Incident Reporting Policy



# Document Control:

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| --- | --- |
| Policy Name | Incident Reporting Policy |
| Policy Number | MSEICB 024 |
| Version | V1.4 |
| Status | Approved |
| Author / Lead | Sara O’Connor |
| Responsible Executive Director | Chief of Staff |
| Responsible Committee | Audit Committee |
| Date Ratified by Responsible Committee | 27 June 2022 (virtual review) |
| Date Approved by Board/Effective Date | 1 July 2022 |
| Next Review Date | July 2025 (review date extended by Audit Committee, 15 April 2025) |
| Target Audience | * Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/voluntary/work experience staff). * Contractors engaged by the ICB. * Staff from other MSE Health and Care Partnership (HCP) organisations who are members of ICB Committees/Sub-Committees and other groups. |
| Stakeholders engaged in development of Policy (internal and external) | * Mid and South Essex CCG Governance Leads. * MSE CCGs Audit Committees meeting in common. |
| Impact Assessments Undertaken  *(Delete if non-applicable)* | * Equality Impact Assessment at Appendix A. |

# Version History

| Version | Date | Author (Name and Title) | Summary of amendments made |
| --- | --- | --- | --- |
| 0.1 | 20/06/2022 | Sara O’Connor, Head of Corporate Governance | Draft ICB Policy |
| 0.2 | 27/06/2022 | Iain Gear, Information Governance Team | Amendment to Information Governance Incidents section and insertion of Appendix B. |
| 0.3 | 29/06/2022 | Pauline Stratford, Lay Member.  Staff Engagement Group | Minor amendments to sections 6.8.4. and 6.8.5.  No comments from SEG. |
| 1.0 | 19/07/2022 | Sara O’Connor /  Charlotte Tannett | Final review before uploading to website. |
| 1.1 | 23/07/2024 | Helen Chasney, Corp Svcs & Gov Support Officer | Review date extended to September 2024 by Audit Committee (23 July 2024). |
| 1.2 | 15/10/2024 | Helen Chasney, Corp Svcs & Gov Support Officer | Review date extended to January 2025 by Audit Committee (15 October 2024) |
| 1.3 | 21/01/2025 | Helen Chasney, Corp Svcs & Gov Support Officer | Review date extended to April 2025 by Audit Committee (21 January 2025). |
| 1.4 | 15/04/2025 | Helen Chasney, Corp Svcs & Gov Support Officer | Review date extended to July 2025 by Audit Committee (15 April 2025). |

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## Introduction

The Mid and South Essex (MSE) Integrated Care Board (‘the ICB’) will work collaboratively across the Mid and South Essex Integrated Care System (‘the ICS’) footprint to manage incidents.

## Purpose / Policy Statement

This policy sets out the ICB’s arrangements for reporting and managing incidents, including identifying and disseminating learning to prevent recurrence.

The purpose of the policy is to establish and maintain a framework for the initial reporting, investigation and management of incidents which:

* Encourages staff to report all incidents, including near misses, with assurance that there is an open and transparent ‘fair blame’ culture with a focus on identifying and sharing learning and implementing appropriate controls to prevent recurrence.
* Ensures there is an accurate record of the circumstances of each incident to support investigation of incidents (either by the ICB and/or other relevant agencies), including those which result in a complaint or legal proceedings.
* Supports the ICB in achieving its strategic objectives and realising the significant safety, quality, financial and other organisational benefits from effectively managing incident reporting.
* Ensures processes are based on best practice, national guidance, legislation, taking account of organisational needs so that incidents are managed systematically and consistently.
* Supports the ICB’s integrated risk management approach across all areas of corporate and clinical/professional risk which is embedded within day-to-day operational functions across MSE. This includes triangulation of themes identified from incidents and other processes, such as the management of complaints and legal claims.

Incidents which meet the criteria of a serious incident will be managed in accordance with the Management of Serious Incidents Policy.

## Scope

This policy applies to the following (collectively known as members of staff):

* Mid and South Essex (MSE) Integrated Care Board (ICB) members.
* Members of staff (including temporary/bank/agency/voluntary/work experience staff).
* Contractors engaged by the ICB.
* Members of staff from other MSE partner organisations who are members of ICB Committees/Sub-Committees, advisory groups/other groups or otherwise involved in ICB business.

The policy applies to all areas of the ICB’s responsibilities and activities and all ICB premises and other assets, including incidents involving ICB staff whilst they are working in premises owned or occupied by other organisations.

## Definitions

* **Incident** - an occurrence or unplanned event resulting in actual or potential loss or harm to persons, property, the environment or other assets. Examples include clinical incidents, health and safety related accidents, incidents of violence or aggression, security breaches or vandalism, information governance breaches, fire, theft and environmental damage. Within this policy, an incident includes a ‘near miss’ (see below).
* **Near Miss -** an event or circumstances that was prevented or narrowly avoided which, had it occurred, had the potential to cause injury, harm, loss, damage or other detrimental impact.
* **Serious Incident** - the NHS England Serious Incident (SI) Framework published in March 2015 defines that serious incidents are events in health care where the potential for learning is so great, or the consequence to patients, families and carers, staff or organisations are so significant that they warrant using additional resources to undertake a comprehensive response. It is emphasised that serious incidents can extend beyond incidents which affect patients directly and can include incidents that may indirectly impact patient safety or an organisation’s ability to deliver on-going healthcare e.g. electrical failure.

Whilst there is no definitive list of events/incidents that constitute a serious incident, this would include acts or omissions in care that result or could have resulted in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm, abuse, never events, incidents that prevent an organisation’s ability to continue to deliver an acceptable quality of healthcare services and incidents that may cause widespread public concern.

Further information on what constitutes a serious incident is set out in the Management of Serious Incidents Policy.

* **Serious Harm** - the SI framework defines serious harm as:
* Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care)
* Chronic pain (continuous long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery)
* Psychological harm, impairment to sensory, motor, or intellectual function or impairment to normal working or personal life which is likely to be temporary (i.e., has lasted, or is likely to last for a continuous period of at least 28 days)
* **Major Incidents** – An event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. Examples include communicable disease outbreaks, terrorist incidents, major transport accidents, loss of healthcare facilities. Please refer to the Incident Response Plan.
* **Never Events** - patient safety incidents that are wholly preventable where guidance or safety recommendations providing strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

See <https://www.england.nhs.uk/publication/never-events/> for the list of never events.

* **Duty of Candour** - Regulations set out duty of candour with definitions of openness, transparency and candour used by Robert Francis in his report.
* **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
* **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
* **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.
* **Root Cause** – can be defined as a fundamental, underlying, system-related reason why an incident occurred that identifies one or more correctable system failures. It can also be described as a triggering event, condition or set of circumstances, often consisting of one or more contributory factors.
* **Contributory Factor** – one or more factors that led to an incident occurring or affected the impact of the incident.

## Roles and Responsibilities

### Integrated Care Board (ICB)

* + 1. The ICB Board has overall responsibility for ensuring that the organisation has a robust system in place for the management, investigation and monitoring of incidents and SIs.

### Audit Committee

* + 1. The Audit committee has responsibility for monitoring the ICB’s compliance with this policy and is the ‘sponsoring committee’ referred to in Section 9 Below.

### Quality Committee

* + 1. The Quality Committee is responsible for monitoring outcomes from SI investigations declared by providers for which the ICB is the lead commissioner and for escalating any concerns to the ICB as set out in the [Management of Serious Incidents Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e).

### Chief Executive

* + 1. The Chief Executive has overall accountability for implementing this policy.

### Chief of Staff

* + 1. The Chief of Staff is responsible for operational implementation of this policy.

### Policy Authors

* + 1. The policy author will have responsibility for developing and updating the policy in line with Section 9.

### Incident Reporting Lead

* + 1. The Incident Reporting Lead has responsibility for managing incidents, including liaising with managers regarding incident investigation, identification of learning, and reporting incidents to enforcing authorities where required.

### Other Directors and Managers

* + 1. Directors and managers are responsible for ensuring that all incidents occurring within their area of responsibility are reported and investigated in accordance with this policy.
    2. Following an incident investigation, directors and managers must ensure that any learning identified is shared with members of their directorate/team and that appropriate action is taken to prevent recurrence, including monitoring its effectiveness.
    3. Where appropriate, directors and managers will be responsibility for ensuring that the Duty of Candour, as set out in the [Management of Serious Incidents Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e), is discharged.

### All Staff

All members of staff are individually responsible for:

* + - Familiarising themselves with the content of this policy and associated procedures and following these.
    - Being aware of their duty under legislation to maintain safe working practices and to take reasonable care of their own health, safety and welfare and that of others by complying with all relevant ICB policies, procedures and guidance to prevent incidents that might cause personal injury or harm.
    - Complying with all relevant ICB policies to minimise the risk of incidents relating to loss or damage to ICB property.
    - Reporting incidents/accidents and near misses using the ICB incident reporting procedure.
    - Co-operating with the investigation of incidents by the ICB, auditors, the police, the Health and Executive or other enforcing authorities.

### Partnership Working

The ICB will work closely with its partner organisations to ensure that incidents which are cross-organisational in nature are investigated in an open and transparent way to ensure that learning is identified and shared.

## Incident Reporting and Investigation Process

### Immediate Action to be Taken Following an Incident

* + 1. Following an incident, the priority is to ensure that immediate action is taken to ensure the safety of those involved and/or that the security/safety of property, other assets or the environment is achieved.
    2. Depending on the nature and seriousness of the incident, the police or other emergency services should be contacted. Where appropriate, access to the site of the incident should be prevented and the scene preserved to enable investigation.
    3. Managers should ensure that staff who are injured or affected by an incident receive appropriate immediate and ongoing support as required. Where an individual suffers serious harm, managers should contact the next-of-kin if the individual is unable to do this themselves.

### How to Report an Incident

* + 1. The ICB will review the method by which incidents are reported internally, with a view to implementing an on-line reporting system, which will ensure that managers receive immediate notification of incidents within their area of responsibility. Until then, all incidents (including near misses) should be reported on the incident reporting form at **Appendix B** and available on the ICB intranet.
    2. Where appropriate and possible, staff who are directly involved in or affected by the incident should complete the initial report as soon as reasonably practicable and submit the report to their line manager for review and sign-off. Alternatively, the relevant manager should complete the report based on information provided to them by those involved.
    3. Reports should be factual (not provide opinion) and must include as a minimum the date and time of the incident (if the exact date/time is not known, this should be stated on the report form along with the date/time the incident was discovered), site/location, circumstances of the incident, details of any injury/harm/damage (including name/contact details of individuals adversely affected), immediate action taken, and any witnesses to the incident (name/contact details). The cause of the incident and any contributory factors should also be provided where these are known at the time of reporting.
    4. Written statements from those directly involved in, or witnesses to, the incident should be sought as soon as possible and appended to the initial report. Statements should be based on what the individual saw, heard, felt, tasted, or smelt, immediately prior to, during or after the incident occurred. Information should be succinct and in chronological order of events. Witness statements must be signed and dated. Where necessary, additional witness statements or clarification may be sought by the investigating manager.
    5. Completed reports and witness statements should be submitted to the Incident Reporting Lead as soon as possible and within 2 working days for logging and dissemination to other managers as required.

### Health and Safety Related Incidents (including Fire Safety)

* + 1. The Health and Safety/Incident Reporting Lead will review all incidents to determine whether a report to the Health and Safety Executive (HSE) or other enforcing authority under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 must be submitted, as per the [Health and Safety Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e).
    2. Where an incident results in death or major injury, the Health and Safety Lead/Incident Reporting Lead must be notified immediately so that a report can be submitted without delay to the Health and Safety Executive, or other enforcing authority, as per RIDDOR.
    3. Where an incident is reported which involves circumstances such as violence or aggression, bullying and harassment, fire, manual handling, breach of security, etc. it will be referred to the appropriate manager(s) and investigated as per the relevant policy.

**Information Governance Incidents**

* + 1. Information Governance (IG) incidents should be reported via the usual incident channels as described in this policy. The Incident Reporting Lead will ensure that any IG incidents are immediately notified to the IG Team.
    2. The IG incident team will consider whether the incident should be categorised as a Serious Incident Requiring Investigation (SIRI). If the incident is categorised as a level 2 SIRI, or meets other characteristics, a report will be submitted to the Information Commissioners Office, Department of Health or other central bodies/regulators via the Data Security & Protection Toolkit. Details of what constitutes a reportable incident is set out within the [Information Governance Framework and Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e).
    3. The IG Team will liaise with managers and staff to investigate the incident, produce an investigation report where required, and agree any action required to prevent recurrence.

**Serious Incidents**

* + 1. The Incident Reporting Lead will ensure that any incidents that appear to meet the serious incident (SI) criteria are drawn to the attention of the Quality Team and/or other appropriate team/managers.
    2. Where it is agreed that the SI criteria is met, the investigation will be conducted in accordance with the [Management of Serious Incidents Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e).

**Major Incidents**

* + 1. Managers and the Incident Reporting Lead must ensure that any incidents that appear to meet the Major Incident (MI) criteria are immediately drawn to the attention of the Emergency Planning, Resilience and Response Team, as per the Incident Response Plan.

**Incidents involving Fraud, Bribery or Corruption**

* + 1. Actual or suspected incidents or fraud, bribery or corruption, must be reported to the ICB’s Local Counter Fraud Specialist and investigated in line with the [Counter-Fraud, Bribery and Corruption Policy.](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e)

**Investigating Incidents**

* + 1. The level of incident investigation required will depend on the nature, severity and categorisation of an incident, as set out in the preceding paragraphs.
    2. Where an incident is deemed to be a SIRI, SI or MI, the investigation must be undertaken in accordance with the relevant policy or procedures.
    3. For all other incidents, managers should ensure that an investigation is undertaken, which should be proportionate to the circumstances and impact of the incident (in terms of time and resources spent / length of report).
    4. The investigation report, which may be included within the final version of the incident report form or submitted within a separate document, should ensure that the following information is documented:
    - The circumstances of the incident. (i.e. Who?, What?, When? Where? Why?)
    - The impact of the incident, i.e. on individuals or the property or assets of the ICB.
    - The root cause and contributory factors are identified to enable action to be implemented to prevent recurrence. Clear timescales and identified leads should be agreed.
    - Confirmation that identified learning has been shared with relevant individuals/teams/organisations or agencies, including details of any training that will be provided. Where necessary, the support of the Communications Lead should be sought to help disseminate learning more widely where appropriate.
    - The report should be signed-off by the relevant manager recommending that the incident is closed. The Incident Reporting Lead will advise if they have any concerns in this regard before finalising closing the incident.
    1. Whilst the primary focus of incident investigation is to identify and disseminate learning to prevent recurrence, if an investigation identifies that there might be grounds for disciplinary action to be taken against one or more members of staff, advice should be sought from the Human Resources Department in line with the Disciplinary Policy immediately this becomes apparent.

## Monitoring Compliance

The Incident Reporting Lead is responsible for monitoring the ongoing compliance with this policy and ensuring that a robust incident reporting culture and reporting to relevant committees/groups on the number and nature of incidents, is embedded across the ICB.

The Audit Committee is accountable to the Board for ensuring that the incident reporting and management process is effective.

## Staff Training and Support

All staff will be made aware of incident reporting requirements as part of their local induction by their line manager, including their role and forms of support available to them.

The Incident Reporting Lead will provide ongoing incident reporting training to relevant staff and will offer support to those involved in the incident reporting process.

## Arrangements For Review

This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

## Associated Policies, Guidance And Documents

State supplementary documents (if applicable)

#### Associated [Policies](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e) and Procedures

* + Complaints, Compliments and Concerns Policy
  + Counter-Fraud, Theft and Bribery Policy
  + Disciplinary Policy
  + Health and Safety Policy
  + Information Governance Framework and Policy.
  + Legal Services Policy
  + Risk Management Policy
  + Security and Lockdown Policy
  + Management of Serious Incidents Policy
  + Incident Response Plan

## References

**Legislation**

* + Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

## Equality Impact Assessment

The EIA has been included as Appendix A.

## Appendix A - Equality Impact Assessment

**INITIAL INFORMATION**

|  |  |
| --- | --- |
| **Name of policy:**  Incident Reporting Policy  **Version number (if relevant):**  1.0 | **Directorate/Service**:  Governance |
| **Assessor’s Name and Job Title:**  Sara O’Connor, Head of Corporate Governance | **Date:**  24 June 2022 |

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| **OUTCOMES** |
| ***Briefly describe the aim of the policy and state the intended outcomes for staff*** |
| **To provide a clear process for the reporting and investigation of incidents.** |
| **EVIDENCE** |
| *What data / information have you used to assess how this policy might impact on protected groups?* |
| The CCGs regular monitor the make-up of the workforce, including protected groups. |
| *Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?* |
| Mid and South Essex CCG Governance Leads.  MSE CCGs Audit Committees meeting in common. |

**ANALYSIS OF IMPACT ON EQUALITY**

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

* ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
* ***Negative outcome*** *–**protected group(s) could be disadvantaged or discriminated against*
* ***Neutral outcome***  *–**there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

| Protected  Group | Positive  outcome | Negative  outcome | Neutral  outcome | Reason(s) for outcome |
| --- | --- | --- | --- | --- |
| Age | x |  |  | The policy will enable all types of incidents to be reported and investigated under this or other appropriate policy, to ensure that learning is identified and appropriate action taken. |
| Disability  (Physical and Mental/Learning) | x |  |  | As above. |
| Religion or belief | x |  |  | As above |
| Sex (Gender) | x |  |  | As above |
| Sexual  Orientation | x |  |  | As above |
| Transgender / Gender Reassignment | x |  |  | As above |
| Race and ethnicity | x |  |  | As above |
| Pregnancy and maternity (including breastfeeding mothers) | x |  |  | As above |
| Marriage or Civil Partnership | x |  |  | As above |

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| **MONITORING OUTCOMES** |
| Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals. |
| *What methods will you use to monitor outcomes on protected groups?* |
| Regular monitoring of incidents, including themes identified*.* |

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| **REVIEW** |
| *How often will you review this policy / service?* |
| Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice. |
| *If a review process is not in place, what plans do you have to establish one?* |
| N/A |

## Appendix B – Incident Reporting Form

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Incident Report Ref No:** (to be inserted by Incident Reporting Lead): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PART 1:**  **Health & Safety related incidents:** To be completed by or on behalf of the injured/affected person.  **Information Governance (IG) and other incidents:** To be completed the person who discovered the incident had occurred. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 1:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Who was injured or affected by the incident?** (please provide full name(s) and contact details – for IG incidents, this will be the person whose confidentiality was breached) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Site and exact location of incident:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Incident:** *(please state if actual date/time is not known, and use date/time incident was discovered)* | | | | | | | | | | | | | **Time of incident or time it was discovered:** *(state which and use 24 hour clock)* | | | | | | | | | | | | | | | | | |
| **Was this an IG Incident?** | | | | | | | | | | | | | Yes / No | | | | | | | | | | | | | | | | | |
| **If Yes, state Incident Type:** *(delete options that do not apply)*  If No, go to Section 2 below. | | | | | | | | | | | | | 1. Information lost/left unattended 2. Information sent in error 3. Information sent unnecessarily 4. Information sent insecurely 5. Information incorrect/misplaced 6. Information mis-used 7. Information disposed of insecurely 8. Information stolen. 9. Other (please describe) | | | | | | | | | | | | | | | | | |
| **Format of Information Governance Breach:** *(delete options that do not apply)* | | | | | | | | | | | | | 1. Electronic 2. Paper 3. Spoken/Verbal 4. Other (please describe) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 2: About the Person Affected** *(If the event affected premises or property/assets only, go to section 3)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Status of person(s) injured or affected? (please mark ‘x’) | | | Employee | |  | Client/Patient | | | | |  | General Public | | |  | | Contractor | | | | | |  | | Visitor | | | |  | |
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| Date of Birth: *(patients only)* | | | | | | | Sex: | | NHS No.: *(patients only)* | | | | | | |  | |  |  |  |  |  | |  | |  |  |  | | |
| Phone Number: | | | | | | | | Job Title: | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 3: Details of the Incident** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Description of incident:** *(facts only, in chronological order that they occurred):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Was the incident witnessed?** Yes / No  *If yes, please supply details below. Witness statements should be obtained and submitted as soon as possible..* | | | | | | | | | | **Name of person(s) who made error*:***  *(if known at the time of reporting)* | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | Name: | | | | | | | | | | | | | | | | | | | | |
| Phone Number: | | | | | | | | | | Phone Number: | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | Address: | | | | | | | | | | | | | | | | | | | | |
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| **Section 4: Action Taken:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Immediate Action Taken:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Action that will be taken to prevent recurrence:** (this should be completed at a later stage if not immediately apparent and/or an investigation is required). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 5: Reporting the Incident:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of person reporting incident: |  | | | Job Title: | | | | | | | | | | Date: | | | | | | | | | | | | | | | |
| Who was the Incident reported to? | |  | | | | | | | | | | | | Date: | | | | | | Time: | | | | | | | | | | |
| **Please pass the form to your line manager to complete PART 2** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **PART 2: To be Completed by Reporters/Injured Party’s Line Manager** | | | | | | |
| **Section 6: Further Action taken to Limit Reoccurrence/Control Measures Instigated** (if applicable) | | | | | | |
| Further Action Taken: | | | | | | |
| Signature of Line Manager: | | | Line Manager’s name, position and email address: | | Date: | |
| **Please forward this form to the Incident Reporting Lead and pass to the person in charge of the area at the time of the incident for investigation**  (maybe same as line manager above) | | | | | | |
| **Section 7: Investigation** | | | | | | |
| Was the incident escalated and reported to an outside organisation? **Yes / No?** | | **If Yes**, please state *(delete those that do not apply)*   1. Serious Incident – Quality Team. 2. RIDDOR Reportable – Health & Safety Executive. 3. Level 2 SIRI – Information Commissioner/Dept of Health or other regulators via the Data Security & Protection Toolkit. 4. Major Incident – Emergency Planning, Resilience and Response Team. 5. Local Counter Fraud Specialis.t 6. Local Security Management Specialist. 7. Other (please state) | | | | |
| Investigation Details: *(this should include information and events leading up to the incident and the incident itself – to be submitted in a separate report if necessary).* | | | | | | |
| **Are any other actions required to reduce or eliminate the likelihood of reoccurrence?** If Yes, please state actions, who will implement and timescales for completion (a separate action plan can be provided if necessary): | | | | | | |
| Signature of investigator counter signed by Service Head if different |  | | | Print Name: | | Date |
|  | | | | | | |