Chesterfield Royal Hospital NHS
NHS Foundation Trust

INCIDENT MANAGEMENT POLICY

1. INTRODUCTION

1.1 The Board are committed to providing a safe environment for both its patients and its staff. An essential component of achieving this commitment is ensuring that when something untoward occurs that it is reported quickly and investigated appropriately. This ensures that the Trust can continue to identify any emerging themes and learning arising from such untoward incidents and put mitigations in place to prevent or minimise recurrence.

1.2 The Board actively promotes a culture in which staff should feel able to report all incidents and seek to ensure that learning from incidents is shared across the organisation.

2. POLICY STATEMENT

2.1 This policy replaces the former incident reporting policy first issued in April 1993 and last updated in June 2015 and outlines the Trust's approach to incident management, which includes both reporting and investigation.

The purpose of this policy is to;

- Provide a framework to promote an open culture that actively encourages staff to report all incidents including near misses
- Ensure that learning where appropriate is identified to enable the Trust to develop service improvements including changes to policies and procedures, to prevent or minimise a similar incident happening again.
- Define the types of incident that must be reported
- Outline the process for grading of incidents in relation to consequence and likelihood
- Ensure processes are in place, which facilitate the investigation of all incidents and near misses to an appropriate level dependent on their identified risk
- Define the roles and responsibilities of staff, line managers, divisional operational teams and central corporate teams in relation to incident reporting, management and investigation.
- Ensure processes are in place to ensure statutory reporting requirements for certain categories of incidents are met

2.2 Both clinical and non-clinical incidents fall within the scope of this policy. It applies to all staff including agency staff, contractors, students, volunteers, patients and members of the general public.

3. DEFINITIONS

3.1 An **incident** is defined as "any event or set of circumstances which has, or could have resulted in; injury, ill health, damage, patient dissatisfaction, theft or other loss relating

to persons, assets, property, income or reputation”

3.2 In broad terms, **serious incidents** are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents, which affect patients directly and include incidents which may indirectly affect patient safety or an organisation ability to deliver on-going healthcare. Additional guidance on the types of incidents which may be included within this definition can be found in the Trust’s Reporting and Investigation of Serious Incidents Procedure.

3.3 A **never event** is a serious largely preventable patient safety incident that should not occur after preventative measures have been implemented. A copy of the most up to date Never Event Framework can be found on the NHS England website.

3.4 A **clinical incident** is any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare

3.5 A **near miss** is defined as any unintended or unexpected event that could have given rise to actual personal harm, patient dissatisfaction, theft or other loss relating to persons, property, income or reputation. Near misses are often difficult to understand, however there are two simple examples within this definition.

- No harm event- an incident that causes no harm but was not prevented (example: wrong drug administered to patient but caused no harm)
- Prevented near miss- any incident which had the potential to cause harm but was prevented (example: nurse about to administer wrong drug by prevented by colleague)

3.6 A **hazard** is defined as something that has the potential to give rise to actual or possible harm, damage or loss either to the individual or organisation

4.0 ROLES AND RESPONSIBILITIES

4.1 Chief Executive

The overall accountability for the effective management of all incidents and risk within the Trust lies with the Chief Executive. At an operational level the Chief Executive has delegated lead responsibility to other members of the Executive Team.

4.2 Director of Nursing & Patient Care and Medical Director

The Director of Nursing & Patient Care (DoN) is responsible for the management of clinical incidents and risks, supported by the Medical Director (MD). The DoN chairs the QDG. Both directors will report to the Executive Team and Board of Directors on matters relating to clinical incidents and risks. Both directors sit on the Quality Assurance Committee(QAC), and work closely with the Chief Executive and other directors with a responsibility for the management of incidents and risks.

4.3 Director of Finance

The Director of Finance holds designated responsibility for the management of non-clinical incidents and risks. The Director chairs the Health and Safety Committee and will report to the Executive Team and Board of Directors on all matters relating to non-clinical incidents and risks. The Director works closely with the Chief Executive and other directors with a responsibility for incidents and risks.

4.4 **Divisional Director**

The Divisional Directors are responsible for ensuring that:

- Incidents within the division are subjected to an appropriate level of investigation.
- Lessons learnt are disseminated to all staff in the division as required.
- Where appropriate lessons learnt are shared trust wide via the Trust QDG
- Patients and / or relatives are informed where an incident has occurred and are provided with feedback on actions taken once the investigation is completed.

4.5 **Heads of Nursing (HoN) (or equivalent)**

The Divisional HoN is responsible for ensuring that:

- All (clinical and non-clinical) incidents and risks are properly documented and corrective action is taken in a timely manner
- The Divisional Director / Clinical Lead/ Lead Consultant is aware of any incidents involving medical staff.
- Lessons learnt are disseminated to all staff in the division as required.

4.6 **Senior Matrons (or equivalent)**

Are responsible for ensuring that:

- All incidents are reported and investigated according to their severity or risk grade,
- Any witness statements required are obtained,
- All appropriate actions are initiated/completed, and recorded in the actions section of the Datix Risk Management System (RMS), and that
- Evidence of completion is attached to the documents section of the incident in Datix and provided to the Patient Safety Team (PST) / Safety Management Team (SMT) prior to closure of the incident.
- Incidents and actions taken are discussed at the divisional quality governance group
- Lessons learnt are disseminated to all staff in the division as required.

4.7 **Matrons/Heads of Service (or equivalent)**

Are responsible for ensuring that:

- any immediate remedial action that may be required in response to any incident is taken,
- that staff involved in the incident are identified and linked appropriately on Datix,
- Initiation of any further investigations necessary and obtaining any witness statements.
- Assisting with the investigation of non-clinical incidents as required by the SMT
- Undertaking RCA investigations as requested by the HoN/SM in relation to clinical incidents
- Reviewing incidents to ensure all appropriate action has been taken and the incidents have been closed.
- Providing feedback to staff involved in incidents and ensuring lessons learned are shared with the team

4.8 **Members of Staff**

All staff have a duty to assist the Trust in maintaining a safe environment for patients, staff and members of the public. Any member of staff who is involved in, or witnesses an incident must ensure that it is properly documented and reported.

4.9 The **Head of Quality Governance** is responsible for the strategic and operational delivery of this policy and for reporting through to the organisational committees

4.10 **Patient Safety Team (PST)**
The PST are responsible for:

- Ensuring that all patient related incidents recorded on the DATIX Risk Management System are reported to the NRLS and other external bodies as required.
- Supporting Divisional Management Teams with the investigation of incidents as required.
- Supporting divisions to ensure the harm severity grading of incidents is correct
- Reviewing all clinical incidents to ensure that appropriate action has been taken and the incident closed.
- Ensuring that clinical incidents are reported to external stakeholders in line with guidance as required

4.11 **Safety Management Team (SMT)**
The SMT will be responsible for ensuring that all incidents related to security, staff or members of the public are recorded on the DATIX Risk Management System, and are followed up until all identified actions have been completed and the incident can be closed.
Bi-monthly incident reports will be produced for:

- Health & Safety Representatives Committee;
- Health & Safety Committee.

4.12 The Fire Responsible Person is a member of the SMT, and is responsible for ensuring that all incidents relating to activation of the fire alarm system are recorded on the Datix Risk Management System and are followed up until all identified actions are completed and the incident can be closed.

4.13 **Medication Safety Officer/ Accountable Officer for Controlled Drugs**
The Medication Safety Officer is responsible for reviewing all incidents related to medicines to ensure that all external reporting requirements are met and that appropriate actions to prevent recurrence have been identified. They are also responsible for providing specialist support to medicine management related incident investigators.

The Accountable Officer for Controlled Drugs is responsible for ensuring all external reporting requirements for incidents involving controlled drugs are met and that specialist support is provided to investigators for incidents involving controlled drugs

5.0 Information Governance Lead

5.1 The Information Governance Lead is responsible for ensuring that all incidents related to information security and information governance (IG) are recorded on the Datix Risk Management System and are followed up until all identified actions are completed and the incident can be closed.

6.0 Serious Incident and Never Events

6.1 The process for the management of serious indents and never events is detailed in the reporting and investigation of serious incident procedure. This procedure also provides guidance on the types of incidents that qualify as serious incidents and never events.

6.2 Staff Action

6.3 All incidents and near misses must be reported using the ('e-form') via Datixweb on the trust intranet. Guidance on the types of incidents that must be reported is provided in the Incident Reporting, Management and Investigation Toolkit.

6.4 In order to facilitate prompt investigation, it is important that the incident form is completed at the earliest opportunity and by the end of the shift on the day the incident occurred Incident forms must be dated accurately and the reasons for any delay in reporting clearly documented.

6.5 Where the incident involves a patient or a visitor, a member of staff must complete the form.

6.6 Wherever possible untoward incidents should be reported directly by either the person directly involved or witnessing the incident. This is irrespective of whether an incident occurs outside of their normal place of work. If for any reason this is not possible, for example, due to incapacity, then the staff member's line manager must report the incident on their behalf.

6.7 Where death or serious injury has occurred, the incident must be reported immediately to a member of the Divisional Leadership Team (DLT) and additionally;

- the Patient Safety Team (PST) if it is a patient that has come to harm,
- the Safety Management Team (SMT) if it is a member of staff or member of public that has come to harm.

6.8 Incidents, including near misses and serious incidents can also be reported anonymously, via the Trust's free, confidential and independent helpline on 0800 389 9973. Full details of this service can be found in the Trusts Voicing Your Concerns Policy.

7.0 MANAGEMENT ACTION

7.1 The manager (matron/head of department) or equivalent must conduct an incident risk assessment and grade the incident in terms of severity of risk **within 1 working day** of receipt of the report, guidance on the grading of incidents can be found in Appendix 1. This initial assessment is to ensure the incident does not need escalating as an externally reportable incident such as a serious incident or RIDDOR reportable incident. Please see the table provided in Section 8.1 on specific incident reporting timeframes.

7.2 An investigation into the incident proportionate to the risk grading must then be completed by the manager and approved by the relevant Divisional Leadership Team Member or their nominated deputy. If the incident is externally reportable the investigation must be completed and approved within the timeframes provided within the table in Section 8.1. All other incidents must be investigated and approved not later than **30 working days**.

7.3 Prior to approving and closing an incident investigation the DLT member or nominated deputy must be assured that an appropriate investigation proportionate to the incident risk grading has been undertaken and all appropriate actions have been identified and completed and that evidence of completion has been provided.

7.4 The following central teams will give final approval for incidents resulting in moderate, severe harm or death within their respective areas;

- Patient Safety Team- clinical incidents
- Safety Management Team- non clinical (health and safety, fire and security) incidents
- Information Governance Lead- Information governance breaches

7.5 On receipt of a clinical incident graded as moderate, severe harm or death an appropriate member of the Patient Safety Team (PST) will, in collaboration with the respective divisional leadership team, undertake the following actions;

Within 1 working day

- Review the risk grading to ensure it is accurate
- Undertake an initial review of the incident against the criteria for a serious incident (SI), where the incident is felt to potentially meet the SI criteria a potential serious incident proforma will be requested from the division

7.6 **With 5 working days of investigation being completed**

- Review the internal root cause analysis where undertaken and request RCA where not submitted.
- Undertake any further action such as issue of clinical alert
- Ensure all of the relevant external reporting requirements as outlined in Appendix 2 are adhered with

On receipt of a non-clinical incident graded as moderate, severe harm or death an appropriate member of the safety management team will undertake the following actions within one working day;

- Review the risk grading to ensure it is accurate
- Undertake any further action such as issue of safety alert
- Ensure all of the relevant external reporting requirements as outlined in Appendix 2 are adhered with

7.7 **External Reporting Requirements**

The external reporting requirements as outlined in the table below must be adhered to by the appropriate designated lead:

8.0

Reporting Requirements	Required timescales	Responsible Trust Lead	Reporting Agency	Linked Trust Document
Serious Incidents (Sis)	2 working days of incident being identified as an SI	Patient Safety Lead	Clinical Commissioning Group (CCG)	Reporting and Investigation of serious incident procedure
Patient Safety Incidents	As soon as possible but no later than 30 days	Patient Safety Lead	National Reporting and Learning System (NRLS)	Incident Reporting Policy
Incidents involving medicines and medical devices	As soon as possible but no later than 30 days	Head of Medicines Management/ Medication Safety Officer Clinical Engineering Manager	Medicines & Healthcare products Regulatory Agency	Medicines Management Policy Medical Devices Policy
Personal injuries-including deaths, major injuries and 7-day lost time incidents	Immediately, but no less than 24 hours for all deaths and major injuries 15 days for all incidents resulting in 7 consecutive days' absence from work.	Head of Safety Management	Health and Safety Executive	Incident Reporting Policy
Physical Assaults	As soon as possible, but no later than 30 days	Head of Safety Management	NHS Counter Fraud and Security Management Agency	Management of Violence and Aggression against Staff Policy
Incidents involving blood or blood products	Immediately	Blood Bank Manager	Via Serious Hazards of Transfusion (SHOT) or Serious Adverse Blood Reactions and Events (SABRE) processes	Policy for transfusion of blood products, including massive haemorrhage clinical practices policy
Infection, Prevention and Control	2 working days of incident being identified as an SI	Deputy Director of Infection, Prevention and Control	Public Health England	Reporting and Investigation of serious incident procedure
Radiation incidents - Exposures "much greater than intended" (MGTI)	As soon as practicable and ideally within 2 weeks of the exposure taking place.	Head of Imaging	CQC IR(ME)R team	IMG-ALL-LP-19 Employers Procedures in line with the Ionising Radiation (Medical Exposure) Regulations
Screening-related incidents	2 working days of incident being identified as an SI	Screening Coordinator	Public Health England	Reporting and Investigation of serious incident procedure
Vaccine-related incidents	2 working days of incident being identified as an SI	Deputy Director of Infection, Prevention and Control	Public Health England	Reporting and Investigation of serious incident procedure

9.0 FEEDBACK

9.1 On completion of the incident investigation feedback will be provided to all staff involved in the incident by the investigating manager or line manager. In addition where staff have provided a contact email address they will also receive feedback via email. Managers should also provide regular updates to staff during the investigation process.

9.2 The Trust actively encourages a culture of openness and transparency with its patients and their relatives. For all untoward incidents which result in moderate harm or above the Trust will inform patients and where appropriate their relatives of the incident and the outcome of the investigation. In addition, staff are encouraged to be

open and transparent with patients wherever possible if they are involved in a patient safety incident even if minimal or no harm occurs. Additional guidance on the processes in place to ensure this can be found in the Trusts Being Open (Duty of Candour) Policy.

10.0 Communication

10.1 The Trust acknowledges the potential for untoward incidents to attract media interest both at a national and local level. Therefore, the Trust recognises the importance of effective internal and external communications with patients, public and staff who may be affected or involved in the incident. It further recognises the need to respond in an appropriate manner to enquiries from the media.

10.2 Communications with the media will be organised and managed by the Trust's Communications Lead, who will appoint an appropriate spokesperson for the Trust. Any requests for information or comments from the media should be directed to the Trust's Communications Team by the incident handler.

11.0 Analysis, Learning and Improvement

11.1 The Trust undertakes analyses of incident as set below in order to identify emerging trends and themes;

- An analysis of all clinical incidents within the quarterly patient safety report to the Quality Delivery Group (QDG). An annual analysis also undertaken within the patient safety annual report
- An analysis of all infection prevention and control incidents, including RCAs within the annual Infection Prevention & Control report presented to the Strategic Infection Prevention & Control Committee.
- Bi-monthly analysis report on all non-clinical incidents is presented to the Health and Safety Committee where any trends will be highlighted for further investigation/action. An annual analysis is also undertaken within the annual health and safety report to the Board.

11.2 All actions identified as a result of incident investigations will be held on the Datix Risk Management Database and monitored by the relevant Divisional Quality Governance Groups until all actions are complete.

11.3 Any learning identified during incident investigations must be shared within the Division via the relevant divisional quality governance group (DQDG). Any Trust-wide learning identified must be escalated to the Trust quality governance group (QDG), via the relevant DQDG. Additional guidance on the sharing of learning from incidents can be found in the Analysis and Improvement Following Incidents, Complaints and Claims Policy.

11.4 Where an event involves or has potential implications for other healthcare agencies the report arising from the investigation, findings and lessons learned will be shared with the relevant local organisation(s) by the investigating manager

11.5 Any risks identified as a result of an investigation will be recorded on the divisional risk register detailing risk reduction measures. Progress with the actions identified will also be monitored through regular review of the risk register by the Divisional Quality Governance Groups. Any risk rated 12 or above will be included on the high level risk register and progress with actions will be monitored by the Hospital Leadership Team,

Quality Assurance Committee and Risk Committee.

12.0 SUPPORTING STAFF

12.1 The Trust promotes an open, non-judgemental and supportive approach to staff involved in incidents recognising the need for prompt investigation and identification of any learning opportunities that may arise as a result of the event.

12.2 Staff directly or indirectly involved in an incident may be affected by the events and require varying levels of clinical, psychological and emotional support. The Head of Nursing/ Senior Matron/Matron or equivalent senior manager will be responsible for ensuring support for staff is available during and after the incident as appropriate. Where incidents occur that directly involve doctors in training, the Director for Medical Education (DME) will also be notified as per the Learning and Development Agreement. Additional information can be found in the Supporting Staff involved in incidents, complaints and claims organisational policy.

13.0 TRAINING REQUIREMENTS

13.1 The PST will provide training in completing incident forms and incident investigation using root cause analysis (see Training Needs Analysis Risk Management Training Policy Organisational Policy 2.24).

13.2 Each Division will have identified lead officers who are trained in root cause analysis.

14.0 KEYWORDS

14.1 Incident, clinical incident, serious incident, root cause analysis, RCA, RCAs

15.0 REFERENCES

15.1 NHS England (2015/16) Never Events Policy Framework
NHS England Serious Incident Framework 2015/16
Managing Safety Incidents in the NHS Screening Programmes March 2015
Managing Incidents Screening Programme Annexe January 2014
Department of Health (2010) Checklist for reporting, managing and investigating Information Governance SUI's
Health and Safety Executive (1995) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

16.0 RELATED POLICIES

16.1 Analysis and Improvement Following Incidents, Complaints and Claims Policy (Organisational Policies 2.25)
Being Open Policy (Organisational Policy 1.22)
Employer's Procedure in line with the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) (Imaging Local Policy 078)
Health and Safety Policy (Health and Safety Policy 010)
Information Governance Framework Policy (Organisational Policy 4.52
Policy for Transfusion of Blood Products Including Massive Haemorrhage (Clinical Practices Policy 2.2).
Policy for Doctors to Report Concerns about the Professional Performance of Health or Medical colleagues (Personnel Policy 11)

Policy for Non-medical Staff to Report Concerns about the Performance or Health of Colleagues (Personnel Policy 26)
Reporting Deaths to the Coroner (Organisational Policy 4.2)
Research Policy (Organisational Policy 1.17)
Risk Management Policy (Organisational Policy 4.64)
Risk management Training Policy (Organisational Policy 2.24)
Safeguarding Adults Policy and Procedure (Organisational Policy 2.16)
Supporting Staff Involved in Incidents, Complaints and Claims (Organisational Policy 2.21)
Complaints, Concerns, Comments & Compliments (Complaints and PALS Service) policy (Organisational Policy 1.16)
Voicing Your Concerns: Code of Conduct & Procedure (Personnel Policy 31)

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Review date:	September 2018
For review by:	Patient Safety Lead Head of Safety Management
Director responsible:	Director of Nursing & Patient Care

Incident scoring matrix and guidance **Appendix 1**

The classification of incidents is scored using a simple risk matrix. The matrix used by the Trust has been adapted from an international Risk Management Standard (Australian Standards / New Zealand Standard 4630:1999).

All incidents will be graded in order to determine the actions to be taken at Division and Trust level. The grading of the incident is determined by two factors:

- The actual consequence, outcome or severity of the incident
- The probability or likelihood of the incident occurring/recurring

Both of these factors are assigned a numerical score ranging 1-5. A detailed description of the numerical scoring is illustrated in Table 1 and 2.

Determining Consequence

Table 1: Measure of consequence/ incident severity

Consequence score (severity levels) and examples of descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Consequence score (severity levels) and examples of descriptors					
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
			An event which impacts on a small number of patients		
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint /inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Consequence score (severity levels) and examples of descriptors					
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating, critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Consequence score (severity levels) and examples of descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slip Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results , Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >4 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Determining Likelihood

Table 2: Measurement of Likelihood

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency (general) How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not	<5 per cent	6-25 per cent	26-50 per cent	51-75 per cent	76-100 per cent

Determining Incident Grading **Appendix 2**

Once the consequence and likelihood of an incident has been identified the grade of the incident must be determined utilising the risk quantification matrix (Table 3 below). The grade of the incident is calculated by multiplying the consequence score by the likelihood score. This is done automatically on the online form once the consequence and likelihood have been entered. All incidents must be graded as soon as possible after an incident has occurred.

Table 3: Grading Matrix

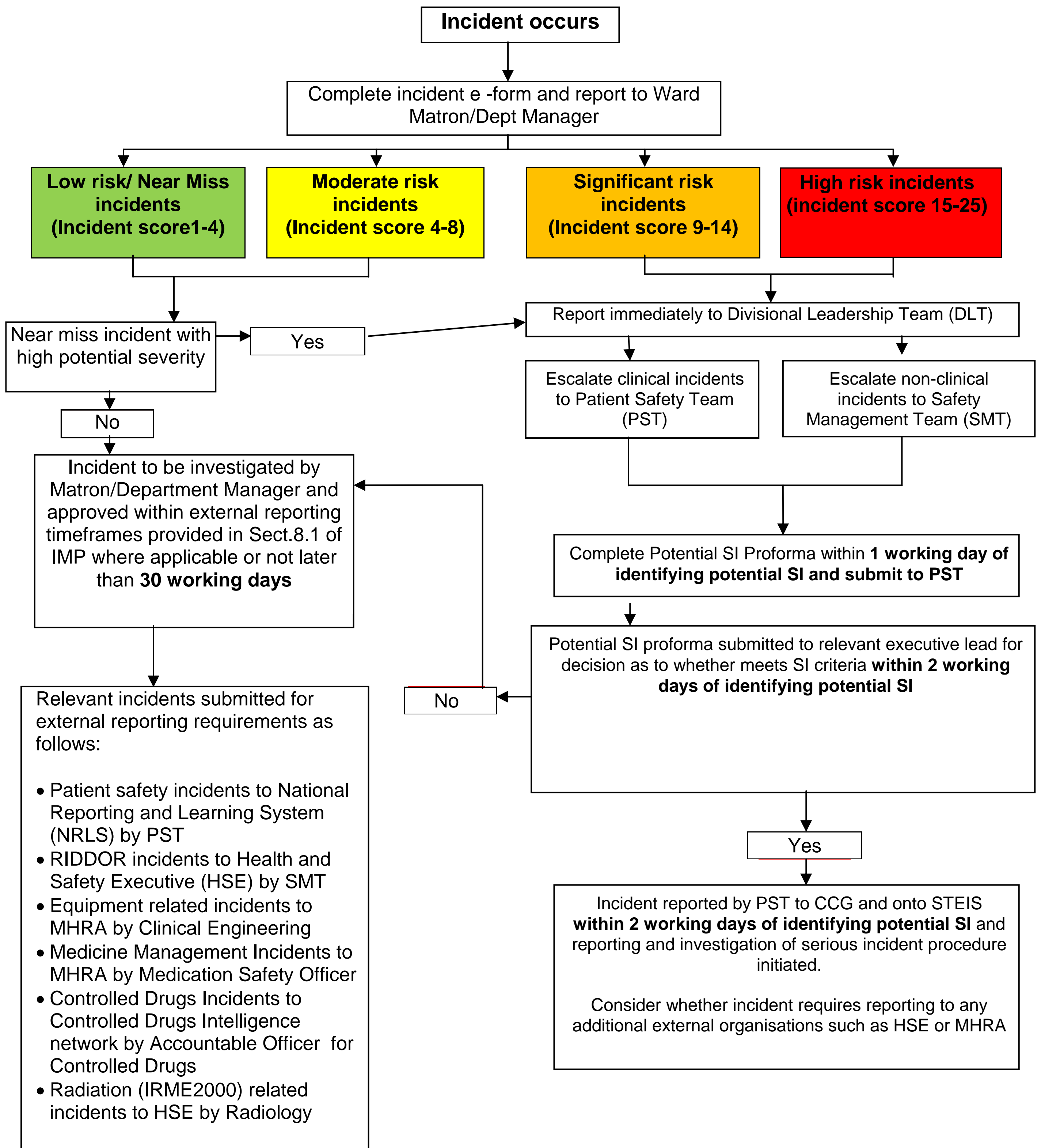
	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

The incident grading 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 incidents.

Consequence X Likelihood = Incident Score

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Reporting and Investigating Incidents Flow chart Appendix 3



Appendix 4

EQUALITY IMPACT ASSESSMENT

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

1. Name of lead	**Jane Bown**
2. Directorate/ Department	**Clinical Governance and Standards**
3. Name of policy	**Incident Reporting Policy**
4. Is this a new or existing policy?	**Existing Policy**
5. Target audience e.g. patients and public; NHS staff; professional health organisations; voluntary organisation; internal staff	**Patients, NHS Staff and other Healthcare providers including commissioners**
6. What are the aims of the policy?	• Provide a framework to promote an open culture that actively encourages staff to report all incidents including near misses • Ensure that learning where appropriate is identified to enable the Trust to develop service improvements including changes to policies and procedures, to prevent or minimise a similar incident happening again. • Define the types of incident that must be reported • Outline the process for grading of incidents in relation to consequence and likelihood • Ensure processes are in place, which facilitate the investigation of all incidents and near misses to an appropriate level dependent on their identified risk • Define the roles and responsibilities of staff, line managers, divisional operational teams and central corporate teams in relation to incident reporting, management and investigation. • Ensure processes are in place to ensure statutory reporting requirements for certain categories of incidents are met
7. Does any part of this policy have a positive impact on our duty to promote good race relations, eliminate discrimination and promote equality based on a person's age, disability, ethnic origin, gender, religion/belief or sexual orientation? If No, please provide brief reasons.	Yes
8. Could any part of this policy have an adverse impact on our duty to promote good race relations eliminate discrimination and promote equality based on a person's age, disability, ethnic origin, gender, religion/belief or sexual orientation? If No, please provide brief reasons.	The incident reporting policy applies to all patients, staff and healthcare providers regardless of their age, disability, ethnic origin, gender, religion/belief or sexual orientation .
9. Are there any factors that could lead to differential take-up, outcomes or satisfaction levels based on people's age, disability, ethnic origin, gender, religion/belief or sexual orientation? If No, please provide brief reasons.	No As above