Wrightington, Wigan and Leigh NHS Foundation Trust

POLICY NAME:	**INCIDENT REPORTING AND INVESTIGATION POLICY** **REPORTING AND INVESTIGATION OF INCIDENTS (NEAR MISS, ADVERSE EVENTS AND SERIOUS UNTOWARD INCIDENTS)**
POLICY REFERENCE:	**TW10-020**
VERSION NUMBER :	**11.1**
APPROVING COMMITTEE:	**Corporate DQEC**
DATE THIS VERSION APPROVED:	**February 2019**
RATIFYING COMMITTEE:	**PARC (Policy Approval and Ratification Committee)**
DATE THIS VERSION RATIFIED:	**March 2019**
DATE THIS VERSION AMENDED:	June 2020 Section 7.1.14 added
AUTHOR(S) (JOB TITLE)	**Patient Safety Manager**
DIVISION/DIRECTORATE:	**Corporate**
LINKS TO OTHER STRATEGIES, POLICIES, SOP'S, ETC.	**TW10/002 Risk Management Strategy Policy & Procedure,** **TW10/054 Being Open/Duty of Candour Policy** **TW10-007 Health & Safety Policy** **TW10-007 SOP 1 RIDDOR Procedure**
CONSULTED WITH	**Corporate QEC Members**

Date(s) previous version(s) approved: (if known)	**Version:8** **9** **10**	**Date: 2008** **Date: 2011** **Date: 2015**
DATE OF NEXT REVIEW:	**March 2022**	
Manager responsible for review: *N.B. This should be the Author's line manager*	**Compliance Lead**	

The WWL Way

AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1. INTRODUCTION

1.1 Reporting an incident or a near miss is an integral part of personal, clinical and corporate governance.

1.2 The aim of reporting incidents is to identify systems and processes which could be improved to promote safety and reduce all types of risk within the organisation, not to apportion blame to individuals and teams.

1.3 The aim of reporting incidents is to learn from them and prevent recurrence in the future, to promote safety and reduce all types of risk within the organisation.

1.4 This policy applies to all staff employed by Wrightingon, Wigan and Leigh NHS Foundation Trust.

2. POLICY STATEMENT

2.1 Wrightington, Wigan and Leigh NHS Foundation Trust is committed to a programme of effective risk management.

2.2 This policy supports the Trust's Risk Management Strategy and Procedure and explains the system to be used by staff for recording, reporting, escalating and investigating incidents both internally and to external agencies.

3. KEY PRINCIPLES

3.1 The aim of this policy is to enable the Trust to:

- 3.1.1 Protect the safety and well-being of patients, staff and visitors.
- 3.1.2 Collect information about events involving patients, staff and visitors and the operation of the organisation.
- 3.1.3 Ensure a systematic and fair approach to the recording, reporting, escalation and investigation of incidents.
- 3.1.4 Learn lessons from reported incidents and identify areas for improvement to reduce the likelihood of such incidents recurring.
- 3.1.5 Comply with legislation and external agency reporting requirements.

3.2 The principles of this policy apply equally to Patient, Staff, Visitor, Contractor and Organisation Safety Incidents (See Section 4 – Incident type definitions)

4. ROLES AND RESPONSIBILITIES

4.1 **Chief Executive**

The Chief Executive has overall accountability for Trust wide legislative compliance and management of risk.

4.2 **Director of Nursing/Medical Director**

- 4.2.1 The Director of Nursing and the Medical Director are the appointed Executive Leads for safety within the Trust.
- 4.2.2 Inform the Chief Executive and Trust Board of any issues or concerns arising from all reported incidents.

4.2.3 Ensure that an appropriate structure and system is in place for the recording, reporting escalation and investigation of all incidents and for appropriate staff support following an incident.
4.2.4 Seek assurance that incidents are appropriately escalated.
4.2.5 In the event of a serious incident to ensure that a Concise Investigation is commissioned and the action plan appropriately monitored via the relevant committee.

4.3 **Director of Governance**

4.3.1 The Director of Governance has delegated accountability for ensuring the Trust has robust risk management arrangements in place, including processed for reporting, responding and commencing investigations into clinical and non-clinical incidents.
4.3.2 This person has responsibility for keeping the Board fully informed of any significant events as well as any general trends.

4.4 **Divisional Governance Leads**

4.4.1 Ensure all reported incidents are reviewed on a daily basis or immediately on the first working day following weekends and Bank Holidays.
4.4.2 Take responsibility for securing and monitoring the progress of the investigation of incidents within their respective Division, Directorate or Service.
4.4.3 Ensure that incident investigations are commenced within 5 working days of the incident being reported.
4.4.4 Ensure that incident investigations (with the exception of serious incidents) are fully completed within 10 days of the incident being reported.
4.4.5 Ensure that all incidents (with the exception of serious incidents) are given final approval and sign off within 10 days of the incident being reported.
4.4.6 Ensure appropriate escalation of serious incidents and never events to an appropriate member of the Corporate Governance and Assurance Team and Divisional Management Team.
4.4.7 Ensure divisional participation in the daily Datix Incidents teleconference and Ensure any serious incident, themes or trends of concern are escalated to the teleconference Chairperson to be considered for referral to the weekly Executive Scrutiny Committee.

4.5 **Compliance Lead**

4.5.1 During any unexpected/unforeseen absence of the Patient Safety Manager act as Chairperson of the daily Datix Incidents teleconference and provide a daily log to all teleconference members.
4.5.2 Appraise the Director of Nursing and/or the Medical Director of any reported incidents giving cause for concern which have been escalated.
4.5.3 Escalate to the Director of Nursing and/or the Medical Director any potential or confirmed serious incidents.
4.5.4 In the event of a confirmed serious incident make the necessary internal and external notifications to the Trust Board of Directors, Clinical Commissioning Group, Care Quality Commission, and to NHSI.

4.6 **Patient Safety Manager**

4.6.1 Liaise and work with the Divisional Governance Leads to develop their local arrangements for reporting, management and investigation of incidents using Datixweb.
4.6.1 Provide training to identified divisional, directorate and service Datix web leads on the use of the system and the recording, reporting, escalation and investigation of all incidents.
4.6.2 Advise and guide staff in the completion of Datixweb incident reports.

4.6.3 Access the Datixweb incident reporting system to identify incidents that may require internal and/or external escalation, reporting and/or investigation for discussion at the daily Datix Incidents teleconference escalating any potential/actual serious incidents.

4.6.4 Act as Chairperson of the daily Datix Incidents teleconference and provide a daily log to all teleconference members and identify appropriate deputies for annual leave cover.

4.6.5 Ensure that the Quarterly Corporate SEC Report (Safe, Effective, Caring) Incident reporting sections and monthly StEIS log are completed and up to date.

4.6.6 Attend the weekly Executive Scrutiny Committee and monthly SIRI Panel (Serious Incidents Requiring Investigation).

4.6.7 In the event of a confirmed serious incident make the necessary notification to StEIS and in the absence of the Head of Governance & Assurance make the necessary internal and external notifications to the Trust Board of Directors, Clinical Commissioning Group, Care Commission, and to Monitor via the Trust Board Secretary.

4.7 **Health and Safety Team**

4.7.1 Review all incidents and ensure the incident is assigned to the most appropriate individual.

4.7.2 Each member of the team can review any incident that has been reported and provide specialist advice within the scope of their practice to the incident handler.

4.7.3 Ensure that the Quarterly Corporate SEC Report (Safe, Effective, Caring) Incident reporting sections are completed.

4.8 **Divisional Operational and Clinical Management Team (Head of Nursing, Matrons and Quality and Safety Matrons)**

4.8.1 Have the responsibility to ensure that staff within their respective areas adheres to this policy and associated procedures.

4.8.2 Have the responsibility for embedding learning from incidents reported.

4.8.3 Have the responsibility for ensuring that all incidents are being investigated appropriately and any actions arising from an investigation are implemented within timescales and evidence of completion detailed.

4.9 **Ward, Departmental and/or Shift Managers**

4.9.1 Ensure that this policy and associated procedures for the recording, reporting, escalation and investigation of incidents are applied within their area of responsibility.

4.9.2 Support staff to enable the timely reporting of all incidents;

4.9.3 Ensure the safety of patients, staff, visitors and the environment (including preserving the scene where necessary or referring for medical help) in the event of all incidents.

4.9.4 Take appropriate action to limit the possibility of recurrence, if this seems likely, and/or if there appears to be an avoidable reason.

4.9.5 When an incident involves a patient, ensure that patient and next of kin/carer, as appropriate, are informed and that this is documented in the patient's record.

4.9.6 When an incident involves a patient, ensure that details of the incident, side effects, injury, outcome etc. and any medical review, investigation and treatment are documented in the patient records.

4.9.7 Remove from use any medical device, electrical or mechanical equipment that is suspected or confirmed as being directly attributable to the incident and arrange secure storage pending further investigation.

4.9.8 Ensure that reported incidents progress through the Datixweb incident reporting system in a timely manner in compliance with required timescales for review and

investigation in readiness for final approval by themselves or the identified governance leads with responsibility for final approval.

4.9.9 Escalate actual and potential serious untoward incidents at the earliest opportunity.

4.10 **All Staff**

4.10.1 All staff employed by the Trust have a legal, professional and moral duty to report accidents/incidents and near misses as soon as reasonably practical via the DATIX reporting system.

4.10.2 All staff have a duty to assist with any accident/incident or near miss investigation that they have been involved in or have knowledge of.

4.10.3 Staff must report any hazards they identify to their manager/the most appropriate person to be resolved before any accidents or incidents occur.

4.10.4 Staff have a duty to follow any changes in any policy, procedure or practice that has been identified as a result of an incident review or a lesson learnt.

4.10.5 Where death or serious injury occurs as a result of an incident this must be reported immediately to a senior manager and the Patient Safety Team in hours or the senior manager on call, out of hours.

5. REPORTING INCIDENTS

5.1 All Incidents must be reported via the Datix Risk Management System. This is accessible via the Trusts intranet.

5.2 Definitions

5.2.1 **Accident/incident** is an unplanned and uncontrolled event which results in or has the potential to lead to loss of life, injury or harm or damage to person, property or equipment.

5.2.2 **Patient Safety Incident** is any incident associated with the patient and their clinical treatment or care which has or could lead to ill health or harm.

5.2.3 **Non Patient safety incident** is an incident involving anyone (staff, patient relative or visitor, contractor or visitor to the Trust) or item, equipment or property that is not directly associated with patient treatment or care.

5.2.4 **Serious Incident** is defined as an incident that occurred in relation to NHS funded services and care and which resulted in one or more of the following:

5.2.4.1 Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public.

5.2.4.2 A Never Event – all never events are defined as serious incidents although not all never events necessarily result in severe harm or death.

5.2.4.3 A scenario that prevents or threatens to prevent an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm may potentially extend to a large population.

5.2.4.4 Allegations or incidents of physical abuse and sexual assault or abuse.

5.2.4.5 Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organization.

5.2.5 **Never Events** are defined as serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers. They are reported in the Trust as a serious incident and managed as such. The full list of Never Events can be found on the NHS Improvement Website.

5.2.6 **Near Miss** is any unplanned, unexpected or an unintended event, occurrence or circumstance that did not result in injury, illness, or damage - but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality, damage or loss.

5.3 **Incident and Near Miss Investigators**

Identified Datix web Investigation Leads for incidents and Near Misses will

5.3.1 Review all incidents notified to them for investigation within 5 days of the incident being reported.

5.3.2 Undertake and/or co-ordinate the investigation and collection of evidence for the investigation of all incidents notified to them.

5.3.3 Record on and/or attach to the Datix web form any information and documentation gathered and relevant to the incident or the investigation.

5.3.4 Record every stage of the investigation in the 'Investigation Details' section of Datix web, within the 'Action Taken' field.

5.3.5 Complete the investigation within 10 days of the incident being notified to them.

5.4 **Serious Incident Investigators**

In the case of Serious Incidents the Executive Scrutiny Committee will identify the lead investigators and level of investigation to be completed.

5.4.1 Serious Incidents submitted to StEIS will be subject to management as per the requirements of NHS England Serious Incident Framework March 2015.

5.4.2 Serious incidents submitted to StEIS will be subject to a full Root Cause Analysis investigation and report by a non-divisional investigation lead identified by the Executive Scrutiny Committee.

5.4.3 Serious incident lead investigators will identify an investigation team which includes relevant Subject-specialists for consultation and clarifications.

5.4.4 Lead investigators will ensure investigations are completed within 40 days of the incident being confirmed as a serious incident and forwarded to the relevant speciality or division for completion of an appropriate action plan.

5.4.5 Divisional Governance Leads will ensure action plans are completed and added to the original investigation report, provided to them by the lead investigator, before returning it to the Governance & Assurance Team within 10 days of receipt.

5.4.6 Completed Root Cause Analysis investigation report and action plans relating to serious incidents will be received and signed off by the Executive Scrutiny Committee (ESC) or Serious Incidents Requiring Investigation (SIRI) Panel prior to submission to Wigan Borough Clinical Commissioning Group 60 days of the incident being declared a serious incident.

5.4.7 Following completion of a full Root Cause Analysis investigation and recommendations report, the non-divisional investigation lead will forward the report to the relevant divisional Governance Lead(s) who will be responsible for ensuring an appropriate, robust action plan is developed and submitted to the Executive Scrutiny Committee.

5.4.8 Serious Incidents relating to divisional or organisational themes but not meeting the StEIS reporting criteria will be subject to divisional or specialty led concise (Rapid Review Report) investigations or full Root Cause Analysis investigations with action as determined by the Executive Scrutiny Committee.

5.4.9 Completed Root Cause Analysis investigation report and action plans relating to serious incidents will be received and signed off by the Executive Scrutiny Committee (ESC) or Serious Incidents Requiring Investigation (SIRI) Panel prior to submission to Wigan Borough Clinical Commissioning Group.

6. SEVERITY OF HARM CLASSIFICATION ON DATIX INCIDENT REPORTING SYSTEM

6.1 **No Harm** Any unexpected or unintended event, occurrence or circumstance which ran to completion but no harm occurred**.**

6.2 **Low Harm** Any unexpected or unintended incident which required extra observation or minor treatment, action or repair and caused minimal harm, to one or more persons or the property or services provided by the Trust.

6.3 **Moderate Harm** Any unexpected or unintended incident which resulted in further treatment, action or repair and which caused short term harm, to one or more persons or the property or services provided by the Trust.

6.4 **Severe Harm** Any unexpected or unintended incident which caused permanent or long term harm, to one or more persons or the property or services provided by the Trust.

6.5 **Catastrophic Harm (Death**) Any unexpected or unintended incident causing the death of one or more persons.

7. RESPONSIBILITIES FOR REPORTING TO EXTERNAL AGENCIES

The Trust has Statutory and Mandatory responsibilities to report some incidents to external agencies:

7.1 **Statutory Responsibilities**

Incident notifications to the Health and Safety Executive , in line with Reporting of Injuries Diseases and Dangerous Occurrences Regulations (2014) is the responsibility of the Trust Health and Safety Manager.

7.1 **Mandatory Responsibilities**

7.1.1 Incident notifications to the Care Quality Commission (CQC) are the responsibility of and are made by the Trust Head of Governance and Assurance on behalf of the Trust.

7.1.2 Incident notifications to Monitor are the responsibility of and are made by the Board Secretary on behalf of the Trust.

7.1.3 Incident notifications to Wigan Borough Clinical Commissioning Group are the responsibility of and are made by the Trust Head of Governance and Assurance on behalf of the Trust.

7.1.4 Incident notifications to the National Reporting and Learning Service (NRLS) are the responsibility of and are made by the Patient Safety Manager on behalf of the Trust

7.1.5 Incident notifications to the Incident notifications to NHS North West are via the Strategic Executive Information System are the responsibility of and are made by the Patient Safety Manager on behalf of the Trust.

7.1.6 Incident notifications to the Police.

7.1.7 Incident notifications to the Coroner are the responsibility of and are made by the Legal Services Manager on behalf of the Trust.

7.1.8 Incident notifications to the North West Medical Physics Radiation Protection Advisor are the responsibility of and made by the Trust nominated IRMER lead.

7.1.9 Incident notifications to the Information Governance Commissioner are the responsibility of and are made by the information Governance Manager.

7.1.10 Incident notifications to Safeguarding Agencies and Local Authorities (social care) are the responsibility of the Trust Adult and Children's Safeguarding Leads.

7.1.11 Incident notifications to Serious Advice Blood Reactions & Events (SABRE) reporting system are the responsibility of the Blood Transfusion Nurse and Consultant Haematologist with responsibility for transfusion and blood products.

7.1.12 Incidents involving medications may be reportable to the MHRA. The Chief Pharmacist is responsible for notifying the MHRA when required.

7.1.13 Incident notifications to the Medical Devices and Healthcare Products Regulatory Agency (MHRA)are the responsibility of all individual staff members (eg the staff member involved in the incident or identifying the device defect or failure). Incidents should be reported viaDatix web in the first instance and then to the MHRA.

7.1.14 Any incidents arising from national screening programmes must be managed in accordance with "Managing Safety Incidents in NHS Screening Programmes"

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pdf) For Antenatal and Newborn Screening incidents the screening co-ordinator must be informed via phone (5702) or email (wwl-tr.ancscreeningresults@nhs.net) and a DATIX completed. The screening co-ordinator will complete a Screening Incident Assessment Form (SIAF) if required.

8 DUTY OF CANDOUR

8.1 Duty of Candour is a requirement on health and adult social care providers to be open and transparent with patients about the care and treatment they have received.

8.2 Duty of Candour applies only to 'notifiable safety incidents' resulting in moderate harm, severe harm, the death of a patient and prolonged psychological harm which a patient has experienced or is likely to experience, for a continuous period of at least 28 days.

8.3 Being Open describes a process offering an apology and an explanation for what has happened in the event of an unsatisfactory patient experience or a patient safety incident.

8.4 It ensures communication is open, honest and occurs following the identification or knowledge of an incident or unsatisfactory patient experience.

8.5 It encompasses communication between the Trust, healthcare teams and patients and/or their families and carers.

9 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this policy and they have, where appropriate, been fully reflected in its wording.

10 INCLUSION AND DIVERSITY

The Policy has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

11 MONITORING AND REVIEW

11.1 The effectiveness of this policy will be evaluated against the Trust incident reporting system and monitored by the Quality and Safety Committee via the quarterly SEC (Safe Effective Caring) Report and monthly StEIS log.

11.2 Compliance with the process of NRLS reporting is monitored by the production of bi-annual reports by the NPSA showing Trust activity on incident reporting and is measured against the overall national reporting of incidents.

11.3 The Board will receive reports in respect of StEIS reportable serious incidents and 'Never Events' via the monthly Trust Board Performance Report and Quarterly Monitor Report

11.4 RIDDOR reportable incidents are investigated locally within wards and departments and monitored by the Health and Safety Team. Quarterly reports are produced and communicated to managers via the Occupational Safety and Health Committee.

11.5 The Policy will be reviewed every 3 years or sooner in the event of any significant changes to which it relates and approved at Corporate Divisional Quality Executive Committee.

12 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.

For more details, please contact the HR Department on 01942 77 (3766) or email equalityanddiversity@wwl.nhs.uk

APPENDIX 1

Terms of Reference	
Committee Name:	**Executive Scrutiny Committee (ESC)**
Chairperson	Director of Nursing or Medical Director
Deputy Chairperson	Deputy Director of Nursing, Director of Governance, Responsible Officer
Date:	October 2018
Version:	1.1
Reports to:	Not Applicable: ESC has the authority to escalate concerns, lessons learnt or themes to an individual or Trust Committee for action.
Reporting Subgroups:	None
Reports Received	**Internal** • Serious Incidents, StEIS incidents and Never Events • Moderate Incidents • Organisational Incidents (including Safeguarding and Unexpected Death of a Child) • Summary of all complaints and concerns received • Letters of Appreciation • New Inquests received and held • New Claims notified and settled • Claims Briefing Reports • Healthcare Safety Investigation Branch (HSIB) Investigations **External** • Trust Solicitors' Briefing Reports following inquests • External Incident Investigation Reports • PHSO (Ombudsman) reports
Meeting and attendance Frequency:	Meetings are weekly with the exception of one week per month when ESC is replaced with SIRI. Members must attend 70% of meetings held yearly (April – March).
Definition of Quorum:	As a minimum the committee will be considered quorate providing 4 members are present
Membership:	• Director of Nursing • Deputy Director of Nursing • Medical Director • Responsible Officer • Director of Governance and Assurance • Trust Audit Lead • Compliance Lead • Head of Legal Services or deputy (Legal Services and Inquest Liaison Assistant) • Patient Safety Manager • Patient Relations Manager or deputy (Deputy Patient Relations Manager) • Deputy Chief Pharmacist, Governance

	• Head of Safeguarding or deputy (Safeguarding Adults Senior Nurse) • Head of Governance, Medicine Division • Head of Governance, Surgical Division • Head of Governance, Surgery, Women & Children • Head of Governance, Specialist Services Division • Bereavement Specialist Nurse
Associate Membership: (must attend on an ad hoc basis dependent on the agenda)	ESC has the authority to invite any member of Trust staff to present relevant items on an ad hoc basis dependent on the agenda.
In Attendance: (to support the committee)	Project Officer, Governance or deputy (Patient Safety/Datix Assistant)

Scope of Responsibilities (duties)	**Inquests** • To receive details of new inquests notified by the Coroner. • To receive details of inquests held and the outcome. • To consider any actions or concerns related to inquests notified or inquests held. **Litigation** • To receive details of new clinical negligence, employee liability and public liability claims. • To receive details of settled clinical negligence, employee liability and public liability claims. • To consider any actions or concerns related to new and settled claims. • To receive notification of potential legal claims referred to the NHS Resolution. **Serious Incidents and Never Events** • To receive notification of new potential serious incidents and never events for submission to STEIS, escalated at Teleconference or by other means [If the decision to STEIS is required prior to the meeting ESC will be notified]. • To allocate the investigation team to undertake a serious incident investigation. • To receive and approve serious incident and never event investigation reports and action plans [If the deadline for submission to the Clinical Commissioning Group prevents SIRI Panel undertaking this]. • To consider any actions or concerns related to serious incidents and never events. • To undertake a weekly review of the StEIS Log. **Other Incidents** • To consider appropriate divisional review and response required for incidents not meeting the 'serious incident framework' criteria. **Complaints** • To receive a summary of all complaints and concerns received. • To receive updates on correspondence and requests from the Ombudsman. • To receive a summary of complaints which are approaching their due date for response. **Duty of Candour** • Ensuring compliance with Duty of Candour for incidents which trigger this regulation. **Lessons Learned** • To identify themes and lessons learned for escalation to appropriate individuals or Trust Committees for action. • Producing and disseminating weekly learning from experience and learning from excellence. **Other Responsibilities** • To triangulate incidents, complaints, claims and inquests. • To provide feedback to divisions via Friday's teleconference notes. • To identify external factors/trends from items discussed

Review Date:	October 2019
Monitoring of Terms of Reference:	A planning meeting takes place weekly prior to Executive Scrutiny Committee to ensure that the terms of reference are met for every meeting.

APPENDIX 2

Terms of Reference	
Committee Name:	**Serious Incidents Requiring Investigation (SIRI) Panel**
Chairperson	Chaired by an Executive Director – Medical Director or Director of Nursing
Deputy Chair	Deputy Director of Nursing Associate Director of Governance
Date:	December 2017
Version:	3
Reports to:	Corporate Quality Executive Committee
Receives reports/ minutes from:	The Panel will receive: • Divisional Action Plan Implementation Reports including evidence of Implementation and monitoring for assurance purposes • Scope for final approval of completed investigation reports where Executive Scrutiny Committee schedules do not allow approval by the StEIS deadline • Monthly StEIS log detailing number and status of StEIS incident submissions (including Clock Stops and approved extensions requests) • Quarterly SIRI Panel Calendar • Wigan Borough Clinical Commissioning Group SINE Panel Feedback following review of Concise and Comprehensive Serious Incident Investigation reports and additional information provided by WWLFT
Meeting and attendance Frequency:	Meetings will normally take place monthly in the 3rd week of each month and a minimum of 10 meetings per year.
Definition of Quorum:	A quorum will normally be three members, one of which will be an Executive Director or deputy When considering if the meeting is quorate, only those individuals who are members can be counted, deputies and attendees cannot be considered as contributing to the quorum (unless they are a Deputy Medical Director or a Deputy Director of Nursing).

Membership:	• Medical Director (Chair) • The Director of Nursing (Chair) • Deputy Director of Nursing (deputy chair) • Responsible Officer • Associate Director of Governance (deputy chair) • Compliance Lead • Patient Safety Manager • Deputy Chief Pharmacist (Governance) • Divisional Heads of Governance • Governor representative • Representative for Clinical Commissioning Group (Quality) • Representative for Clinical Commissioning Group (Safeguarding)
In Attendance: (to support the Panel)	Patient Safety/Datix Assistant (Agenda items to be distributed a week in advance of meeting). The Chair of the Panel may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such personnel will be in attendance and will have no voting rights.
Core Membership : (must attend should the relevant director not be able to attend)	• Deputy Director of Nursing (Chair) • Responsible Officer • Associate Director of Governance (deputy Chair) • Compliance Lead • Patient Safety Manager
Associate Membership: (must attend on an ad hoc basis dependent on the agenda)	• Investigation Lead and/or Report Authors • Health & Safety Manager • Patient Relations Manager • Head of Legal Services • WWLFT Safeguarding Representative • Clinical and non-clinical MDT members with responsibility for action plan implementation, monitoring, audit and/or assurance • External clinical / non clinical advisors on request
Authority:	The Panel is authorised by the Corporate Quality Executive Committee to: • Promote a learning organisation and culture, which is open and transparent. • To return Investigation reports to the relevant author and division if incomplete or further enquiry required. • To agree the timescales for the completion and closure of the action plan. • To commission (task and finish groups) to deliver service improvement that address gaps in assurance identified in the Investigation reports

Scope of Responsibilities (duties)	• Provide assurance to the Corporate Quality Executive Committee on effective structures and systems in place to support the investigation of serious incidents followed by implementation and monitoring of appropriate action plans • The Panel will provide Chair's reports monthly to the Corporate Quality Executive Committee • Advise the Corporate Quality Executive Committee on issues not resolved or that require escalation for action via the Chair Person's Report • Review and monitor Trust performance and compliance against the NHS England Serious Incidents Framework national timescales of StEIS submission within 48 hours of a serious incident being identified and 60 day investigation and report completion • Give scrutiny to investigation reports and findings to ensure all contributory factors have been thoroughly examined, root causes and/or care and service delivery problems established, lessons learnt, and recommendations made with appropriate action plans developed • Ensure that lessons learnt are shared so that the risk of similar incident(s) occurring is mitigated. • Delegate to Division's Governance structures the task of following through all action plans resulting from the investigation of Serious Incidents • Authorise the closure and sign off of Serious Incident investigation reports and implemented action plans following receipt of suitable evidenced assurance of completed actions.
Other Matters:	
Review Date:	December 2018
Monitoring of ToR:	• A planning meeting takes place the week prior to SIRI Panel to ensure that the terms of reference are met for every meeting. • The quarterly SIRI Panel Calendar provides an annual schedule of business and completed business by month • The Annual Incident Reporting and quarterly Corporate SEC Reports provide summarised overviews of the operation and business of the SIRI Panel.

APPENDIX 3

References and Further Information:

- Health and Safety at Work etc. Act 1974
- Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
- The Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER)
- Care Quality Commission: Guidance about Compliance - Essential Standards of Quality and Safety, March 2010
- Safety First: A Report for Patients, Clinicians and Healthcare Managers, DoH, December 2006
- Building a Safer NHS for Patients: Implementing an Organisation with a Memory, DoH, April 2001
- An Organisation with a Memory, DoH, 2000
- 7 Steps to Patient Safety, NPSA, 2004
- Root Cause Analysis, NPSA 2004
- Medicines & Healthcare Products Regulatory Agency, 2003

Useful Web Sites:

Care Quality Commission (CQC)
www.cqc.org.uk

Medicines and Health Products Regulatory Agency (MHRA)
www.mhra.gov.uk

Health & Safety Executive (HSE)
www.hse.gov.uk

National Patient Safety Agency (NPSA)
www.npsa.nhs.uk

Serious Hazards of Transfusion (SHOT)
www.shotuk.org

APPENDIX 4

Related Policies and Procedures

- Risk Management Strategy, Policy and Procedure
- Incident Reporting Procedure
- Health and Safety Policy
- Major Incident Planning Policy
- Raising Concerns Policy and Procedure
- Being Open Policy and Procedure

APPENDIX 5

Glossary of Terms

SI – Serious Incident

NRLS – National Reporting and Learning Service

DoH – Department of Health

HSE – Health and Safety Executive

StEIS - Strategic Executive Information System

Appendix 6

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Sex** (male/female/transgender)	**Age** (18 years+)	**Race/Ethnicity**	**Disability** (hearing/visual/physical / learning disability / mental health)	**Religion/Belief**	**Sexual Orientation** (Gay/Lesbian/	**Gender Re-Assignment**	**Marriage/Civil Partnership**	**Pregnancy & Maternity**	**Carers**	**Other Group**	**List Negative/Positive Impacts Below**
Does the policy have the potential to affect individuals or communities differently in a negative way?	N	N	N	N	N	N	N	N	N	N	N	
Is there potential for the policy to promote equality of opportunity for all/promote good relations with different groups – Have a positive impact on individuals and communities.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	N	N	N	N	N	N	N	N	N	N	N	**If Yes**: Please state how you are going to gather this information.

Job Title	**Patient Safety Manager**			**Date**	January 2019

IF 'YES an NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation

Appendix 7

POLICY MONITORING AND REVIEW ARRANGEMENTS

Para	Audit/Monitoring requirement	Method of Audit/Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
11.1	The effectiveness of this policy will be evaluated against the Trust incident reporting system	Audit and analysis of all incidents reported via Datix web. Monitoring by the Quality and Safety Committee via the quarterly SEC (Safe Effective Caring) Report and monthly StEIS log.	Patient Safety Manager	Quarterly	Quality & Safety (Q&S)	SEC Report StEIS log	Datix web incident reporting system. SEC Report and StEIS log are held on the Director of Nursing shared drive.
11.2	Compliance with the process of NRLS reporting is monitored by the production of bi-annual reports by the NRLS showing Trust activity on incident reporting and is	Trust performance and reporting rates measured against the overall national reporting of incidents via twice yearly reports issued via the NRLS.	Patient Safety Manager	Twice yearly	Quality & Safety (Q&S)	NRLS Report	Datix web incident reporting system. NRLS reports are held on the Director of Nursing shared drive and also on NRLS site
11.3	The Board will receive reports in respect of StEIS reportable serious incidents and 'Never Events'	Audit and analysis of all incidents reported via Datix web and submitted to StEIS.		Monthly & Quarterly	Trust Board	Trust Board Performance Report and Quarterly Monitor Report	Datix web incident reporting system. Trust Board Performance Report - Board Secretary. StEIS log - Director of Nursing shared drive
	RIDDOR reportable incidents	Quarterly reports are produced	Health & Safety	Quarterly	Risk and	Quarterly	Health & Safety Team

Para	Audit/Monitoring requirement	Method of Audit/Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
11.4	are investigated locally within wards and departments and monitored by the Health and Safety Team.	and communicated to managers via the Occupational Safety and Health Committee.	Manager		Environmental Occupational Safety and Health Committee.	RIDDOR and SEC Reports	shared drive
11.5	The Policy will be reviewed every 3 years or sooner in the event of any significant changes to which it relates and approved at Corporate Divisional Quality Executive Committee.	Review and analysis of requirements of and compliance with 11.1 to 11.4 above alongside any issued annual changes to national incident reporting requirements (eg: NRLS, StEIS, RIDDOR, CQC)	Patient Safety Manager	Annually	Corporate Divisional Quality Executive Committee. Quality & Safety (Q&S)	Incident Reporting Annual Report	Director of Nursing shared drive