London Ambulance Service NHS Trust

Serious Incident

Policy and Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To define the Trust's reporting process for Serious Incidents.

Sponsor Department: Governance and Compliance

Author/Reviewer: Assistant Director of Corporate Services. To be reviewed by March 2015.

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Links to Related documents or references providing additional information		
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TP/034	Being Open Policy	
TP/004	Complaints and Feedback Policy	
H&S011	Incident Reporting Procedure	
TP/035	Risk Identification and Assessment Policy	
TP/054	Investigation and Learning from Incidents, PALs, Complaints and Claims Policy	
TP/024	Managing Patient Confidentiality when Dealing with the Media	
HR/07/07	Management Policy Statement on Staff Responsibilities Regarding Communication	
TP/003	Policy Statement on Duties to Patients	

TP/049	Risk Register Procedure	
TP/005	Risk Management Policy and Strategy	
H&S012	Staff Safety Policy Statement	
H&S018	Stress Management Policy	
HR/07/22	Whistle Blowing Policy	
LA 52	Incident Report Form	
LA 277	Abuse and High Risk Address Information report form	
LA 042	Crew safety report forms	
	Serious Untoward Incident Guidance (2009), NHS London, http://www.london.nhs.uk/publications/tools-and-resources/serious-untoward-incident-SI-reporting-guidance	
	Reporting, Managing and Investigating Information Governance Serious Untoward Incidents 2009, Department of Health http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/SIchecklist.pdf	
	Local Authority Social Services & NHS Complaints (England) Regulations (2009) - http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1	
	References to the resources provided by the National Patient Safety Agency have been removed as the NPSA ceased to exist on April 1st 2012. When a link to the archived documents is published it will be included in the Policy.	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

1.1 The London Ambulance Service NHS Trust (LAS) manages in excess of 1.4 million 999 calls and attends more than 1 million patients every year. The vast majority of patients receive very high standards of care. We recognise however that sometimes things do go wrong and it is therefore important that such incidents are reported and managed effectively and that we learn and improve as an organisation.

1.2 This document sets out the Trust's policy and practice guidelines regarding the identification, investigation and reporting of Serious Incidents (SI).

1.3 The LAS is required to report Serious Incidents to NHS London and, where appropriate, to the Health & Safety Executive (HSE), Information Commissioner's Office and the Care Quality Commission (CQC). A copy of the notification must also be sent to the co-ordinating commissioner.

1.4 The LAS observes the requirements as set out in the *SI Reporting Policy* issued by NHS London (July 2009), and this guidance draws on the references cited in the NHS London document. The following should be therefore considered alongside the NHS London *SI Reporting Policy* - http://www.london.nhs.uk/publications/tools-and-resources/serious-untoward-incident-SI-reporting-guidance

1.5 The LAS observes guidance as regards information governance incidents as set out by the Department of Health. This policy should therefore be considered alongside the *Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents*

http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/SIchecklist.pdf

1.6 The LAS believes that SIs should be managed in accordance with the principles of the *Making Experiences Count* programme to achieve consistency of approach and this guidance is consequently compatible with the principles of *Local Authority Social Services & NHS Complaints (England) Regulations (2009)* - http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1

2. Scope

The focus of the Serious Incident Policy and Procedure is to deliver outcomes aimed at preventing recurrence and improving patient care. The LAS is committed to ensuring robust governance mechanisms are in place so that these benefits are realised.

This policy should be read and implemented in conjunction with a number of other Trust policies detailed on page 4.

3. Objectives

The purpose of this policy is to enable the LAS and its staff to:

- Understand what constitutes a Serious Incident
- Respond quickly and appropriately to an Serious Incident
- Take a consistent approach to the management of such incidents.
- Act in an open and transparent way.
- Involve and fully inform service users, stakeholders and staff, taking account of cultural belief systems
- Manage cases where poor practice is identified as a contributory factor in accordance with the Trust's workforce policies.
- Learn from all incidents and prevent recurrence as far as reasonably practicable.
- Address the lessons to be learnt from such incidents recognising that the majority of incidents occur because of failure in systems rather than individual practice.
- Share any learning across the health and social care economy

4. Responsibilities

4.1 The **Trust Board** will have overall responsibility for monitoring incident outcomes.

4.2 The **Chief Executive** is responsible for reporting an overview of any SI investigations to the Trust Board.

4.3 The **Quality Committee** will be responsible for providing assurance to the Trust Board through reports.

4.4 The **Learning from Experience** group will monitor the implementation of the action plans.

4.5 The **Serious Incident Group** (SIG) will be responsible for determining the severity of the incident, drafting the investigation Terms of Reference and the appropriate response to the incident.

4.6 The **Senior Management Group** will review completed investigation reports and approve recommendations

4.7 The **Associate Directors Group** will review draft reports and following approval at SMG will identify individuals responsible for implementing the actions associated with the report recommendations and will monitor progress against set time frame.

4.8 **The Assistant Director Corporate Services** is responsible for co-ordinating the serious incident process and liaising with external agencies.

4.9 **The Head of Communications** will be responsible for media relations and liaison with other relevant agencies in this respect.

4.10 The **Head of Legal Services** is responsible for notifying the National Health Service Litigation Authority (NHSLA)

4.11 **The Governance and Compliance team** will take the responsibility for facilitating the investigation and drafting the final report.

4.12 **The Deputy Director of Operations** has responsibility for informing the Health & Safety Executive of an incident that falls within the jurisdiction of that agency

4.13 **Local Managers** are responsible for documenting events prior to reporting the incident up to the relevant Assistant Director of Operations (ADO) / or line manager.

4.14 **All** members of staff are responsible for reporting any incident that may be a cause of concern.

5. Definitions

5.1 The principle definition of a SI is something *out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest, that occurs on NHS premises or in the provision of an NHS or a commissioned service.* This may be because it involves a large number of patients, there is a question of poor clinical or management judgement, a service has failed, a patient has died under unusual circumstances, or there is the perception that any of these has occurred.

5.2 Serious Incidents are not exclusively clinical issues, for example a breach of information governance, a technology systems failure, ambulance vehicle fire, a road traffic accident incident involving a Trust vehicle may have consequences that make it an SI.

5.3 A 'near miss' and any identified emerging trends which constitute a significant risk are included. However, excluded from this definition are adverse outcomes reasonably associated with routine NHS activity.

6. Who is responsible for identifying and reporting an incident that may be Serious?

6.1 Every member of staff has a responsibility to report any incident that may be a cause of concern. Staff should immediately bring to the attention of their line manager, or any manager if the line manager is not available any incident that they have observed or been involved in if it has given cause for concern.

6.2 It is essential that concerns are reported without delay and staff should also use the LA52 incident reporting procedure which is managed by the Health, Safety & Risk Department. The incident reports are reviewed to confirm the grading is accurate and if required the incident will be escalated as a potential Serious Incident. (see Appendix 1).

6.3 A SI may be identified from a wide variety of sources throughout the Trust, including the service-user and stakeholder feedback mechanisms managed by the Patient Experiences Department (PED), concerns raised at a Coroner's Inquest, or a legal claim against the Trust.

6.4 In instances where a local manager has been made aware of an incident, this should be reported to the relevant ADO or line/senior manager and by using the email facility PotentialSUINotification@lond-amb.nhs.uk. An LA52 should also be completed, the incident graded (Appendix 1), and the form sent immediately to the Health Safety & Risk department.

6.5 In the Control Centre, if an incident of concern becomes apparent as it occurs, all relevant details of the incident must be recorded on the Call Receipt Form, using the electronic call logs. The incident must be reported through the management structure and reported via the dedicated email facility cited. An LA52 should be completed, the incident graded (Appendix 1), and the form sent to Safety & Risk.

6.6 In the case of safeguarding children incidents, the named professional will liaise with the London Safeguarding Children Board and other relevant agencies in accordance with the requirements of NHS London.

6.7 Those incidents involving vulnerable adults the named professional will liaise with any relevant agencies.

6.8 In all cases, notification via the email facility should be made within 24 hours or the next normal business day, with an LA52 completed, graded (Appendix 1) and sent to Safety & Risk within 5 working days.

7. Immediate Management of the Incident

7.1The first priority for the Trust is to ensure that the needs of individuals affected by the incident are attended to including any urgent clinical care which may reduce the harmful impact. A safe environment should be re-established, all equipment or medication retained and isolated, and relevant documentation copied and secured to preserve evidence and facilitate investigation and learning. If there is a suggestion that a criminal offence has been committed, the police should be contacted. Early consideration must be given to the provision of information and support to patients, relatives and carers and staff involved in the incident, including information regarding support systems which are available to patients/ relatives/visitor/contractors.

8. Serious Incident Group

8.1 The dedicated email facility will auto-forward to members of the Senior Management Group (SMG), a number of Senior Operational Managers, the Head of Legal Services, the Head of Safety & Risk and the Head of Communications and the Head of Patient Experience. This is to ensure that there is organisational awareness at a senior level of a potential Serious Incident.

8.2 The SI Group will meet weekly to review Pending incidents. The severity and circumstance of a potential incident will dictate if meeting has to be called between scheduled meetings.

8.3 The Assistant Director Corporate Services and the Governance and Compliance Department are responsible for compiling the supporting documentation and preparing a brief summary of events. This information will be placed on a secure designated intranet folder.

8.4 At least three of the following senior managers will constitute the Trust's Serious Incident Group and come to a decision as to declaration of the incident as a SI:

- Chief Executive Officer
- Chief Operating Officer
- Medical Director or Director of Quality and Health Promotion
- Director of Corporate Services
- Deputy Director of Operations
- Assistant Director Corporate Services

The Head of Communications will be kept informed and invited to join the SI group as appropriate.

8.5 The SI Group will review the information available about the incident and determine the severity using the grading matrix (Appendix 1) this will establish whether it meets the threshold for declaration. A Serious Incident, with a score of 15 and above will be reported onto the Strategic Executive Information System (STEIS) website.

8.6 The SI Group will identify an appropriate Director to be responsible for presenting the final report to Senior Management Group.

8.7 In the case of an information security or information governance incident, the Trust's Caldicott Guardian and the Director of Information Management & Technology (the Senior Information Risk Owner) must be involved in the SI Group. The Information Security Manager is responsible for IT forensic investigation and determining the physical and electronic evidence to be gathered as part of the Incident Investigation, as defined in the LAS IT Forensic Readiness Policy.

The appropriate technical resources from IM&T are responsible for monitoring any damage from a security incident and that it is repaired or mitigated and that the vulnerability is eliminated or minimised where possible.

The SI Group will determine if a widespread LAS communication is required, the content of the communication, and how best to distribute the communication.

The assessment matrix in relation to data loss incidents is set out at Appendix 3.

8.8 When requested the named professional will arrange for a senior Safeguarding practitioner, via liaison with the Safeguarding Lead at NHS London or any other appropriate agency, to attend the SI Group.

8.9 The SI Group may also decide to invite an external advisor, for example a senior manager from another ambulance, acute, primary care or mental health Trust, local authority or Clinical Commissioning Group to assist and advise the SI Group.

8.10 Where appropriate the SI Group will appoint a representative to act as point of contact to enable a regular flow of information on behalf of the Trust to patient(s) and/or relatives except in cases when it is decided by the SI Group not to be necessary or appropriate; or, in joint agency cases, where it is agreed that another responsible body will undertake this role.

8.11 The Assistant Director of Corporate Services will maintain a record of each incident considered at the Serious Incident Group.

8.12 An SI investigation should not be confused with an investigation conducted under the LAS Disciplinary Procedure. If, as a consequence of the SI investigation, a disciplinary issue is identified, a separate investigation will be undertaken in accordance with the LAS Disciplinary Procedure.

8.13 Where an SI is not declared, the Assistant Director Corporate Services will be responsible for ensuring that an investigation is undertaken ensuring compliance with the Investigation of incidents, complaints and claims Policy

9. Reporting Serious Incidents

9.1 The Trust Board will receive details of incidents being investigated under the SI policy at the next formal meeting. In the event that an incident is so severe or is likely to attract media attention before that meeting, the Trust Board will be notified by email by a member of the SMG.

9.2 The Chief Executive will report an overview of any SI investigations in Part I of the Trust Board meeting, however the organisation reserves the right to discuss sensitive and confidential matters relating to the incident in Part II.

9.3 The Quality Committee will oversee the SI implementation plans and outcomes and will provide assurance to the Trust Board.

9.4 The Learning from Experience group will ensure action has been taken, lessons learned and improvements made where necessary. This group will provide assurance to the Quality Committee.

10. External Agencies

10.1 The LAS is committed to cooperating fully with external agencies when they declare an SI which directly or indirectly involves the LAS and will share information, providing that relevant statutory responsibilities (Data Protection, etc.) are met. The LAS will also involve and include other agencies as appropriate, e.g. if an LAS employee reports a criminal offence then the Police should be contacted immediately. The investigation lead will liaise with the agencies involved to agree which will conduct the investigation.

11. Other Notification responsibilities

11.1 If an SI occurs out of normal office hours (defined as Monday – Friday 9am -5pm) the senior manager on-call should notify the on-call Communications Manager who will inform the NHS London Communications Team.

11.2 Within 24 hours of an SI being declared, the Assistant Director of Corporate Services is required to notify NHS London via UNIFY, to the Department of Health electronic Strategic Executive Information System (STEIS) in the format required by the system.

11.3 The Assistant Director Corporate Services will update the risk management system and inform Communications, Legal Services, Patient Experiences and Health, Safety & Risk departments when an SI is declared.

11.4 Following declaration of an SI all identified personnel will be informed within 24 hours of the incident occurring, where contactable, via a local management representative who will ensure the appropriate debriefing and support for all staff involved.

11.5 The Head of Safety & Risk is responsible for notification to the National Reporting and Learning System via the Trust risk management system.

11.6 The Deputy Director of Operations or delegated senior manager with advice from the Head of Safety & Risk should inform the Health & Safety Executive of an incident that falls within the jurisdiction of that agency.

11.7 The Head of Legal Services is responsible for notifying the National Health Service Litigation Authority (NHSLA). NHS London must be informed of all critical dates i.e. Coroners' Inquest etc.

11.8 Where there may be a direct consequence for patient safety the Director of Corporate Services will notify the Care Quality Commission.

11.9 In the case of a data loss incident, the Assistant Director Corporate Services will ensure notification to the Information Commissioner and any other relevant agencies in accordance with Department of Health and NHS London guidance.

11.10 In the case of a safeguarding incident, the named professional will notify the local Safeguarding Board and any other appropriate agencies.

12. Media Relations

12.1 The Head of Communications will be responsible for media relations and liaison with other relevant agencies in this respect.

12.2 The Head of Communications will liaise with the AD Corporate Services and appointed family liaison officer and agree arrangements for informing the patient(s) involved and/or relative(s) if any information relating to an SI is to be released to the media, where practical to do so. This will usually be undertaken by an appointed representative. There may be occasions when this may not be practical for example where contact has not yet been made with the patient/family, or where the release of information is in response to the patient/family disclosing details to the media but where an approach to the LAS has not been made.

12.3 No member of staff will provide statements to the media independently of this process and should refer to the *Policy Statement on staff responsibilities regarding communication* (HR/07/07). Other relevant Trust policies include the *Policy Statement on Duties to Patients* (TP/003) and *Managing Patient Confidentiality when Dealing with the Media* (TP/024).

13. Being Open

13.1 *"Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately. This open approach minimises the trauma they feel."* ('Seven Steps to Patient Safety' NPSA 2003).

13.2 The LAS is committed to being open with patients who have been unintentionally harmed. 'Being Open' involves acknowledging, apologising and explaining when things go wrong as well as conducting a thorough investigation into the incident and offering reassurance that lessons learned will help prevent a similar incident recurring. The LAS *Being Open* policy has been developed in line with the NPSA guidance.

14. Administrative Management

14.1 The Governance and Compliance Department will have responsibility for the administrative management of declared Serious Incidents.

14.2 Details of the progress of the investigation will be updated on STEIS by the Assistant Director Corporate Services or delegated manager. NHS London may report the incident to the Department of Health including the Chief Medical Officer if considered necessary.

14.3 In the event that preliminary investigations indicate that the incident should no longer be classified as an SI, STEIS will be updated and a request will be made to NHS London to re-grade the incident.

14.4 When an incident is reported a file will be opened in the risk management system which will provide a unique identification number. This will be maintained by the Governance and Compliance department through to completion of the investigation and the final report.

14.5 Weekly progress reports will be provided to the SI Group on the progress of the investigation and appropriate *Root Cause Analysis* methodology will be utilised.

14.6 The Governance and Compliance team will co-ordinate the investigation process and will draw on expertise from around the Trust and any external agency to undertake the investigation and produce a report and recommendations.

14.7 Governance and Compliance will ensure contact with a patient/family is maintained,

recording each contact and all the information that is provided to the patients, carers, relatives and families of those involved during and after the SI investigation.

14.8 Governance and Compliance will ensure that patient(s) and other involved or interested parties affected by the incident are informed at the earliest opportunity and in advance of any public announcement, taking into account the circumstances.

14.9 Governance and Compliance will liaise with the ADO or relevant senior manager to identify a nominated representative from the local management team who will provide regular feedback and support to any staff involved.

14.10 Governance and Compliance will liaise with other agencies to agree arrangements where a joint investigation is being undertaken. Agreements for sharing the final reports which have been led by other organisations will be explicit in the terms of reference at the beginning of the investigation.

14.11 Appendix 2 details the investigation process and should be followed in all SI investigations

14.12 The SI Group will monitor progress, maintain a strategic overview and assist the management of the investigation and dissemination of the outcome(s).

14.13 A draft report will be circulated for discussion by the Associate Directors group who will confirm or agree amendments to the list of recommendations arising from the investigation.

14.14 The Assistant Director Corporate Services will circulate the draft report to the Serious Incident Group and Director responsible for the report for comment.

14.15 The report will then be submitted to the Senior Management Group for approval.

14.16 The Head of Communications will be party to the final discussions and recommendations and will advise the SI group, SMG and the Trust Board on media handling.

14.17 The approved report recommendations and action plan will be implemented and monitored by the Associate Directors Group.

14.18 The report and action plan will be sent to NHS London and the Commissioner

within 45 workings days from declaration of the incident.

14.19 Where possible, and with the authorisation of all parties involved (including the patient/authorised representative) anonymised versions of the final report will be published on the Trust's website, subject to familiar reporting restrictions, e.g. those imposed by the Courts where a criminal matter is subject to legal proceedings.

15. A Special investigation team

15.1 The most serious incidents are likely to require a Chair person from outside of the Board or the SMG. Incidents involving clinical matters will require the inclusion of appropriate senior clinical staff who are not associated with that aspect of the service under scrutiny.

15.2 Where legal matters are raised in the initial report, the Trust's legal advisors should be consulted.

15.3 Decisions also need to be taken at this stage on the level of support required for all involved in what is often a traumatic and stressful process. The need for Involvement of the Police and/or the Health and Safety Executive, in accordance with the draft Memorandum of Understanding, must be considered.

15.4 Terms of reference for the investigation must be produced in writing. The investigating panel should be the minimum size necessary to do the job, but this will depend on the breadth and scope of the enquiry set out in the Terms of Reference, and the need to co-ordinate with other agencies.

15.5 In the case of safeguarding incidents, the named professional will liaise with relevant agencies and in consultation with the SI Group, consider the appointment of an external practitioner to act as Investigating Manager.

16. Implementing agreed action measures.

16.1 The Associate Directors group will oversee the implementation of the recommended actions and the changes to practice.

16.2 Monitoring to ensure implementation of any agreed actions will be undertaken by the Information Governance Group, the Clinical Quality, Safety & Effectiveness; Learning from Experience; and Risk Compliance & Assurance Committees as appropriate

16.3 The Quality Committee will receive reports and assurance from the committees in 16.2

above and will provide assurance to the Trust Board.

16.4 Feedback on implementation of any recommended actions will be provided to the patient/family by the Investigation lead or an individual nominated by the SI group.

16.5 In the event that, following an SI, concurrent and related investigations are ongoing (e.g. disciplinary investigation), such investigations will not normally delay the report being made available to patient/family.

17. Audit

The LAS commits to monitor compliance with this procedure and to ensure that the audit cycle is completed with learning identified and implemented when an SI is declared. An annual audit will be completed by the Governance & Compliance team and presented to the Learning from Experience group as evidence of lessons learnt and improvements made to the quality of care provided to patients.

18. Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. At present, it is unlikely that the Trust would experience such an incident, given the existing definitions. The Trust will, however, continue to monitor the position and give consideration to developing its own criteria so that it may be compliant with national guidance.

19. Supporting staff

It is recognised that being involved in an incident, complaint or claim which is under investigation may be an incredibly stressful experience.

19.1 It is the duty of the manager of any staff member involved in an investigation to support that staff member and to ensure that they are aware of other sources of support which they may access. The ADO or Senior Manager is responsible for ensuring that this information has been communicated in the case of more serious incidents or complaints. Occupational Health will be able to see staff that wish to self-refer for health advice. The Human Resources Department should be contacted in the first instance in order for members of staff to have full information regarding such support.

19.2 Managers who have concerns about a staff member's fitness to work may wish to formally refer the individual to Occupational Health for advice and possible

recommendations. Staff counselling, Occupational Health and HR Department are able to assist with support following a significant traumatic event.

19.3 Independent support may be obtained through Occupational Health, the Counselling Service which staff can access without a referral from their line manager. Additionally, staff may wish to seek the advice of any professional organisation of which they are a member.

20. Policy Review

The Policy will be reviewed by the Associate Directors Group and ratified at the Senior Management Group. The Risk Compliance and Assurance Group, Learning from Experience Group, Clinical Quality, Safety & Effectiveness Committee will note the policy and it will then be endorsed by the Quality Committee.

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.
Training	The Trust provides Root Cause Analysis training sessions. Where an investigation needs to use Root Cause Analysis an appropriately trained multi-disciplinary team will be appointed.

NHSLA Criteria	What is monitored	How it is monitored and frequency	Responsibility- who will carry this out	Which Committee/groups monitors the outcomes/recommendations
2.2a) Duties				
2.2b) How all incidents and near misses involving staff, patients and others are reported	LA 52 and Potential SUI notification email.	Incidents are loaded into risk management database.	Governance & Compliance team. Health, Safety & Risk dept.	Area Quality Governance meetings. Risk Compliance & Assurance Group, Learning from Experience Group, Quality Committee
2.2c) How the organisation reports incidents to external agencies	Serious Incidents	Weekly review of reported Serious Incidents	AD Corporate Services, Head of Health Safety & Risk, D D of Operations, Head of Legal Services, Director of Corporate Services, Named professional.	NHS London, NRLS & SIRS, Health & Safety Executive, NHS Litigation Authority, Care Quality Commission
2.2d) How staff can raise concerns for example whistle blowing, open disclosure, etc;				

Appendix 1

Incident Grading Matrix
Table 1 Impact Score

Instructions

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use Table 1 to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use Table 2 to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a 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. Use Table 3 to calculate: I (Impact) x L (Likelihood) = R (risk score)
5. Identify the level at which the risk will be managed, assign priorities for remedial action and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings.

NB: Using the Trust's risk management schema, consideration should be given to inclusion of an identified risk in the Trust's Risk Register at the appropriate level.

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Table 1

	Impact score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident 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

Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to Occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%
	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Table 3 Risk Score = Impact x Likelihood (I x L)

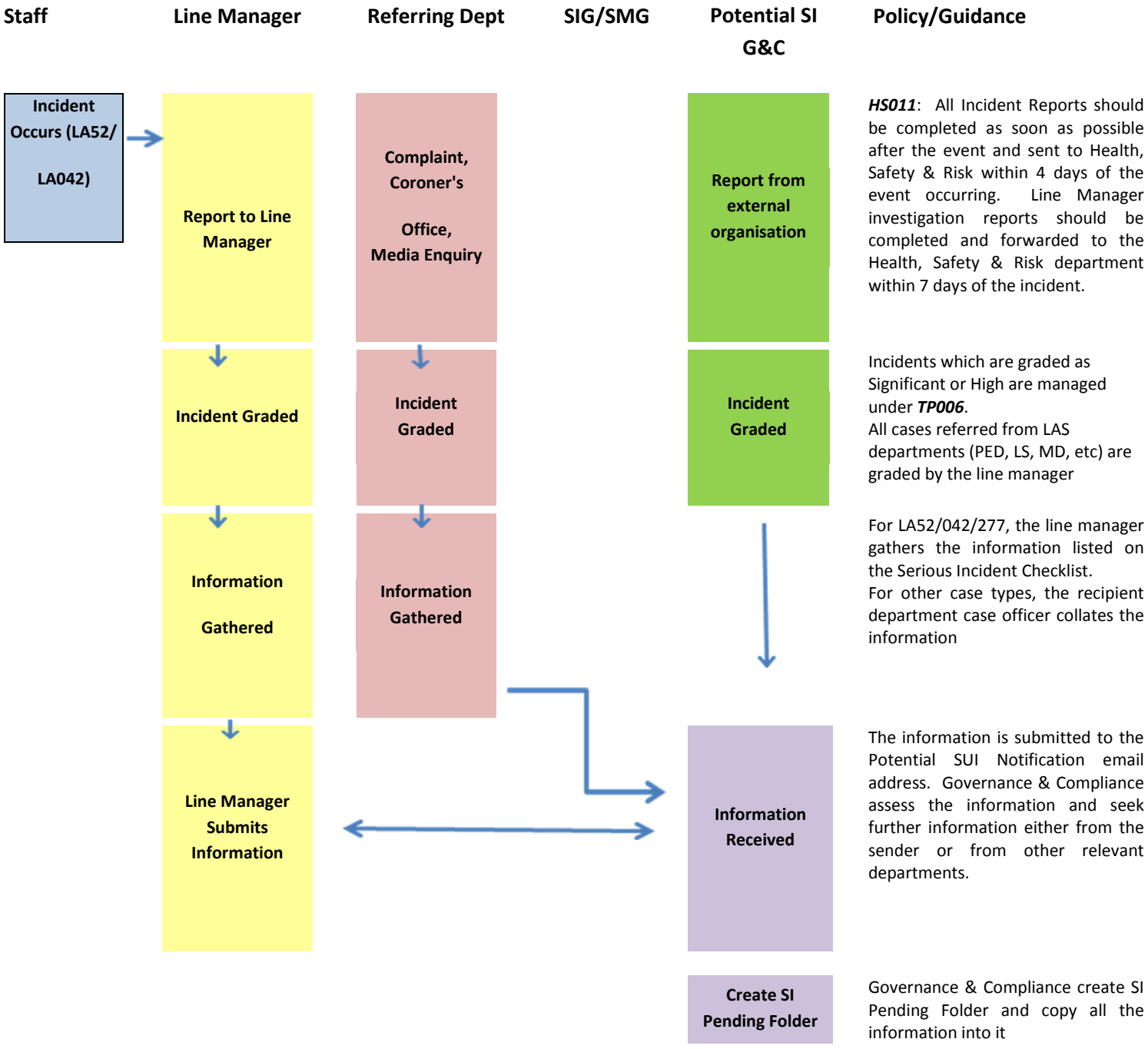
	Likelihood Score				
Impact Score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

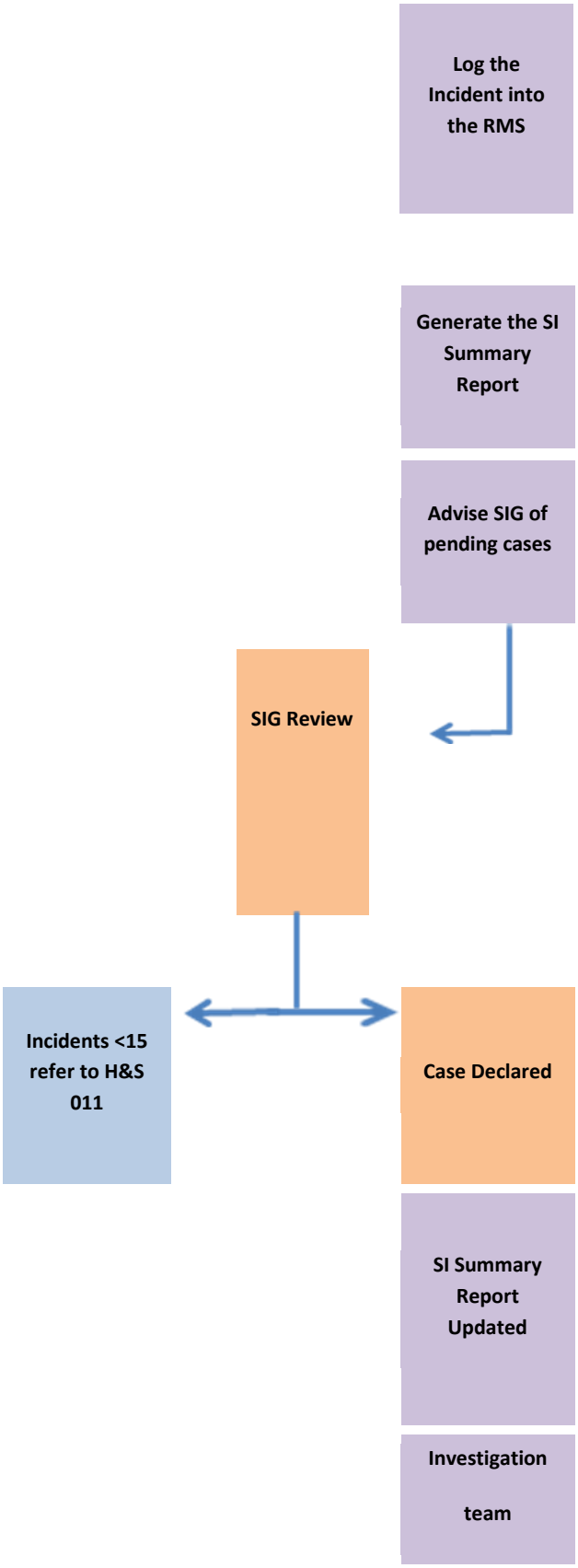
For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

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

Appendix 2

Workflow of Management Process




Log the Incident into the RMS
Governance & Compliance log the incident into the **Incidents** module of the Risk Management System (RMS).
Update the Folder with the RMS Reference Number
Generate the SI Summary Report
Governance & Compliance generate the SI Summary Report and save into the Pending Folder.
Advise SIG of pending cases
Governance & Compliance email SIG of pending cases along with the SI Progress report (Friday afternoon)
SIG Review
Weekly SIG Meeting to discuss pending incidents
SIG decides on declaration and provides the SI Risk Scoring, specifies Terms of Reference and nominates sponsor Director for the investigation
Incidents <15 refer to H&S 011
Case Declared
The ADCS uploads the incident to STEIS within 24 hours of SIG declaration, recording the STEIS reference and report due date into risk management system.
SI Summary Report Updated
SIG provides TOR for declared cases
SI Summary Report updated to reflect decision
Transferred from Pending to Declared Folder
Investigation team
ADCS identifies Investigation team and confirms family liaison plan.

Investigation Process

SIG/SMG/ADG	Potential SI/G&C	Policy/Guidance
	Planning Meeting	AD Corporate Services or G&C lead liaise with other departments and interested parties.
	Risk Assessment **Investigation Plan** **Milestones**	Review the documentation Perform a Risk Assessment & Check the Risk Register Prepare an investigation plan - collate statements & arrange interviews Discuss, agree and confirm timescales
	Root Cause Analysis Investigation	Gather information, conduct interviews, etc Map information Identify Care and Service Delivery Problems Analyse the information & identify Root Causes
	G&C team Challenge and Confirm	Progress report and review
	Draft report	Governance & Compliance - draft recommendations and action plans
	Assoc. Directors Group	Circulate draft report for comment and review to all interested parties. Response required within 3 working days.
	Director sponsoring report	Director sponsoring report reviews and provides feedback to G&C on actions necessary to complete the report. G&C update the SI Tracker for the Weekly Progress report

	Submit Report to SMG	SMG may decide that the report needs further review and will provide feedback to G&C on actions necessary to obtain full approval. If no further review is required the report is saved in pdf. G&C update the SI Tracker for the Weekly Progress Rpt
Associate Directors Group		ADG tasks individuals with the responsibility for implementing action plans. Progress with implementation will be monitored by ADG. Exception reports will be provided to SMG and individual Directors.
Submit Report to NHS London & NWL Commissioners Update SI Tracker		The ADCS submits the final approved report. G&C update the SI Tracker for the Weekly Progress Rpt & move the SI folder to 'Closed' folder
	NHS London Feedback	The ADCS meets with NHS London on a monthly basis to discuss their feedback on completed reports and to provide updates on action plan progress.
Monthly review at SMG	**Review Action Plan**	Action plans are monitored at the monthly ADG meeting. Escalation to SMG if action plans aren't progressing to time.
	Submit to ADG	
	Monitor Implementation	The ADCS is responsible for ensuring that action plans are complete and up to date for Clinical Quality Safety & Effectiveness Committee, Learning from Experience Group
	Action Plans Completed	Completed action plans are archived. Lessons learned and progress on action plans is included in the quarterly Learning from Experiences Group report. Annual audit of implementation and effectiveness included in the annual review and report.

Resources and Guidance for investigations are available in the secure Serious Incident folder.

Appendix 3

Data loss risk matrix

A score of 3 – 5 indicates that a Serious Incident should be declared to the Information Commissioner

0	1	2	3	4	5
No significant reflection on any individual body. Media interest very unlikely	Damage to an individual's reputation. Possible media interest.	Damage to a team's reputation. Some local media interest that may not go public	Damage to services reputation. Low key media coverage	Damage to an organisation's reputation. Local media coverage	Damage to NHS reputation. National media coverage
Minor breach of confidentiality Only a single individual affected.	Potentially serious breach. Less than 5 people affected or risk assessed as low. e.g. files were encrypted	Serious potential breach & risk assessed High. Up to 20 people affected. e.g. Unencrypted clinical records lost.	Serious breach of confidentiality. Up to 100 people affected	Serious breach with either particular sensitivity, e.g. sexual health details or Up to 1000 people affected	Serious breach with potential for ID theft or Over 1000 people affected