Management of Incidents
Policy

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<th>Document Reference</th>
<th>POL015</th>
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<td>Document Status</td>
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<td>Version:</td>
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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. The 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 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 take place, and learn from incidents and near misses, as part of the Trust’s safety culture. Adherence to the policy will assist 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.

2. **Purpose**

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 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.
- To ensure that the Trust complies with current legislation.

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 **Avoidable Mortality Group (AMG)**

The AMG 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 AMG 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 Safety and Risk Lead and Patient Safety Team

The safety and risk lead is responsible for leading the patient safety team to monitor incidents and near misses reported, and for escalating potential serious incidents to the SI Panel (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 safety and risk lead acts as an advisor to managers when assistance or support is required in the management of incidents. The safety and risk lead is the data owner for all incidents held on the Datix system and will advise on changes to be made to the incidents module.

### 3.7 Data Protection Officer

The Data Protection Officer (DPO) is a statutory role for all public bodies. They are required to monitor compliance to data protection legislation and compliance with data protection policies. This includes managing internal data protection activities, of which incident reporting is a crucial part. They also provide the link between the organisation and the Information Commissioners Office (ICO) to ensure that there is effective cooperation and cohesion.

### 3.8 Heads of Departments and General Managers

Heads of departments and general managers are responsible for the provision of care, or portfolio of work, within their allocated designation. 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 head of department, 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 head of department, general manager, or equivalent, in the area 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 head of department or 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 the Investigations Guidance document, and that the process is undertaken efficiently and effectively using root cause analysis methodology when required and is proportionate to the incident. The IO must produce a report through the completion of the ‘investigate this incident’ section of the incident record on Datix, which addresses every area of the incident, identifying 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 IO 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 All staff

All staff employed by EEAST share the responsibility of reporting any incident or near miss. Staff should also be empowered to report any event or occurrence which they feel is an incident, some example of which can be found at Appendix 1. Staff should report any such concerns via the Datix system as soon as possible, and always within 24 hours of the incident occurring. 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 ambulance operations centre. Supporting documentation should also be passed on without delay.

Should a member of staff require to report an incident whilst on duty, the Patient and Vehicle Support Hub should be contacted and adequate out of service time shall be granted to complete a Datix report. If reporting an incident whilst on duty, the member of staff should make every effort to report the incident via the Trust’s Single Point of Contact (SPOC) phone number, as this can often be more convenient that using a Trust computer.

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 lessons can be learned to avoid recurrence.

3.11 Trust specialists

Specialist staff such as safeguarding, infections prevention and control, information governance and medicines management are responsible for monitoring issues arising within their specialist field. They are not responsible for routinely conducting incident investigations. However, they 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 adverse incident can be described as anything which occurs away from the intended course of action, which may or may not have resulted in harm occurring.

Some examples of incidents which should be reported on Datix are as follows:

- A patient becoming physically or verbally aggressive towards a crew.
- Patient given the wrong dose of a medication or via the incorrect route.
- Staff member injures themselves whilst undertaking a manual handling procedure.
- Confidential staff or patient information misplaced.
- Equipment malfunctions during a patient care episode.

This is not an exhaustive list. A more detailed list (but still not exhaustive) can be found at Appendix 1.

**Near Miss** - An incident which has the potential to cause harm but careful management has prevented the incident. For example, a slippery floor where no signs have been laid out but resolved prior to a slip, or a delayed ambulance attendance where the patient does not come to harm.

**Serious Incident** – Serious incidents in the NHS include acts and/or omissions occurring as part of NHS-funded healthcare that result in:

- Unexpected or avoidable death of one or more people
- Unexpected or avoidable injury to one or more people resulting in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional to prevent death or serious harm
- Actual or alleged abuse during the provision of NHS-funded care
- Never events (see NHS England Never Events Framework)
- Significant data breach
- Loss of public confidence in the service

5. Incident reporting and management process

5.1 Key timeframes

EEAST: POL015 – Management of Incidents Policy, V8.0
POLO15 - Management of Incidents Policy

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

1. Incident or near miss should be reported on Datix as soon as is safe and practical to do so, and certainly within **24 hours** of it being identified.
2. An investigating officer should be assigned as soon as is practical after the incident is reported on Datix to review the incident and take immediate action to ensure the safety of staff and patients. In any case, an investigator must be assigned within five calendar days of the incident being reported.
3. Duty of Candour to be discharged within **10 working days** of the incident being reported if appropriate to do so. Refer to the Duty of Candour Policy for further information.
4. Investigation completed within **35 calendar days** of the incident being reported.
5. The investigation reviewed and finally approved within **five calendar days** of investigation completion.

Incidents will appear as ‘overdue’ on Datix after 45 calendar days.

The following flow chart demonstrates the steps above:

Some specialities such as information governance also have legal obligations to report certain incidents with strict timelines. The Data Protection Act 2018 requires certain incidents to be reported to the ICO within 72 hours of the incident.

5.2 Incident reporting

Incidents must be reported by the staff member who witnessed it. When more than one member of staff witnessed the incident, it only needs reporting once. As such, members of staff should decide who reports it.

An incident must be reported on Datix and no further consultation with a manager is required to do so. If the member of staff deems an occurrence to be an incident, it should be reported so a further examination can take place.

An incident report can be made in the following ways:

- Via the Single Point of Contact phoneline, on: 0345 602 6856
- Via the link on the electronic patient care record

If there is a need to take significant action following an incident to prevent reoccurrence, the reporter may decide to highlight this to the duty manager at the time in addition to reporting the incident on Datix.

The incident report must include the following details (where known):

EEAST: POLO15 – Management of Incidents Policy, V8.0
POL015 - Management of Incidents Policy

- Accurate incident date and time.
- Accurate location of where the incident took place.
- CAD or Adastra number (if relevant).
- Accurate details of the people involved.
- A detail and factual account of what happened, including whether the reporter feels that harm was caused as a result of the incident.

There may be local agreements in place to manage certain occurrences outside of Datix. These agreements may include damaged items of uniform or lack of, or broken, equipment at the start of a shift – if this is the case, no incident is required to be raised on Datix. However, all incidents relating to patient or staff safety must be reported on Datix without delay or consultation.

5.3 External reporting of patient safety incidents

The Trust has a duty to report all patient safety incidents to NHS Improvement via the National Reporting and Learning Service (NRLS). This is to assist with national learning and action via the Central Alerting System (CAS). The following incidents should be reported to the NRLS:

- Patient injury
- Medication errors
- Inability to deliver treatment (equipment error or lack of equipment)
- Clinical errors
- Deterioration of patient condition due to response delay

This list is not exhaustive. The patient safety team is responsible for grading and reporting patient safety incidents to the NRLS. This should be undertaken on a monthly basis and should be reviewed by the safety and risk lead prior to upload.

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 NHS Trust 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 several 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 their investigation. If feedback is received from the other organisation, this should be attached to the Datix and shared with the staff member at the later date.

5.5 Incident risk scoring and proportionality of investigation

In order to be able to identify what level of investigation is required for an incident, a risk score (using a risk matrix) must first be established.

For further information on risk scoring and proportionally investigating an incident, please see Investigations Guidance.

5.6 Duty of Candour
The Trust is statutorily required to implement the Duty of Candour for appropriate cases as per the Health and Social Care Act, 2008, Regulation 20.

For further information about the Duty of Candour, please see the Duty of Candour Policy.

5.7 Outcomes and learning

Following completion of an investigation, a conclusion must be reached. The Trust advocates the principles of fair blame as part of its just culture and recognises that in many 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), or the police, if appropriate.

An incident decision tree is available to use in the Investigations Guidance for instances when support is required to manage a member of staff involved in an incident.

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 published 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, as long as a secure email address has been provided. This ensures that feedback is always given. If a secure email address has not been provided, the investigating officer should seek contact with the reporter, and give feedback manually if desired.

6. Equality Impact Assessment

EEAST: POL015 – Management of Incidents Policy, V8.0
POL015 - Management of Incidents Policy

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, 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 Avoidable Mortality Group (AMG). Regular reports identifying trends, remedial action and any organisational learning will be prepared by the patient safety team for submission to the AMG. Assurance papers will also be provided by the patient safety team to the Quality Governance 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 reported per month (monitoring)
- Number of serious incidents reported per month (monitoring)
- Proportion of serious incidents involving harm (monitoring)
- Number of overdue incidents (<100)
- Incident trends and themes (monitoring)
Appendix 1 – 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
- manual 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
- Data protection breaches or breaches of confidentiality
<table>
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<th>Name of process/policy</th>
<th>Management of Incidents Policy</th>
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<tbody>
<tr>
<td>Is the process new or existing? If existing, state policy reference number</td>
<td>Existing</td>
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<tr>
<td>Person responsible for process/policy</td>
<td>Safety and Risk Lead</td>
</tr>
<tr>
<td>Directorate and department/section</td>
<td>Clinical Quality and Improvement</td>
</tr>
<tr>
<td>Name of assessment lead or EIA assessment team members</td>
<td>Safety and Risk Lead</td>
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<tr>
<td>Has consultation taken place?</td>
<td>No</td>
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<tr>
<td>Was consultation internal or external? (please state below):</td>
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The assessment is being made on:

- Guidelines
  - Written policy involving staff and patients X
- Strategy
- Changes in practice
- Department changes
- Project plan
- Action plan
- Other (please state)
## Equality Analysis

### What is the aim of the policy/procedure/practice/event?

To document the Trust’s process for managing incidents reported via the Datix system, except for serious incidents, which are managed under the Serious Incident Policy.

### Who does the policy/procedure/practice/event impact on?

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<tr>
<th>Race</th>
<th>Religion/belief</th>
<th>Gender</th>
<th>Disability</th>
<th>Age</th>
<th>Gender re-assignment</th>
<th>Marriage/Civil Partnership</th>
<th>Sexual orientation</th>
<th>Pregnancy/maternity</th>
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### Who is responsible for monitoring the policy/procedure/practice/event?

Anthony Brett, Safety and Risk Lead

### What information is currently available on the impact of this policy/procedure/practice/event?

No impact – every person affected by an incident or its investigation is treated equally.

### Do you need more guidance before you can make an assessment about this policy/procedure/practice/event?

No

### Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics?

No

Please provide evidence:

### Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics?

No

Please provide evidence:

### Action Plan/Plans - SMART

N/A

### Evaluation Monitoring Plan/how will this be monitored?

N/A
## Appendix 3 – Monitoring Table

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
<th>How</th>
<th>Frequency</th>
<th>Evidence</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations</th>
<th>Change in practice and lessons to be shared</th>
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<tbody>
<tr>
<td>Ensure the style and format of the document is in line with the Trust’s requirements</td>
<td>Safety and Risk Lead</td>
<td>The Safety and Risk Lead will review this aspect of the document prior to it being proposed for recommendation for approval.</td>
<td>At each review of the document.</td>
<td>The document register / library will act as an audit trail</td>
<td>Reported to and discussed at the Avoidable Mortality Group.</td>
<td>The document author will address any actions or changes required.</td>
<td>Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
<tr>
<td>The document has passed through the correct route for approval to ensure that the relevant group / committee has given the final sign off.</td>
<td>Safety and Risk Lead</td>
<td>The Safety and Risk Lead will review this aspect of the document prior to it being proposed for recommendation for approval.</td>
<td>At each review of the document.</td>
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<td>For the document to be reviewed in advance of its formal review date to ensure changes can be consulted on and approved in good time for it to be re-published before ‘expiry’</td>
<td>Safety and Risk Lead</td>
<td>The Safety and Risk Lead will review this aspect of the document prior to it being proposed for recommendation for approval.</td>
<td>At each review of the document.</td>
<td>Using minutes from Recommending and Approving Groups / committees, the document register / library will act as an audit trail</td>
<td>Reported to and discussed at the Avoidable Mortality Group.</td>
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</tr>
<tr>
<td>Monitoring of KPIs included in policy</td>
<td>Safety and Risk Lead</td>
<td>The Safety and Risk Lead will report monthly on all KPIs to relevant groups and committees within established reporting mechanisms.</td>
<td>Monthly</td>
<td>Group/committee minutes and formal reports.</td>
<td>Reported to and discussed at the Avoidable Mortality Group.</td>
<td>The Safety and Risk Lead will either address actions raised or identify alternative action holders</td>
<td>Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
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