



## Management of Incidents Policy

Document Reference	POL015
Document Status	Approved
Version:	V7.0

DOCUMENT CHANGE HISTORY		
Initiated by	Date	Author (s)
Serious Incident Panel	June 2009	Risk Manager
Version	Date	Comments (i.e. viewed, or reviewed, amended approved by person or committee)
V2.0	September 2009	Approved at Trust Board
V2.1	March 2011	Reviewed by Implementation Manager and Claims and Litigation Manager for NHSLA compliance
V2.1	July 2011	Approved by Risk Management Group
V3.0	August 2011	Approved by Executive Management Team
V3.1	January 2015	Risk Manager
V3.1	February 2015	Approved by Clinical Quality and Safety Group
V4.0	June 2015	Approved by ELB
V5.0	February 2015	Minor amendments approved by ELB
V5.1	June 2017	Amended and reviewed by Clinical Quality and Safety Group
V6.0	September 2017	Approval at SLB and ELB
V7.0	March 2019	Approval by MAG

Document Reference	Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Regulation 19. Directorate: Nursing and Clinical Quality
Recommended at Date	Executive Leadership Board March 2019
Approved at Date	Executive Leadership Board March 2019
Review date of approved document	January 2020
Equality Analysis	March 2019
Linked procedural documents	Duty of Candour (formerly Being Open) Policy Claims Policy Complaints Policy Investigation Guidance Whistle-blowing Policy Risk Management Strategy Serious Incident Policy
Dissemination requirements	All managers and staff, via email and intranet
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.



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## 1. Introduction

It is recognised that within a healthcare organisation, incidents and near misses can and do occur. Recognition and reporting of incidents and near misses is vital to the way in which the Trust can respond to issues and avoid repetition of avoidable incidents.

Through effective incident reporting, investigation and review, the East of England Ambulance Service NHS Trust aims to learn, change and develop processes, procedures and strategies, in order to reduce the level of risk within the organisation.

The aim of this policy is to encourage incident reporting, ensure robust investigations and learn from incidents and near misses, in order to maintain a high standard of care to patients, as well as to reduce the risk of loss, damage or injury to patients, staff and others, protecting the Trust's assets.

## 2. Purpose

This policy has been updated in line with the Trust's Patient Safety Strategy.

The purpose of this policy is to make clear the Incident reporting and investigation process, from incident recognition through to completion of the actions and closure.

If the policy is implemented successfully, the result will be:

- Continuous reduction in levels of avoidable harm
- The provision of a safe environment for staff, patients, visitors and contractors
- All incidents and near misses reported and investigated in a timely manner and appropriate learning and actions taken as a result

Successful implementation of this policy has the overarching aim of reducing patient harm and improving safety for patients, staff and other key stakeholders.

## 3. Duties

### 3.1 The Trust Board

The Trust Board will receive information on Incidents via the Quality Report. This is in order to seek assurance that internal controls are in place and are operating effectively in relation to incident management and safety improvement.

### 3.2 Quality Governance Committee

The Committee is directly accountable to the Board and seeks to provide assurance relating to systems and procedures concerning patient safety. The Committee will receive reports relating to incident management and issues highlighted through investigations in order to provide assurance to the Board, or to raise concerns.

### 3.3 Clinical Quality and Safety Group (CQSG)

The CQSG is directly accountable to the Executive Leadership Team and has decision-making powers devolved from the Board. Its purpose is to promote the delivery of safe, effective patient care outcomes and ensure patient and carers' views are actively sought, considered and acted upon and to ensure that appropriate mechanisms are in place to deliver high quality care. The CQSG will receive reports on incidents including trends, themes, issues to note, and lessons learned where appropriate.

### **3.4 Chief Executive Officer**

The Chief Executive, as Accountable Officer, has overall responsibility on behalf of the Trust Board for risk management, including the management of Incidents.

### **3.5 Director of Clinical Quality and Improvement**

The Director of Clinical Quality and Improvement is responsible for overseeing the arrangements for Clinical Governance. This will provide assurance of the quality of clinical care and patient safety.

The Director is the designated Board member responsible for compliance with the incident reporting procedures on behalf of the Board and Chief Executive.

### **3.6 SI Learning Group**

The SI Learning Group is responsible for the monitoring of trends and themes in relation to aggregated information from complaints, concerns, litigation, incidents, Serious Incidents and any other forms of patient experience data, with required actions to be taken. The Group is responsible for monitoring completion of the actions and reduction in the trends and issues seen as a result.

### **3.7 Patient Safety Team**

The Patient Safety Team is responsible for the monitoring of incidents and near misses reported and for escalating potential Serious Incidents (see Serious Incident Policy).

The Patient Safety Team acts to provide a quality assurance mechanism in relation to investigations undertaken. They are also responsible for identifying trends and themes and reporting these to the appropriate managers and groups/committees for action.

The Patient Safety Team acts as advisors to managers when assistance or support is required.

### **3.8 General Managers/Heads of Department**

General Managers are responsible for the provision of care within their allocated locality. They are responsible for ensuring that an investigation into any incident is conducted in a timely manner and to a high standard, in order to ensure that actions are taken to prevent a recurrence.

The ownership of an incident or near miss sits with the General Manager, or relevant equivalent. These Managers are responsible for overseeing the investigation process and to provide guidance and support to any manager they may have delegated the investigation to.

The General Manager or equivalent in which the incident occurred is responsible for assigning an appropriate Investigating Officer and ensuring sufficient time for the investigation is allocated. They are responsible for ensuring that the investigation follows due process and that the conclusions drawn are sound and accurate. They are also responsible for ensuring learning is disseminated and shared.

The General Manager is also responsible for implementing Duty of Candour discussions with patients and their families, supporting the Investigating Officer.

### **3.9 Investigating Officer (IO)**

The Investigating Officer is responsible for ensuring that the investigation is in conjunction with this policy and that the process is undertaken efficiently and effectively using root cause analysis methodology and is proportionate to the incident. The IO must produce a report through the completion of the 'investigate this incident' section of the incident report on Datix, which addresses every area of the incident and also identify any areas where remedial action may be taken.

Throughout the investigation the IO will maintain regular contact and provide feedback to staff involved in the incident and to ensure appropriate support is made available where appropriate.

Where appropriate, the Investigation Officer should make and maintain contact with the patient/family to ensure a record of any meeting(s) or information shared is documented and enclosed with the final report (as per Duty of Candour policy).

### 3.10 Staff and Other Workers

All staff employed by EEAST share the responsibility of reporting any incident or near miss Staff or workers should report any such concerns via the Datix system as soon as possible and without delay. If staff are concerned in relation to a possible Serious Incident, this should also be identified to the manager on duty on that shift, or via the Emergency Operations Centre. Supporting documentation should also be passed on without delay.

Staff involved in an incident or near miss are required to fully participate in an investigation openly and honestly, in order to assist with establishing the facts and the reasons for the incident, and to identify ways in which this lessons can be learned to avoid recurrence.

### 3.11 Trust Specialists

Specialist staff such as Safeguarding, Infections, Prevention and Control, Health and Safety and Risk are responsible for monitoring issues arising within their specialist field. They are not responsible for routinely conducting incident investigations; however should make themselves available to provide advice and support to managers and investigators where there are specialist considerations to take.

## 4. Definitions

- **Adverse Incident** – An incident can be defined as something unexpected that has happened, which resulted in patient or purchaser dissatisfaction, injury to a patient, visitor or member of staff or loss or harm to the Trust or its property. Clinical adverse incidents are events or circumstances arising during NHS care that could have, or did, lead to unintended or unexpected harm, loss or damage.

Some examples of incidents that would need to be reported on the Datix system include:

- Patient became aggressive towards crew.
  - Patient given incorrect dosage of medication.
  - Staff member pulled muscle whilst lifting a patient.
  - Patient information lost/misplaced.
  - Equipment malfunctions whilst being used to treat a patient.
- **Near Miss** – An incident that has the potential to cause harm but careful management has prevented the incident. For example, slippery floor where no signs have been laid out but resolved prior to a slip; delay in ambulance but deterioration prevented by transporting by Rapid Response Vehicle.
- **Serious Incident Requiring Investigation**  
A serious incident requiring investigation is defined as an incident that occurred in relation to an NHS funded service and care resulting in one or more of the following:
    - **Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;**

- **Serious harm** to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, **major surgical/medical** intervention, **permanent harm** or will shorten life expectancy or result in **prolonged pain or psychological harm** (for a continuous period of 28 days);
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of **abuse**;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of Never Events as updated on an annual basis
- Data loss and serious breaches of confidentiality

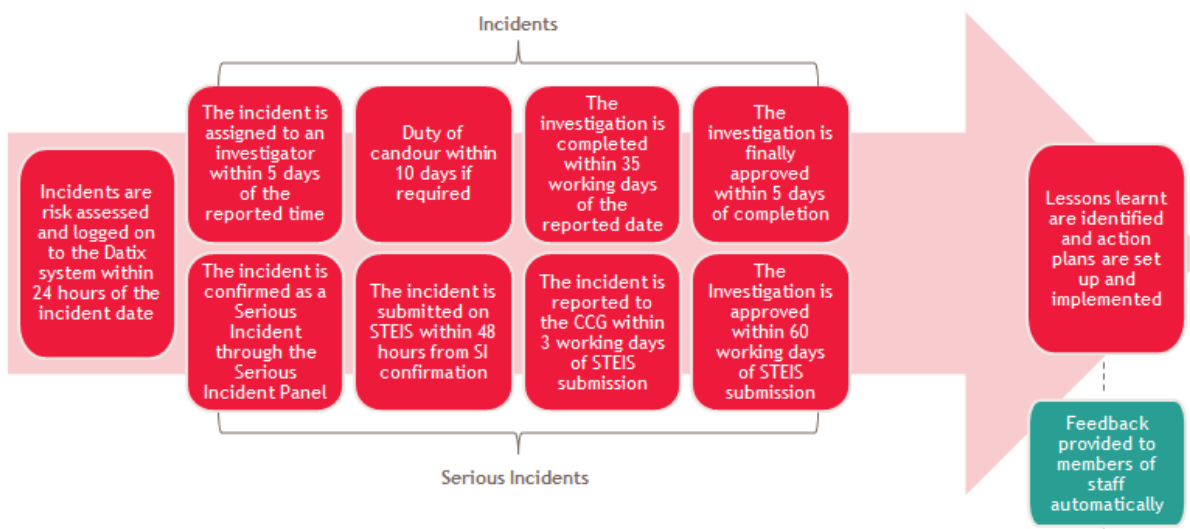
## 5. Incident Reporting and Management Process

### 5.1 Incident Reporting and Management Flowchart

Key timeframes within the incident management process and who is responsible:

1. Any incident or near miss should be reported within 24 hours of it being identified (staff member responsible) and verbally to their line manager in order to identify whether immediate action needs to be taken
2. An Investigating Officer should be assigned within the incident being reported on Datix (Senior Locality Manager or equivalent) within five days of the incident being reported
3. Duty of Candour to be discharged within 10 days of the incident being reported (Senior Locality Manager or equivalent with the Investigating Officer)
4. Investigation completed within 35 days of the incident being reported (Investigating Officer)
5. The investigation reviewed and finally approved within 5 days of investigation completion (Senior Locality Manager or equivalent)

The following flow chart demonstrates the steps within the incident management process and sets out the timescales for each component:





## 5.2 Incident Reporting

Staff are responsible for reporting every incident or near miss that they are aware of. In the instance of two or more staff being witness/involved in an incident, it should only be reported once and therefore the staff involved must determine who will report it.

An incident or near miss must be reported via the Datix incident reporting system. There are three ways:

1. Via the Datix web page on the Trust intranet: <http://eoe-nrdatix01/datix/live/index.php>
2. Via the 24/7 Single Point of Contact telephone line 0345 6026856
3. Via the link on the Toughbook

If there is a need to take significant action to manage the incident immediately, staff should escalate their concern to the manager on Duty at the time, **in addition to reporting the incident on Datix**. In order for a robust and thorough investigation to occur, the standard of the incident report submission is vital. Key aspects that must be included:

- Accurate incident date and time
- Accurate location of where the incident occurred
- Incident number (CAD event, cleric or Adastral number) if applicable
- Accurate details of the people involved (in the 'persons affected' section)
- A detailed and factual account of what has happened, and what outcome the reporter would like to see. Whether any harm has occurred must be clearly stated and if so, what it was

For examples of incidents and near misses, please see Appendix A.

## 5.3 External notification of Patient Safety Incidents

The Trust has a duty to report all patient safety incidents externally to the National Patient Safety Agency, via the National Reporting and Learning System (NRLS). This is to assist with national learning and action via the Central Alerting System (CAS).

The following incidents should be reported through the NRLS:

- Patient injury (fall, skin tear, etc.)
- Medication errors (overdose, incorrect medication, out of date drugs, inability to administer, adverse reactions etc.)
- Inability to deliver treatment (equipment errors, lack of equipment)
- Clinical errors/inappropriate treatment/misdiagnosis
- Deterioration in condition through delays etc.
- Personal/sensitive information loss

This list is not exhaustive and other incident types should be considered on a case by case basis.

The Patient Safety Team is responsible for grading and reporting patient safety incidents to the NRLS. This should be undertaken at least monthly, but ideally weekly. Prior to upload, NRLS reportable incidents should be reviewed by either the Safety and Risk Lead or Deputy Director of Clinical Quality to ensure consistency in the grading and reporting approach.

Incidents are uploaded via <https://report.nrls.nhs.uk/nrlsreporting/>

## 5.4 Incidents relating to external organisations

Due to the nature of the work the Trust undertakes, staff have occasion to report incidents and near misses relating to other provider organisations, including hospitals, care homes and care agencies. These incidents are reported on the Trust's incident reporting system (Datix) in the same way as an internal incident.



As these incidents relate to another organisation, it is not possible or appropriate for the East of England ambulance service to conduct the investigation. Our responsibility is to notify the provider organisation of the details of the incident and to share the necessary details to enable them to conduct their own investigation. This can be done in a number of ways:

- Email (via nhs.net account) to the relevant department at the provider organisation
- Telephone to the provider organisation’s PALS department (document in the incident report on Datix)
- Via external organisation notification letter (template on Datix)

Once this has been passed to the relevant organisation, it is appropriate to close this incident report, providing feedback to the reporter that it has been passed to the correct organisation for internal investigation. If feedback is received from the other organisation, this should be attached to the Datix and shared with the staff member.

Incidents relating to external organisations will be completed by the Patient Safety Team

### 5.5 Incident Scoring and appropriate levels of investigations

The level of investigation and analysis required for each incident or near miss should be assessed through the risk matrix and not solely on the ‘actual’ consequences of the incident. For example, a near miss on one occasion could become a fatality in the future if the potential risk is not identified and investigated thoroughly.

The risk matrix is found on the ‘Investigate this Incident’ page of the incident on Datix and should be completed by the Investigating Officer. It should be noted however that this may be completed by the General Manager (or equivalent) or the Patient Safety Team in the instance of a potential Serious Incident. The table is as follows, but see appendix B for more detail:

**RISK MATRIX – R (Risk) = C (Consequence) x L (Likelihood)**

LIKELIHOOD	CONSEQUENCES (IMPACT)				
	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 Almost Certain	5	10	15	20	25

If the risk is high (red or amber), it is important that the contributory factors and root causes are investigated and addressed and therefore an in-depth investigation should occur and be documented within the Datix system.

The purpose of an investigation is to establish what happened and identify the root cause so that steps can be put in place to prevent a recurrence. To investigate incidents and near misses, the Trust uses Root Cause Analysis methodology and investigation tools in order to systematically review what occurred and identify the underlying causes.

Investigations should generally always include:

- Ensure all immediate remedial actions have been taken (injuries treated, scene preserved, defective equipment isolated etc.)
- Ensure relevant individuals have been fully informed of the incident
- Identify people to be interviewed and document interviews and statements etc.
- Involve internal specialists as required
- Review any necessary physical evidence (patient care record, equipment, training records, policies and procedures etc.)
- Identify all root causes and contributory factors which led to the incident

- Identify what learning and action is required to prevent a recurrence

Useful tools for carrying out an investigation include (appendix C for templates):

- Tabular timelines
- The five whys
- Fishbone analysis
- Reactive barrier analysis

All findings should be documented in the investigations screen of the Datix report. All evidence gathered during the course of the investigation must be attached via the Datix report documents section.

For more detail in relation to how to conduct a robust investigation, please refer to the Investigations Guidance V4.0, or contact the Patient Safety Team for support and training.

## 5.6 Duty of Candour

In 2014 Duty of Candour came into force as part of the Health and Social Care Act. It is now essential that the Trust is open and honest with patients and families where harm has occurred. Where it is identified that harm or deterioration has occurred as a direct result of an incident, the Senior Locality Manager (or equivalent), in conjunction with the Investigating Officer, must:

- Make personal contact (telephone or meeting) with the patient or their family
  - Advise them of the incident
  - Apologise that the incident has occurred
  - Explain what the investigation will include
  - Ask whether the patient/family wishes to be involved in the investigation
  - Offer a report once the investigation is included
- Follow up this meeting or telephone call with a summary letter

This must be completed within seven days of the incident being reported.

If it has not been possible to make contact with the patient or family, documentation of the attempts made and the reason for no success must be documented within the Datix. A lack of address or family details is not sufficient – consideration to sourcing this information from the patient's GP or in an instance of death the Coroner is required.

For more information please refer to the Duty of Candour (formerly Being Open) Policy.

## 5.7 Outcomes and Identification of Learning

Following completion of an investigation, a conclusion must be reached. The Trust advocates the principles of fair blame and recognises that in the majority of incidents, the root causes of errors are based in process and system errors. The Incident Management system therefore works on the premise that investigations are conducted in a non-punitive and supportive manner, unless it is determined that a member of staff has knowingly acted in a reckless, intentionally unsafe or criminal manner.

Potential outcomes for individual staff involved:

- Discussions about the case and the raising of awareness with regards to how the incident can be avoided. This includes reference to relevant policies, procedures and guidelines
- Reflective practice or personal development with regards to the cause of the incident
- Additional training
- Clinical debrief

- Referral to Clinical Variations Panel, stage one or stage two
- If the investigation evidences deliberate, unsafe or criminal acts, referral to the relevant HR process and referral to relevant professional regulatory body (HCPC/GMC/NMC) if appropriate.

The Investigating Officer must determine whether the incident is likely to be an isolated occurrence related to the patient or individual staff involved, or whether there is a likelihood of recurrence. In this instance, learning should be shared more widely to minimise recurrence. This can include:

- Memos to staff within the team
- Team training
- Amendments to local processes (within the framework of Trust policies and procedures)

If it is felt that Trust wide learning is required, this should be escalated to the Patient Safety Team for review and consideration. Trust wide actions can include:

- Articles through the Communications team
- Addition to Professional Update and Induction Training
- New policies/procedures and guidelines

## 5.8 Feedback to Staff

Ongoing contact with the member of staff reporting the incident throughout the course of the investigation is important, in order to ensure involvement of the relevant persons in the investigation.

- Upon completion of an investigation, when the incident has been finally approved, datix generates automatic feedback to the reporter of the incident through the use of the e-mail supplied when the reporter reported the incident. This ensures that feedback is always provided.

## 5.9 Quality Assurance

Following completion of an investigation, the Investigating Officer will refer the incident to the General Manager (or equivalent) for review and sign off. The Manager is responsible for ensuring the investigation has covered the requirements and has identified appropriate issues, learning and action.

Final closure of an incident investigation is completed by the Patient Safety Team who quality assure the process and identify any Trust wide learning or repeat incidents that may require more robust review.

## 6. Equality Impact Assessment

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors, or visitors on the grounds of race, colour, age, nationality, ethnic (or national) origin, gender, sexual orientation, marital status, religious belief or disability. This policy will apply equally to full and part time employees. All East of England Ambulance Service NHS Trust policies can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals who require them.

## 7. Process for Monitoring Compliance and Effectiveness

The Executive Leadership Team has devolved responsibility for monitoring the Incident Management process to the Clinical Quality and Safety Group (CQSG). Regular reports identifying trends, remedial action and any organisational learning will be prepared by the Patient Safety Team for submission to the CQSG. Assurance papers will also be provided by the Patient Safety Team to the Patient Safety and Care Standards Committee for Board assurance purposes.

Compliance with the policy will be measured through set standards and Key Performance Indicators (section 8 below).

## 8. Standards/Key Performance Indicators

- Number of Incidents occurring each month
- Proportion of those incidents involving harm
- Timeframes for investigation completion
- Feedback provided to the staff reporting the incident
- Duty of Candour implemented where relevant

## 9. References

**Department of Health. (2004).** *Memorandum of understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm: A protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive.* London: Department of Health. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) and [www.acpo.police.uk](http://www.acpo.police.uk)

**National Patient Safety Agency (NPSA). (2005).** *Building a Memory: Preventing Harm, Reducing Risks and Protecting Patient Safety.* London: NPSA. Available at: [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

**National Patient Safety Agency (NPSA) 2004.** *Seven Steps to Patient Safety. The full reference guide.* Available at [www.npsa.nhs.uk/sevenstepsApril 2004](http://www.npsa.nhs.uk/sevenstepsApril 2004)

**Health and Safety Executive (HSE).** *The reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 1995 (RIDDOR).* [www.hse.gov.uk](http://www.hse.gov.uk)

## **Appendix A - Example incidents and near misses (not exhaustive)**

Examples of adverse incidents, near misses and other hazards **affecting clients, staff or members of the public:**

- slips, trips falls and collisions
- healthcare associated infection
- incorrect treatment (e.g. failure to defibrillate when indicated)
- any event which results in restraint of a patient by ambulance staff, regardless of section status or presence of other services
- medication errors (e.g. wrong drug, incorrect dosage, incorrect time administered, contra indications to drug not assessed etc)
- adverse reaction to medicines
- accidental injury to a patient or client (e.g. damage to patient's foot during transfer)
- accidental injury to employee or member of the public arising out of work activities
- all road traffic accidents involving Trust vehicles or vehicles used for Trust activities on and off Trust premises
- inoculation, needle stick or sharps incidents
- self-harm incidents
- contact with moving machinery or electricity
- moving and handling incidents (including musculo-skeletal injuries)
- physical or verbal abuse or threatening behaviour
- medical device or equipment failure
- contact with harmful or hazardous substances
- client, contractor or staff use of alcohol or illicit drugs on Trust premises
- theft, loss or damage to client, staff or Trust property
- clinical waste and general waste incidents (including spillage of hazardous substances, inappropriate segregation, labelling of waste)
- delay in diagnosis, wrong or incomplete diagnosis or incorrect patient assessment
- suspected or actual abuse of vulnerable adults
- unplanned release of hazardous substances into the environment
- dangerous occurrences that require reporting under the RIDDOR regulations
- security incidents - involving people, property, equipment and information
- adverse incident involving contractors and sub contractors, e.g. failure to observe safety rules, poor attitude etc

Examples of **organisational and system failures** include:

- breaches of good clinical practice, policies, procedures or protocols (or lack of them)
- variance from clinical pathway
- health records not available
- lack of patient consent to treatment
- communication problems between patient and healthcare staff
- information arising from client record reviews or audits
- breach of computer password security
- computer viruses
- loss of electronic data
- unauthorised access to IT systems
- inappropriate use of IT and Internet facilities, e.g. to download obscene material
- failure of business continuity or contingency plans
- breach of confidentiality incidents
- any breach of the law or statutory instrument
- purchase of goods and services that do not follow the Trust's Procurement Policy or Standing Financial Instructions

## Appendix B – Risk Matrix

### Purpose

The purpose of the risk matrix is to provide a consistent approach to the grading of risks arising within the Trust, however and from wherever, they are identified. This means that risks, whether identified from, e.g. a health and safety risk assessment or a clinical incident or a legal claim or a controls assurance self-assessment, may be graded in the same consistent manner against the same generic criteria. The Trust Board (and its sub-committees) can then be confident that, when considering risks within the same grading band, that these have been graded using the same method and the same criteria. This will allow for comparisons between different types of risk and for judgements and decisions to be made on that basis.

### Method

The accepted formula for grading risk is: ***Consequences x Likelihood***

This involves making a judgement both as to the ***Consequences*** to the person(s) involved and the Trust if the risk is realised, and the ***Likelihood*** (or probability) of the risk occurring, or recurring, and then allocating a number from 1 to 5 to reflect this. The numbers represent the following values: ***Consequences:***

1 = *insignificant*  
 2 = *minor*  
 3 = *moderate*  
 4 = *major*  
 5 = *catastrophic*

### ***Likelihood:***

1 = *rare*  
 2 = *unlikely*  
 3 = *possible*  
 4 = *likely*  
 5 = *almost certain*

(In the case of a ‘near miss’, by definition, no injury or damage has resulted. However, in slightly different circumstances, injury or damage could have resulted and it is the risk of this potential injury or damage which should be graded.)

### Instructions for use

1. Define the risk(s) explicitly in terms of the adverse impact that might arise from the risk;
2. Use **Table 1** (see below) to determine the **evidence based** Impact score(s) for the potential adverse outcome(s) relevant to the risk being evaluated;
3. Use **Table 2** (see below) to determine the **evidence based** Likelihood score(s) for those adverse outcomes. If possible score the likelihood by assigning a predicted frequency of the adverse outcome occurring. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of the project or the patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.
4. Multiply the Impact Score for each of the descriptors with the Likelihood Score to obtain the risk rating which should be a score between 1 and 25;
5. Use the risk matrix, shown below to determine the colour banding for the risk in respect of each descriptor (the highest score will determine the overall risk level).

**RISK MATRIX – R (Risk) = C (Consequence) x L (Likelihood)**

CONSEQUENCES (IMPACT)					
LIKELIHOOD	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 Almost Certain	5	10	15	20	25

When assessing the risk of an adverse event occurring consideration should be given to using the likelihood and the *consequence* tables below.

	PROBABILITY	DESCRIPTION
RARE	1 in 100,000 chance	DO NOT BELIEVE WILL EVER HAPPEN
UNLIKELY	1 in 10,000 chance	DO NOT EXPECT TO HAPPEN
POSSIBLE	1 in 1000 chance	MAY OCCUR OCCASIONALLY
LIKELY	1 in 100 chance	WILL PROBABLY OCCUR
MOST CERTAIN	1 in 10 chance	LIKELY TO OCCUR



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	1	2	3	4	5
<b>Domains</b>	<b>Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
<b>Impact on the safety of patients, staff or public (physical/psychological harm)</b>	Minimal injury requiring no/minimal intervention or treatment No time off work required	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 An event which impacts on a small number of patients	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
<b>Quality/ complaints/ audit</b>	Peripheral element of treatment or service sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal 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) 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	Incident leading to 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
<b>Human resources/ organisational development/ staffing/ competence</b>	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day) 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 attendance for 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

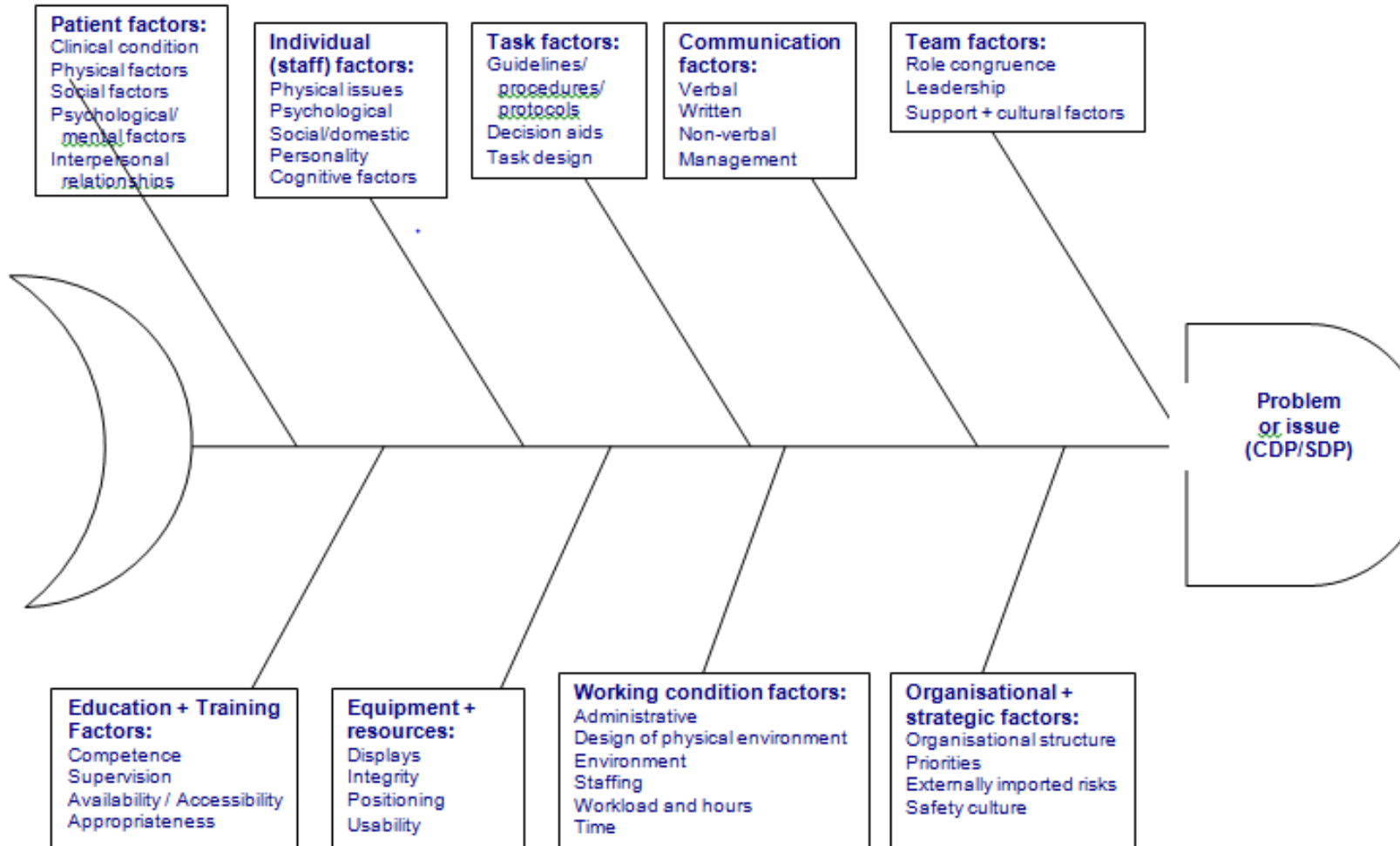
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
<b>Statutory duty/ inspections</b>	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement 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
<b>Adverse publicity/ reputation</b>	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 concern(questions in the House) Total loss of public confidence.
<b>Business objectives/ projects</b>	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 objective not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
<b>Finance including claims</b>	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
<b>Service/ business interruption</b>	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
<b>Environmental impact</b>	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

**Appendix C – Investigation Templates**

**Tabular Timeline - template**

Policy/Protocol (What should >> have happened)						
Event date and time >>						
Event (What actually happened) >>						
Supplementary information						
Missing info. / data gaps						
Notable practice						

**Fishbone template**



**Contributory Factors identification grid**

<b>Care and Service Delivery Problem 1</b>	
<b>Contributory Factors / Root causes</b>	Patient
	Task
	Individual Staff
	Team and Social
	Education and training
	Equipment / Resources
	Communication
	Working Conditions
	Organisational / strategic

<b>Care and Service Delivery Problem 2</b>	
<b>Contributory Factors / Root causes</b>	Patient
	Task
	Individual Staff
	Team and Social
	Education and training
	Equipment / Resources
	Communication
	Working Conditions
	Organisational / strategic

**Appendix D**

**Equality Impact Assessment: Executive Summary**

**Executive Summary Page for Equality Impact Assessment:**

Document Reference:	Document Title: Management of Incidents Policy
Assessment Date: 18 March 2019	Document Type: Policy
Responsible Director: Tracy Nicholls, Director of Clinical Quality and Improvement	Lead Manager: Anthony Brett, Safety and Risk Lead
Conclusion of Equality Impact Assessment: No adverse impact on any group or patient characteristic	
Recommendations for Action Plan: None	
Risks Identified: None	
<b>Approved by a member of the executive team:</b>	
<b>YES</b>	
Name: Tracy Nicholls	Position: Director of Clinical Quality and Improvement
Signature:	Date: 18/03/2019
This whole document should be stored with the master document and a final approved electronic copy must be sent to the Equality & Diversity Lead at Bedford Office	