and investigation of an incident

The stages of incident management include investigation, analysis & reporting, follow-up, monitoring of actions and feedback to staff.

Not all of these steps will apply to each incident.

Each category of incident (green, yellow, orange and red) will require specific action by the individual(s) involved in the incident, the service Manager, the Chief Executive.

In general:

- **Green and yellow** status incidents will be investigated and managed locally and require local remedial action by the service and department concerned.
- **Orange** status incidents will be investigated, within the service, utilising root cause analysis tools.
- **Red** status incidents will be investigated using the root cause analysis tools by the service, in conjunction with the Chief Executive and Medical Director (if clinical).

Investigation, Analysis and Reporting

Green and Yellow Status Incidents

Certain green status incidents will require further local investigation and may result in the development of an action plan. A summary of this investigation and any resultant action should be documented via the risk mitigation process outlined within the risk management policy.

Orange Status Incidents

Once an incident has been classified as orange, a formal investigation using root cause analysis (RCA) must be undertaken. An RCA tool is available at in the appendices.

The Service Manager should begin by obtaining statements from all the employees involved in the incident and ensuring the Medical Director (clinical) Chief Executive (non-clinical) are aware of the incident and current actions.

The Chief Executive will formally request a root cause analysis and action plan from the Service Manager within 20 days, who must ensure the incident is fully investigated. How the incident will be discussed with the patient, in line with the Duty of Candour will be agreed.

Upon completion the service manager must forward the investigation paperwork (i.e. the completed RCA, action plan, statements, correspondence etc.) to the head office administrator who will store the documentation in line with the relevant retention dates.

This will also help to inform potential future complaints, claims or an inquest in relation to the incident.

For orange status incidents, the service manager should also seek advice from an expert advisor, where appropriate. For example, in the case of a prescribing issue, contact a clinical pharmacist or GP.

Red Status Incidents

All red incidents should be managed directly by the service manager reporting directly to the Chief Executive and Medical Director, who will lead the incident management and investigation.

Follow up of Actions arising from all Incidents

For all incidents it is the responsibility of line managers to: Feedback to the individual(s) concerned, and any other employee who may have been affected by the incident, any action taken as a result of the incident or, where action cannot be taken, to feedback the reasons why this is so.

Feedback, where appropriate, may be undertaken by the service manager.

Communicate any action resulting in changes affecting other individuals, or reasons for non-action, within the local team.

Ensure staff affected, are made aware of and offered the opportunity to access appropriate support.

Ensure that where incident follow up has identified a risk that cannot be resolved locally, that this is recorded and managed in accordance with the Risk Management Policy.

Formal action plans, as a result of incidents, will not always be required for low risk (green, yellow incidents) and where appropriate local and immediate actions may be recorded on the incident report form or other suitable record.

Any follow up action will be the responsibility of the service manager and will be monitored for progress at a local level.

Action plans developed as a result of the root cause analysis investigation into an orange status incident will be reviewed by the Chief Executive to ensure that the agreed actions occur.

The action plan should contain clear detail of what action is required, together with timescales and the name of the person responsible for the action.

For Red incidents the Medical Director and Chief Executive will take overall responsibility for ensuring implementation and monitoring of action plans through to completion by an appropriate working group.

Appendix 4: Incident Management Form (IR1 Form)

To be completed on the same day as the incident

Reported by:	
Date:	
Time:	
Patient details:	
Details:	
Impact (incident, near miss)	
Initial severity: (G,Y,A, R)	
Cause:	
Externally Reportable?	
Escalated to:	
Immediate actions taken:	
Name	
Signed (Statement of Truth: I believe that the facts stated in this statement are true)	
Date	

For all medicine incidents you must also complete for following table:

NRLS Code	Field Name	Entry
IN01	Date of incident	
IN03	Location	
IN05	Incident category	Medication
PD01	Patient age	
PD02	Patient gender	
PD05	Medical specialty	
RP02	Care setting	
RP07	Organisation code	
RP01	Unique ID of incident	
RP05	Local reference	
ST01	Staff type reporting	e.g. nurse, GP
MD01	Stage of medication process	e.g. prescribing
MD02	Medication error category	e.g. wrong dose
IN06	Contributing factors	
IN07	Description of incident	
IN10	Recurrence prevention	
IN11	Underlying causes	
MD05	Approved names of medicine(s)	
MD07	Formulation	e.g. oral liquid
MD08	Dose/strength	
MD10	Manufacturer (if appropriate)	
MD16	Route (if appropriate)	
PD16	Was the patient harmed	
PD09	Clinical outcome	

Appendix 5: RCA Toolkit

Root Cause Analysis is an investigative tool used to understand why an incident has occurred. RCA emphasises the critical exploration of underlying and contributory factors. Root Cause Analysis tool can be used for the investigation of claims, complaints and incidents.

Purpose

MBPCC has a duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Act 1974 and more specifically in accord with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

It is also a requirement to report certain incidents to a national body (e.g. Medicines and Healthcare Regulatory Agency, NHS Estates, Department of Health and NHS Resolution within a specific timeframe.

How to Complete This Document

1. This document is designed to be completed electronically.
2. Complete the right hand column for all sections relevant to the investigation.
3. Review the explanatory guidance text in the right hand column to understand the type of issues to consider and positively enter information. For example, in section 4, even if policies were followed and were in-date, state this otherwise there is no evidence that you have considered the possibility.
4. The examples given in the right hand column are not exhaustive but are provided as examples. Consider whether anything similar might be relevant to your particular incident investigation.
5. Once you have entered your text into each section of the right hand column, delete the explanatory guidance.
6. Following completion of the RCA review any areas in which you have ticked “yes”. For each section with a “yes” you should consider an action to prevent or minimise the problem from recurring.

In developing your actions consider the problem by way of the following hierarchy of controls, in order:

Eliminate-can you eliminate the problem, for example stopping a high risk procedure altogether or not using a hazardous piece of equipment?

Substitute-can you substitute the problem with something less harmful? An example is the use of latex free gloves for staff allergic to latex

Isolate/distance-can you isolate or distance the problem from people?

Safe Systems of Work-can you create, or improve upon, safe operating procedures to minimise or eliminate the problem?

Training/knowledge/information/Supervision-can you provide additional training or supervision to employees to minimise or eliminate the problem?

Personal Protective equipment-can you provide protective equipment to employees or patients to minimise harm to them. Examples include hip protectors for patients at risk of falls, eye protectors to prevent splash injuries, sharps boxes to prevent sharps injuries etc.

For any actions identified, which cannot be managed locally, please document that these issues have been escalated to the appropriate person

RCA Document and guidance

	Question	Findings
1	Give a background history and description of the event	Issues to consider in this section include: The reason for the patients admission (where the incident involves a patient) Relevant patient medical history including level of confusion, mobility etc. (where the incident involves a patient) Where the incident involves a patient fall-the number of previous falls and details of falls risk assessments
2	Confirm day, date, time of incident	
3	Where did the incident occur?	
4	Did deviation from current systems or processes contribute to the event?	Issues to consider in this section include: Whether any policies, procedures or protocols (or the lack of them) affected the incident. Were policies, procedures or protocols followed, out of date, ambiguous, or unavailable?
5	Did staff actions contribute to the event?	Issues to consider in this section include: Staff motivation e.g. boredom, low job satisfaction Personality issues e.g.: low self-confidence or overconfidence Domestic or lifestyle issues Physical ability, fatigue, stress, mental impairment due to illness, drugs, alcohol etc.
6	Did inadequate staff training/skill contribute to the incident?	Issues to consider in this section include: The quality of any relevant training staff had undergone including local induction The level of experience of the staff Whether staff had adequate supervision and/or mentoring Had staff had refresher training to update themselves Were the staff subject to regular appraisal
7	Did inadequate staffing resources contribute directly to the incident?	Issues to consider in this section include: Skill mix Staff to patient ratio Use of agency/bank staff
8	Did poor communication or information contribute to the incident?	Issues to consider in this section include: Conflicting information, either verbally or within medical records etc. Inaccurate information Poor communication due to language barriers, inappropriate medium (e.g.: email, fax etc.) Relevant persons not included in communication Poor/absent documentation within medical records
9	Did a malfunction or absence of equipment appear to contribute to the adverse event?	Issues to consider in this section include: Whether the equipment was subject to an up to date maintenance programme Whether the equipment was familiar to those using it and if they were competent to use it Whether a safety mechanism failed

10	Did controllable environment factors directly affect the outcome?	Examples might include water on the floor, a door that was locked preventing entry/exit, poor flooring, inadequate lighting, or poor ventilation. Has the area been subject to a risk assessment? If answering yes provide a copy. If answering no state why
11	Are there any uncontrollable external factors truly beyond the organisation's control? Give reasons why.	Examples might include an ambulance strike, a failure of BT systems rendering pagers inoperative etc.
12	Are there any other factors that have directly influenced this outcome?	Please detail

Appendix 6: Serious Incident procedure

Serious Incident Identification and Immediate Action

A Serious Incident, or suspected serious incident, MUST be reported as soon as the CCG (or healthcare provider) becomes aware of the incident. For Providers a senior manager or clinician MUST be identified by the health care provider's chief executive or equivalent, or the officer with relevant delegated authority, to undertake the following:

Arrange for any immediate actions required to ensure the safety of the patient(s), other services users and staff.

- Obtain all relevant physical, scientific and documentary evidence, and make sure it is secure and preserved. Initial actions of local managers in the collection and retention of information are important for the overall integrity of the investigation process.
- Identify witnesses, including staff, and other service users, to ensure they receive effective support.
- Identify an appropriate specialist/clinician to conduct an initial incident review (characteristically termed the 72-hour review or report) to confirm whether a serious incident has occurred and if applicable, the level of investigation required and to outline immediate action taken (including where other organisations/partners have been informed)
- Ensure the CCG and other relevant parties (for example, police, Safeguarding Professionals, the Information Commissioner's Office) are informed at the earliest opportunity and within 2 working days of a serious incident being identified.
- Agree who will make the initial contact with those involved, or their family/carer(s). Where an individual(s) has been harmed by the actions of a patient, particular thought should be given to who is best placed to contact the victim and/or their family. Where necessary the provider must contact the police and agree with them who will make the initial contact with the victim(s), their family/carer(s) and/or the perpetrator's family. Those involved should have a single point of contact within the provider organisation.
- Arrange appropriate meeting(s) with key stakeholders, including patients/victims and their families/carers as required.
- Ensure the incident is appropriately logged on the serious incident management system STEIS (the Strategic Executive Information System, NHS England's web-based serious incident management system) or its successor system which is currently under development.

Reporting and recording StEIS Incidents

- NHS organisations should report any Serious Incident to the CCG within 2 working days of occurrence or as soon as they become aware. NHS organisations should do this by using the StEIS database where they have access. Organisations that do not have access to StEIS should notify the CCG who will report the incident via StEIS on their behalf.
- Incidents falling into any of the serious incident categories below should be reported immediately to the relevant commissioning organisation upon identification. This should be done by telephone as well as electronically:
    - Incidents which activate the NHS Trust or Commissioner Major Incident Plan
    - Incidents which will be of significant public concern:
    - Incidents which will give rise to significant media interest or will be of significance to other parties (e.g. police, other statutory agencies)

- Care should be taken to ensure that all sections within StEIS are completed and as much detail as possible is included when reporting the incident. Information should be provided in a manner, which maintains the anonymity of patient(s) and staff involved, in line with Caldicott principles. In the event of a StEIS system failure, the incident should be reported directly to the CCG as identified in the NHS Standard Contract schedule 4 and 6, and the incident entered onto StEIS once the system is back on line.
- If relevant, the following information should also be provided:
    - Number of patients affected;
    - Impact of the incident on patient(s)
    - CCG where patient registered
    - Designation of staff involved;
    - Confirmation of which, if any, medical devices or equipment were involved;
    - Confirmation of which, if any, medicines were involved;
    - The impact of the incident on staff
    - Whether the patient and, or their family has been informed of the incident and if not, what plans are in place to do so in order to ensure Regulation 20 (Duty of Candour); where a decision has been made not to contact the patient or their family, has the rationale been recorded;
    - If the family has been contacted – how is contact with the family being maintained; is there a named person for this purpose;
    - Any other information deemed relevant by the reporting organisation
- The provider is requested to record key milestones onto StEIS as the investigation progresses
- Serious incident reports must clearly state the relevant bodies that have been informed.

In circumstances, where a serious incident or multiple serious incidents raise profound concerns about the quality of care being provided, organisations should consider calling a Risk Summit, which provides a mechanism for key stakeholders in the health economy to come together to collectively share and review information.

Reporting Flowchart

Having completed the initial StEIS report form, the reporting organisation (NHS Provider or equivalent) must then take appropriate measures to investigate the incident. Please refer to the flowchart (appendix 1 and/or appendix 2) for details of the recommended process for incidents which meet the CCGs escalation criteria and will therefore remain the responsibility of the CCG to performance manage.

Contact Out of Hours

Where the authorised named person in the NHS organisation believes that the incident has significant implications for the NHS in terms of clinical care, management of media issues, and warrants the immediate involvement of the CCG out of hours, the CCG on-call Executive Director can be contacted when the situation requires escalation. If so, they will agree any action that needs to be taken with the relevant NHS organisation.

Initial Assessment

Once the CCG has received notification of a StEIS reportable incident, an internal assessment will be carried out by the Reporting Organisation (RO). The CCG will also consider the incident (advice may be sought from NHSE). 2.6 Follow up (72 Hour Review)

An initial review (termed a 72 hour review or report) should be undertaken and uploaded onto the StEIS system by the provider. This should be completed within 3 working days of the incident being identified. The aim of the initial review is to:

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

The information submitted as part of the initial review should be reviewed by the appropriate stakeholders and the investigation team in order to inform the level of investigation.

Grading of serious incidents and examples

Grade 1 - Action required

Notification only – it is unclear if a serious incident has occurred

The provider organisation must update the CCG with further information within three working days of a grade 1 being notified. If within three working days it is found not to be a serious incident, it can be downgraded with the agreement of the CCG. If a serious incident has occurred it will be re-graded as a grade 1 or 2.

Grade 2 – Investigation should be completed within 45 working days from the date the incident was notified. (Short report – see RCA toolkit)

The CCG will monitor the investigation process, ensuring that the incident is investigated applying robust methodologies with a fully completed action plan with clear trajectory to address any recommendations falling out of root causes and lessons

Grade 3 - Investigation should be completed within 60 working days from the date the incident was notified. (More detailed report – see RCA guidance)

The CCG will monitor the investigation process, ensuring that the incident is investigated applying robust methodologies with a fully completed action plan with clear trajectory to address any recommendations falling out of root causes and lessons

Examples of a Grade 2 incident

- Adverse incident affecting business continuity, Avoidable or unexplained death,
- Grade 3 or 4 pressure ulcer, Health Care Associated Infection,
- Inappropriate treatment or treatment delay resulting in a requirement for further intervention or treatment or permanent harm,
- Information governance or confidential information loss or breach, Medication error (not falling within the current Never Event list), Poor discharge planning causing harm to patient,
- Serious damage to property including fire flood or explosion, loss of IT, Serious health and safety incident,
- Suicide, attempted suicide or self-harming behaviour.

Examples of a Grade 3 incident

- Accusation of physical misconduct or harm by a health or non-health care professional providing treatment or care.
- Homicide following recent contact with mental health services or domestic homicide (90 day investigation),
- Never Event,
- Safeguarding vulnerable adult or child,

It should be noted the above list has been provided as an example and is not intended to be exhaustive.