



## INCIDENT MANAGEMENT PROCEDURE

The aim of this procedure is to set out the way in which the Incident Management Policy is to be implemented and it should be read in conjunction with that document.

### Linked Policies, Procedures and Written Control Documents

Incident Management Policy  
Risk Management Policy  
Risk Management Procedure

### Scope

This procedure applies to all Public Health Wales staff, visitors, contractors, agency staff and volunteers and any reference to staff should be interpreted as including these groups. The procedure applies to all events which fall under the following criteria (as defined in paragraph 4)

- Incidents
- Serious incidents
- Never events
- Near misses
- No surprises

The following are not within the scope of this procedure:

- Raising concerns
- Whistleblowing
- Complaints and Claims
- Putting Things Right (PTR)

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## Disclaimer

**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Governance.**

### Summary of reviews/amendments

<b>Version number</b>	<b>Date of Review</b>	<b>Date of Approval</b>	<b>Date published</b>	<b>Summary of Amendments</b>
2.1	08/10/19			Minor revision to text in section 3.5
2.0	3/12/18			Extensive re-write

## **Important Note**

**In the event of any incident occurring which requires immediate action, nothing in this procedure should prevent or delay any person taking any action required to save life, prevent harm or limit the damage caused by the incident.**

**All staff are reminded of the need to consider the reputational impacts of certain types of incidents and to escalate any incident which could pose a risk to Public Health Wales to a senior manager without delay should there be any doubt.**

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# 1 Introduction

This procedure details the process for identifying, managing, reporting, investigating, and learning from incidents that arise in the course of Public Health Wales conducting its business and must be read in conjunction with the Incident Management policy.

It is the responsibility of all Public Health Wales staff<sup>1</sup> to follow this procedure and report any incidents or near misses which they become aware of.

## 2 Objectives

The objectives of the procedure are:

- To set out the roles and responsibilities of those staff who need to follow the policy
- To clearly define the events for which the procedure is intended
- To outline the reporting arrangements both internal and external
- To explain and signpost the use of the Datix platform
- To detail the procedures to be followed for:
  - Incident identification and notification
  - Categorisation
  - Investigation
  - Escalation
  - Reporting
  - Closure

## 3 Definitions

### 3.1 Incident

An incident is any unplanned event which leads to an undesirable effect on Public Health Wales. This can include effects on

- Service users
- Staff
- Visitors
- Members of the public
- Premises or property
- Other assets (including physical, virtual, information etc.)

### 3.2 Serious Incident

A Serious Incident (SI), is defined as:

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<sup>1</sup> In the interests of brevity, the term staff is used throughout this document to refer to staff, contractors, agency staff, volunteers, and secondees and visitors

An incident that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS;
- One of the core set of 'never events' (see below)

### 3.3 Never Event

Never events are a list of specific events which are defined by NHS Improvement in their Never Events Policy and Framework. Never events are defined as:

*...'Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Strong systemic protective barriers are defined as barriers that must be successful, reliable and comprehensive safeguards or remedies – for example, a uniquely designed connector that stops a medicine being given by the wrong route. The importance, rationale and good practice use of relevant barriers should be fully understood by and robustly sustained throughout the system, from suppliers, procurers, requisitioners, training units to frontline staff.'*

The full list of never events is provided in Appendix B.

### 3.4 Near Miss

A near miss is any unplanned event which had the potential to lead to one of the above, but did not actually do so. A near miss can happen in any area of the organisation. Examples would include a letter containing personal data being addressed to the wrong person but spotted before being sent out, or a staff member tripping over a loose carpet tile but suffering no injury.

### 3.5 No surprises

This is not a specific type of event, but is the term used for reporting incidents to Welsh Government (WG) which whilst not actually meeting the

criteria for a SI, are considered sufficiently noteworthy that an early report to WG is desirable. The decision to report via the 'no surprises' route will normally be taken by the Executive Director for Quality, Nursing and Allied Health Professionals in consultation with the Chief Risk Officer.

### *3.6 Investigating Officer*

This will apply to any person who has been tasked with leading the investigation into an incident, regardless of the level of the incident or the depth of the investigation required.

## **4 Roles and responsibilities**

### *4.1 Public Health Wales Board*

According to the Auditor General for Wales, the role of the Board is to govern Public Health Wales effectively and in doing so build public and stakeholder confidence that their health and healthcare are in safe hands.

In order for the Board to discharge its responsibilities, it needs to receive assurances that the organisation is effectively managing incidents and taking action to prevent recurrences and learn lessons in an effort to promote a culture of continuous improvement.

### *4.2 Chief Executive*

The Chief Executive is the responsible officer for Public Health Wales and is accountable for ensuring that the organisation can discharge its legal duties in relation to the health and safety of patients, service users and visitors. Operationally, the Chief Executive has delegated responsibility for implementation of this procedure to the Executive Director Quality Nursing and Allied Healthcare Professionals.

### *4.3 Executive Director, Quality, Nursing and Allied Healthcare Professionals*

- Is responsible for operational implementation of the incident management policy and procedures
- Approve the submission of any SI or No Surprises notifications to Welsh Government
- Brief the Chief Executive and/or Board as necessary on any SI or No Surprises incidents

### *4.4 All staff*

- Report any events which occur without undue delay through Datix
- Under exceptional circumstances, where the use of Datix is not immediately possible, ensure that the incident is reported verbally to a line manager. In these circumstances the staff member reporting

should ensure that the incident is reported through Datix as soon as practicable

- Cooperate with any investigation into an event

#### *4.5 Line managers*

- Ensure that any necessary preventative action has been carried out once an incident has been highlighted
- Ensure that a Datix report has been properly completed for all incidents
- Act as initial handler for any event reported by any of their direct reports
- Carry out the initial investigation into an event so reported
- Arrange where appropriate for handover of the event to a more suitable person for the purposes of handling and investigation

#### *4.6 Executive Director/ Director*

- Appoint an investigating officer to all Level 4 incidents
- Maintain oversight of any such investigation
- Ensure learning and remedial action is shared and instigated
- Provide update reports to Board / Committee on any SI investigations ongoing

#### *4.7 Divisional Director / Head of Department*

- Ensure that all incidents within their Division / department are managed and investigated in line with the requirements of this procedure
- Appoint an investigating officer to all incidents which fall into their area of responsibility
- Maintaining oversight of any investigations within their area
- Ensuring that lessons learned from incidents are identified and disseminated as necessary
- Ensuring that all incidents are closed within Datix in line with the requirements of this procedure

#### *4.8 Chief Risk Officer*

- Act as the organisation's Senior Investigations Manager
- Provide advice and support to the Director/ Divisional Director when appointing an investigating officer
- Maintain and ensure effective operation of the Incident Management System
- Ensure that the Datix system is adequately resourced and maintained
- Conduct investigations into Information Governance incidents
- Ensure that an appropriate risk assessment is carried out in relation to any potential data breaches.

## *4.9 Investigating Officer*

- Carry out the required impact and risk assessments on any incidents to which they have been assigned
- Conduct an investigation into such incidents which are proportionate in scale and depth to the severity of the incident, and in line with the instructions of their Directorate / Divisional Director
- Escalate any identified risks in accordance with the Public Health Wales Risk Management Procedure

## **5 Stages in incident management**

### *5.1 Stage 1 – Preventative Action*

In any incident, it is imperative that the first consideration must be to determine whether or not any immediate action is required to contain or control the incident, to prevent or minimise harm to people or the organisation and where necessary to take steps to prevent a recurrence of the incident. The line manager of the person reporting the incident will be responsible for ensuring that all necessary preventative action has been carried out.

In the event of an incident with safeguarding implications, this would include any necessary referrals (e.g. Police or Local Authority).

Use of the Incident Management Toolkit (Appendix A) at this early stage will help identify risks of recurrence and/or harm.

### *5.2 Stage 2 – Incident identification and notification*

All staff have a responsibility to report via Datix (see below) any event which falls into any of the criteria above as soon as reasonably practicable.

Public Health Wales uses the Datix platform for incident reporting. The Datix Incident Form (DIF1) captures the detail of the incident, and the organisations and the people involved. It acts as a record of the incident and a prompt to support action planning and reporting. All staff have access to Datix for the purposes of reporting incidents. Access is through the Public Health Wales intranet.

Any member of staff who is involved in, witnesses or discovers an incident or near miss must complete a Datix form DIF1 as soon as reasonably practicable and in any case within 24 hours of the incident coming to their notice..

Additionally staff should where possible make a verbal report to their line manager or to any suitably responsible person as soon as possible.

### *5.3 Stage 3 – Categorisation*

In order to determine an appropriate response, all incidents will be assessed and categorised. Incidents will be categorised according to both the impact they have (or may have had in the case of a near miss), and the likelihood of recurrence. Categorisation of incidents will be carried out using the Incident Management Toolkit (Appendix A). A simplified version of the Toolkit is provided as part of the Datix form and this must be completed for each incident.

Where the incident is known to meet the criteria for a Serious Incident, then a further assessment is not required and the matter will be dealt with as an SI from the outset.

## 5.4 Stage 4 - Investigation

### 5.4.1 General

An investigation is a fact-finding exercise to collect all the relevant information on a matter. A properly conducted investigation can enable an employer to fully consider the matter and then make an informed decision on it<sup>2</sup>.

All incidents will be investigated at one of four levels, as determined by the Toolkit.

Level 1	Incidents graded as Level 1 will be managed at operational level by team / laboratory / department manager in accordance with the day-to-day operational management procedures. No formal, detailed investigation is likely to be required.
Level 2	Incidents graded as Level 2 will be notified to the relevant departmental manager, who will determine the scope and depth of any investigation. It is unlikely that a detailed investigation will be required at this level.
Level 3	Incidents assessed as Level 3 must be investigated at a senior level within the Division / Directorate. The scope and depth of the investigation will be determined by the Director responsible who will be responsible for appointing an investigating officer. Whilst it is unlikely that a full root cause analysis will be required, an action plan will be required to address any outstanding issues.
Level 4	Incidents assessed as Level 4 must be notified as soon as possible to the Executive Director responsible and the Chief Risk Officer. Level 4 will include all incidents meeting the criteria for a Serious Incident (SI). The Executive Director, in conjunction with the Chief Risk Officer will appoint an appropriate senior manager to carry out the investigation. The investigating officer will be appointed within 24 hours of the incident coming to notice. A full investigation will be required, including root cause analysis and a formal action plan developed to address any outstanding issues. If the incident meets the criteria for a SI then a formal report must be submitted (see para 6 below).

### 5.4.2 Documentation

All incident investigations at all levels will be documented in Datix, and any documents associated with the investigation (minutes, notes, witness statements, reports etc.) will be uploaded to the relevant Datix Incident report.

If the incident is of a particularly sensitive nature, then it may be acceptable to store documents securely outside of the Datix platform, but this will only be done with the approval of the Chief Risk Officer.

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<sup>2</sup> [ACAS Guidance on Workplace Investigations, 2015](#)

### 5.4.3 Responsibilities

The Chief Risk Officer is responsible for ensuring that all incidents receive an appropriate level of investigation.

Incidents - All events classified as incidents will be investigated by the appropriate manager within the division where the incident or event occurred. If there is any doubt as to who should carry out the investigation, the Chief Risk Officer should be consulted.

*All events where there is an allegation that harm has or may have been caused **MUST** be referred to the Chief Risk Officer for advice.*

Serious Incidents / Never Events - In all cases the investigation will be carried out by a senior member of staff determined by the Divisional Director in conjunction with the Chief Risk Officer.

Near Miss - Investigation of near misses will depend on the potential outcome of the event had it not been dealt with, but broadly should follow the pattern above.

All investigations will be carried out in accordance with the guidance issued from time to time.

### 5.4.4 Joint investigations

If there is an incident involving a number of different Health Boards / organisations, a multi-agency investigation may be conducted. This will normally be led by the primary agency / organisation involved in the service user's care or the organisation in which the incident occurred.

For investigations which are multi agency, the final report and lessons learned will be shared with all the organisations involved.

### 5.4.5 Specialist investigations

Some incidents such as:

- Protection of Vulnerable Adults
- Safeguarding Children
- Information Governance / Security incidents and data breaches
- Health and Safety related incidents

...may require specialist investigations and the relevant policies and procedures must be followed.

Additionally, in some situations the investigation process may be complicated by other factors such as:

- The incident being subject to a Coroner's Inquest
- Investigation by the Health and Safety Executive or other external agencies

- The incident being subject to a complaint or claim
- Staff being subject to a HR investigation relating to the incident

If there is any doubt as to the appropriate engagement for specialist investigations, then immediate advice should be sought from the Chief Risk Officer.

#### *5.4.6 Serious Incident investigations*

All SIs reported to Welsh Government are graded by them for the purposes of investigation.

##### Grade 1

It is expected that a comprehensive investigation (RCA level 2 investigation) should be completed within **3 calendar months**. The investigation report and action plan and learning will be reviewed by the Public Health Wales Quality, Safety and Improvement Committee. The report and action plan will also be sent to the Welsh Government for review and confirmation that they are content with the actions undertaken prior to closing the incident.

If it appears that an incident investigation cannot be completed within the timescale agreed the Chief Risk Officer must be notified as soon as possible, and an extension to the reporting timescales will be sought from the Welsh Government.

##### Grade 2

This will follow a similar process to the above, but in addition to the internal investigation the incident may also be referred for independent external review by Health Inspectorate Wales (HIW) or other regulatory bodies.

#### *5.4.7 Confidentiality in investigations*

Great care must be taken when reporting and investigating incidents not to breach confidentiality. In particular, the use of Datix must be carefully considered in cases of Safeguarding, Whistleblowing or matters concerning HR. Additionally, personal data must not be put into any Datix record unless there is a clear need and then only in the appropriate fields. In case of doubt advice should be sought from the Chief Risk Officer.

### *5.5 Stage 5 – Learning lessons*

It is important to remember that a key element of the incident management system is identifying lessons and learning from them, in order to prevent recurrences and promote continuous improvement. Any

incident at any level can have lessons for the organisation and so lessons must be shared as widely as possible across the organisation. Even where a lesson is obvious and an improvement measure can be put in place locally very quickly, the lesson needs to be passed to other parts of the organisation who may also benefit from the experience.

The Board Committees support organisational learning, which is then shared locally through Divisions and throughout Public Health Wales. Action plans and risk reduction measures are managed and followed up locally within Divisions by the Divisional Director and Divisional General Managers / Business Managers. Following the conclusion of an incident, an analysis will be undertaken to extract the lessons learnt, to prevent recurrence. The Divisions are responsible for ensuring that lessons learned from analysis of incidents result in a change of practice.

Within Public Health Wales, lessons learned arising from incidents will be shared via the following routes:

### **Individual**

- Reflective practice
- Discussed as part of staff supervision
- Policies and procedures to be made available to staff

### **Team / Laboratory / Programme**

- Reviewing incidents that have occurred within the Team / Laboratory / Programme area
- Team / Laboratory / Programme briefings on lessons learnt
- Discussed at team meetings

### **Divisional**

- Management Meetings to review incidents, along with reports from individual teams, laboratories, programmes
- Monitoring of progress against action plans
- Promotion of learning and best practice through Divisional structures and staff

### **Trust Wide**

- Staff e-bulletin
- Service users / staff stories
- Mandatory training – incorporating learning from incidents into relevant training courses.
- Review of reports and external investigations by the following Committees and Groups
  - Quality Safety and Improvement Committee
  - Information Governance Working Group
  - Health and Safety Group
  - Infection Control Group
  - Dissemination of safety alerts
  - Service User Experience and Learning Panel

Where appropriate the Public Health Wales will share learning from incidents with the host organisations, stakeholders and partners.

## *5.6 Stage 6 – Closure*

Incidents will be closed off in Datix once there is no further benefit in them being kept open. This will usually be when the investigation has been completed, the lessons or improvement measures identified and the action plan to address the lessons and improvements has been accepted by the appropriate management team.

It will not normally be necessary for the incident to remain open until the action plan has been delivered as this may take many months.

Divisional Directors / Head of Department are responsible for ensuring that wherever possible, incidents will be closed in Datix within 30 days of the incident being reported. Where this is not possible, the Chief Risk Officer must be notified and agreement reached for an extension of the 30 days deadline.

## **6 Internal incident reporting**

### *6.1 Datix*

All incidents will be reported via the Datix platform. Any member of staff can access the system to report an incident. Standard Operating Procedures for the use of all Datix applications will be issued from time to time and all staff are required to follow these procedures. Such procedures will be available through the Datix application or the Risk and Information Governance Sharepoint site on the Public Health Wales intranet.

### *6.2 Committee and Board reports*

All SIs reported to Welsh Government must be subject of a report either to the Public Health Wales Board, or the appropriate Board Committee at the first available opportunity.

It is the responsibility of the Director / Executive Director overseeing the investigation to ensure that an update report is prepared and submitted to the relevant Committee or Board in line with the publication deadlines for the relevant meeting.

## **7 External incident reporting**

### *7.1 Serious Incident and 'No Surprises' reporting to Welsh Government*

The Chief Risk Officer is responsible for notifying Welsh Government of Serious Incidents (SI). Where possible, SIs must be reported to the Welsh Government within 24 hours of the incident, otherwise the report must be made as soon as is reasonably practicable. Incidents are notified using the Welsh Government notification form.

Prior to reporting of an SI to Welsh Government, all reports must be approved by the responsible Director, along with the Executive Director for Quality, Nursing and Allied Health Professionals.

It is important to remember that the reporting of SIs to the Welsh Government (and consequently the National Reporting and Learning Systems - NRLS) does not exclude the requirement where appropriate to report to other bodies, e.g. Health Inspectorate Wales, Health and Safety Executive, Information Commissioners Office etc.

Early consideration should also be given to provision of information and support to patients, relatives and staff involved in the incident, in line with the Putting Things Right Policy.

The Head of Communications should also be notified. However, if this occurs out of hours (i.e. weekdays after 5pm or before 8 am or at weekends) the matter should be escalated through the recognised Communications Team on call arrangements by ringing the central office on 029 20 348755 for the details of Communications Officer on call. The on call Communications Officer will be responsible for contacting the Welsh Government's press office and notifying the Executive Director on call.

From time to time incidents will occur which, whilst not meeting the criteria for a Serious Incident, will still need to be reported to Welsh Government. An example would be where there is potential for an impact on Welsh Government directly, or nationwide publicity on a subject. In this case it is usual to submit a 'No Surprises' notification to Welsh Government. This is done by completion of a similar form to that for Serious Incidents and the submission route is the same.

## *7.2 Health & Safety Executive (HSE)*

In line with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Incidents, Public Health Wales has a statutory responsibility to report certain incidents / accidents which occur during the course of work activity to the HSE. Failure to comply with this may lead to Public Health Wales being prosecuted for a breach of regulations and further enforcement action being taken.

RIDDOR incidents are reported to the HSE by the Head of Estates and Health and Safety following notification. Details of the incident need to be reported to the HSE within 10 days of the incident. Early notification of accidents/incidents means that Public Health Wales is able to comply with this requirement. Liability lies with the "responsible person" i.e. the person in charge of the work activity in that area in line with managers' responsibilities.

All RIDDOR reports and supporting information will be uploaded into Datix and linked to the relevant incident (see para 5).

There may be other instances where the HSE may need to be notified of incidents which occur. This will depend on the circumstances and severity of the incident. The Head of Estates and Health and Safety will advise

whether it is necessary to inform the HSE and whether the area involved needs to be isolated until a HSE Inspector has visited.

### *7.3 The Information Commissioner's Office (ICO)*

The ICO must be notified of any data breach, where a risk assessment shows there to be a risk to the rights and freedoms on the data subject. All Information Governance incidents will be reported through the Datix platform in the usual manner, and any potential data breaches are risk assessed by the Chief Risk Officer who will make a decision and report the incident where appropriate.

Under no circumstances should data breaches be reported outside of the organisation without prior approval of the Chief Risk Officer (or in his absence the Senior Information Risk Owner).

### *7.4 The Medicines and Healthcare Products Regulatory Agency (MHRA)*

The MHRA is the Executive Agency of the Department for Health responsible for protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely.

Public Health Wales is required to report to the MHRA, any adverse incident involving a medical device, especially if the incident has led to or, were it to occur again, could lead to death or serious injury, medical or surgical intervention (including implant revision), hospitalisation or unreliable test results.

Electronic reporting using the online form on the MHRA website is the preferred method. Reports may however also be sent by e-mail, fax or post. Report forms may be downloaded / printed from the MHRA website.

Any report being considered for the MHRA must first be notified by Datix in the usual manner, and also notified to the Chief Risk Officer and the Head of Estates and Health and Safety.

### *7.5 Shared Services Partnership - Facilities*

The following incidents, which involve defects and failures of buildings, plant, nonmedical equipment or fire protection installations and equipment, will be reported to the Shared Services Partnership - Facilities, via the Head of Estates and Health and Safety:

- Any event, which gives rise to or has the potential for unexpected or unwanted effects involving the safety of service users, staff and others;
- Incidents that arise through incorrect use, inappropriate modifications or adjustments, or inadequate servicing and maintenance procedures;

- Deficiencies in the technical or economic performance of equipment;
- Any defects in product, instructions, identified by Health & Safety Inspectors or Local Authority Inspectors;
- Failure in critical services (electricity, water, steam, gas, communication etc.) that would affect the safety of service users and others.

## 7.6 *Other*

Depending on the circumstances and severity of the incident, other external stakeholders may need to be notified (and in some instances involved in the investigation) of incidents which occur.

Examples of external reporting would include:

- Members of Parliament / Assembly Members
- Other hospitals / Health Boards
- Legal representatives
- Police
- Coroner
- General Medical Council / General Nursing Council
- Local Authorities
- Social Services
- Emergency Services
- Ombudsman
- Deanery
- Trades Unions or other staff associations

In all cases where external agencies are being considered for notification of an incident the advice of the Chief Risk Officer must be obtained prior to making any report.

## **8 Incident reporting and Risk Management**

It is imperative that there is a clear link between incident management procedures and the organisation's risk management procedures. This will ensure that when dealing with incidents a clear understanding is developed of the risks of the incident happening again and what that would mean for the organisation.

For this reason all incidents, in addition to the assessment of the actual impact, must be assessed for the risk of recurrence. This is done by using the same toolkit as described in para 4.2.

The investigating officer will be responsible for reporting and escalating any risks identified in accordance with the Public Health Wales Risk Management Procedure.

## **Appendix A – Incident Management Toolkit**

The purpose of this toolkit is to guide you through the stages required to assess the impact of any given incident as it happened, together with the likelihood and potential impact of any future recurrence. This toolkit is based upon the Public Health Wales Risk Management Policy and Procedure and for further detail, these documents should be consulted. It is recognised that the vast majority of incident will be reported through Datix, and a simplified version of this toolkit is available on the incident pages within Datix (see below)

### ***Step 1 – Assess the impact of the incident***

This is the impact of the incident as it actually happened, in other words what was the actual outcome. This is assessed against the impact criteria outlined in the Public Health Wales Risk Management Procedure which is reproduced below. This can also be found.

On the incident investigation tab within Datix can be found the set of domains, or criteria (e.g. safety of service users, quality, service continuity and so on). With reference to the table below, select the domains which may apply - there may be several. Then, for each domain that applies, decide the level of impact that the incident has had. For each domain, there are descriptions available in the table that describe what each level might look like, so all you need to do for each applicable criteria, is to find a description that closest matches the incident that you are dealing with. You should not interpret these descriptions too literally, they are only descriptions of what certain levels of impact could look like.

Once you have completed the Datix entry for all applicable domains, you need to decide on the overall score. This will usually be the highest of the individual scores but not necessarily. Again it is a matter of judgement. The overall score will determine the level of incident management required (See para 4.3). All level 4 incidents must be considered for management as a Serious Incident.

Table 1	Impact score and examples of descriptors				
	1	2	3	4	5
<b>Domains</b>	<b>Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Critical</b>
<b>Safety of service users, staff or visitors</b>	Superficial injury requiring first aid treatment.  No sickness absence  Not reportable  No long term effects	Minor injury or illness requiring medical intervention  Sickness absence up to 7 days  Not reportable  No permanent effects	Injury or illness resulting in hospital treatment as an in-patient  Sickness absence up to 28 days  RIDDOR/agency reportable incident  Potential for long term effects	Injury or illness resulting in long term hospitalisation or long term effects  Protracted sickness absence  RIDDOR/agency reportable incident  Life changing illness or injuries	Life threatening traumatic injury  Potential ill-health retirement  Reportable to Police  Death of a service user, staff member or visitor
<b>Quality</b>	Single instance of suboptimal service  No failure to meet Health and Care Standards 2015	Repeated instances of suboptimal service  Single failure to meet Health and Care Standards 2015	Repeated failure to meet internal standards  Repeated failures to meet Health and Care Standards 2015	Service delivery not fit for purpose  Repeated major failures in the Quality Management System	Service delivery impossible / ceased  Complete breakdown of Quality Management System
<b>Staffing (availability of competent, trained staff)</b>	No impact on staffing levels	Staffing levels impacted but no impact on service delivery	Staffing levels having major impact on service delivery	Staffing levels make service delivery unsafe	Staffing levels such that service delivery impossible
<b>Legislative / Regulatory compliance</b>	No breaches of legislation or regulatory requirements	Minor isolated breaches of legislation or regulatory requirements	Breaches of legislative / regulatory compliance requiring formal reporting to the relevant authority	External investigation resulting in formal notices from regulators	Criminal / penal sanctions for legislative breaches
<b>Adverse publicity/ reputation including Social Media (SM)</b>	No media interest  No WG interest  No social media traffic	Minor local media coverage  Informal enquiries from WG  Small amount of SM traffic	Extensive local media coverage including TV/Radio  Enquiries from WG Officials  Noticeable increase in SM traffic requiring a response	National / professional media coverage  WG Ministerial interest  Extensive SM traffic requiring additional resource to manage	Extensive national / professional media coverage  Parliamentary questions tabled  Intense SM traffic outstripping our ability to manage it

	Potential for public concern	Elevated levels of complaints and concerns raised by public	Noticeable drop off in appointments from service users	Extensive cancellation of appointments or lack of bookings	Total loss of public confidence
<b>Business objectives/ projects</b>	No impact on project	Project cost over-run	Significant cost over-run on project	Severe cost / time over run on project. Project delivery in jeopardy.	Failure of project
	No impact on delivery of objectives	Isolated instances of missing deadlines with objectives	Repeated missed deadlines, objective delivery in doubt	Significant additional resources required to deliver objective(s)	Failure to deliver objective(s)
<b>Finance including claims</b>	Insignificant or no financial loss	Loss of 5 per cent of budget	Loss of 10 per cent of budget	Loss of 15 per cent of budget	Loss of 20 per cent of budget
	Possibility of a claim remote	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Claim(s) >£1 million
<b>Service continuity</b>	No impact on service delivery	Minor impact on service delivery managed locally	Major impact on service delivery requiring additional resources	Major impact on service delivery requiring major incident response	Failure of service delivery
<b>Information Security</b>	No impact on Information security	Data breach resulting in loss of personal data of <10 people	Data breach resulting in loss of personal data of <100 people	Data breach resulting in loss of personal data of <1000 people	Data breach resulting in loss of personal data of >1000 people

Table 2	Impact score and examples of descriptors				
	1	2	3	4	5
<b>Domains</b>	<b>Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Critical</b>
Safety of service users, staff or visitors					
Quality					
Staffing (availability of competent, trained staff)					
Legislative / Regulatory compliance					
Adverse publicity/ reputation including Social Media (SM)					
Business objectives/ projects					
Finance including claims					
Service continuity					
Information Security					
<b>Incident Category</b> (tick one only)	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>	<b>Level 4</b>	

## Step 2 – Assess the risk of recurrence

You now need to assess the likelihood and impact of a recurrence of this incident. Again, this will be done through the Datix application.

### Likelihood

First, assess the likelihood of the incident recurring. To do this we use the standard PHW risk assessment tool reproduced in Table 3 below.

Table 3	Likelihood Score				
	1	2	3	4	5
Frequency	Highly Unlikely	Unlikely	Likely	Highly Likely	Almost certain
How often would you expect this event to occur within the next five years	No history, or very isolated historical examples. Almost certainly will not occur	Has occurred in the past but considered unlikely to occur again	Has occurred on numerous occasions in the past and / or other evidence exists to suggest that the likelihood exists that this will occur	Historical and / or other evidence suggests strong likelihood that this will occur	Significant historical and / or other evidence exists that suggests this will almost certainly occur

### Impact

Once we have determined likelihood, we move onto impact. It is important to remember that in assessing the risk of recurrence, the impact of a future occurrence may not be the same as the impact of the incident you are currently managing. Now you must work on what is called the 'reasonable worst case scenario', and not simply on what happened last time. For example, you may be dealing with an incident where a member of staff was injured, but the actual impact was very minor, the injury was superficial and no time off work was required. However, the nature of the incident suggests that this was more by good luck and if this happened again there is every likelihood that someone could be seriously injured. So in assessing the risk of future occurrence, we do not assess the impact of what actually happened, rather the most probable impact; in other words the reasonable worst case scenario.

Once again, decide which domains are most appropriate and then work across the columns to find the description that closest matches your reasonable worst case scenario. Again the impact score will usually be the highest of the domains that you assess but not necessarily, it is a matter of judgement.

Once the likelihood and impact in each case have been determined, the two are multiplied to generate the final risk severity score, which translates into one of four severity levels (as shown on the risk map below).

### Risk Map

The risk map is where the two scores come together. The Impact and the likelihood are multiplied and the product of the two is the severity score. The severity score translates into one of four severity levels: low, moderate, high or extreme.

<b>Impact</b>	<b>5</b>	<b>Critical</b>	<b>5</b>	<b>10</b>	<b>15</b>	<b>20</b>	<b>25</b>	Low Risk
	<b>4</b>	<b>Major</b>	<b>4</b>	<b>8</b>	<b>12</b>	<b>16</b>	<b>20</b>	Moderate Risk
	<b>3</b>	<b>Moderate</b>	<b>3</b>	<b>6</b>	<b>9</b>	<b>12</b>	<b>15</b>	High Risk
	<b>2</b>	<b>Minor</b>	<b>2</b>	<b>4</b>	<b>6</b>	<b>8</b>	<b>10</b>	Extreme Risk
	<b>1</b>	<b>Negligible</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	
<b>Table 4</b>			<b>Rare</b>	<b>Unlikely</b>	<b>Likely</b>	<b>Highly Likely</b>	<b>Almost certain</b>	
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	
			<b>Likelihood</b>					

### ***Step 3 – Risk Management***

Once the assessment has been carried out then the investigating officer is responsible for ensuring that any risks are managed through the Public Health Wales Risk Management Procedure. This will normally mean reporting the risks to the appropriate manager, but this will be a matter for discussion between the investigating officer and the responsible Director/Head of Department.

## **Appendix B – Approved list of ‘Never Events’**

For full details and an up to date listing, go to: [https://improvement.nhs.uk/documents/2899/Never\\_Events\\_list\\_2018\\_FINAL\\_v6.pdf](https://improvement.nhs.uk/documents/2899/Never_Events_list_2018_FINAL_v6.pdf)

### **Surgical**

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post procedure

### **Medication**

- Mis-selection of a strong potassium solution
- Administration of medication by the wrong route
- Overdose of insulin due to abbreviations or incorrect device
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation

### **Mental health**

- Failure to install functional collapsible shower or curtain rails

### **General**

- Falls from poorly restricted windows
- Chest or neck entrapment in bed rails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients
- Unintentional connection of a patient requiring oxygen to an air Flowmeter
- Undetected oesophageal intubation