NHS
East Staffordshire
Clinical Commissioning Group

INCIDENT REPORTING POLICY

INCLUDING INVESTIGATION PROCEDURE

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Approvals

This document requires the following approvals:

Lead	Name	Signature	Title	Date of Issue	Version
Quality Committee	H Johnstone		Chair	31.07.13	1.1
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PART ONE: Policy Details and Context

Introduction and Scope

An incident is seldom a single-isolated event that leads to error, but rather a number of factors, usually outside an individual's control. In many instances, the root causes of adverse incidents lie in management and organisational systems, and blame cannot simply be attributed to individuals.

The CCG and its Governing Body is committed to reducing risk and improving safety by implementing appropriate processes throughout the organisation, and by analysing and tackling the root causes of incidents.

Incident reporting is a fundamental tool in our Risk Management approach as it helps identify and address any failures, both from incidents and near misses. Understanding what went wrong and learning the lessons from incidents is critical to reducing the future risk and improving safety. To this end, the CCG has developed this Policy and Investigation Procedure to provide a framework and guidance for staff. It also links with the CCG Whistleblowing Policy (raising concerns at work).

The Policy applies to all directly-employed CCG staff, and anyone working for, or on behalf of the CCG on its premises. The CCG expects that commissioned health service Providers report all health care incidents and near misses, if they affect our residents, as part of their own, separate reporting procedures.

Policy Statement and Principles

- ✓ This Policy applies to all adverse incidents that must be reported, investigated and managed in accordance with the arrangements described in this document;
- ✓ The CCG will encourage, and make incident reporting as easy for staff as possible, with a process that is simple and straightforward;
- ✓ A sound system of reporting allows incidents to be investigated quickly; to review practice and to identify trends / patterns. It also allows problems resulting from inadequate procedures, lack of training or pressure of work, to be identified and resolved as soon as possible;
- ✓ The CCG will follow a systematic approach to identifying what goes wrong and learn lessons from these events to ensure action is taken to prevent recurrence;
- ✓ The CCG's aim is to become a 'high reliability organisation' where the numbers of errors are few relative to the volume of business activities undertaken;
- ✓ The CCG will foster a culture of fairness and openness, in which staff feel confident to report anything which causes them concern and in which doing so is the normal response;
- ✓ The CCG believes that the majority of incidents are caused by system failure rather than solely by human error, and therefore will adopt a systems-centred approach to investigation;
- ✓ The CCG advocates and supports the view that rapid support must be made available to anyone who experiences an adverse incident whilst working for the organisation;

Policy Objectives

- ***To reduce risk and improve safety by:***

- Analysing and tackling the root causes of adverse incidents
- Capturing accurate information on hazards / incidents, enabling trends to be identified
- Learning lessons and identifying necessary corrective actions
- Minimising the risk of similar incidents occurring in the future

- ***To ensure timely collection of incident reports (in case of future complaints or litigation)***

- ***To ensure onward reporting of Serious Incidents to the relevant stakeholders***

ESCCG Structural Arrangements

Corporate Governance structures have been established within the CCG, and a Risk Management system is in place. Heads of Service are expected to take the lead on incident reporting matters within their specific areas.

The Team in which CCG staff work will determine the contact person for receipt of incident forms, assistance with incident investigation and general queries or information in respect of the incident reporting process.

Principal Definitions

Hazard	Something with the potential to cause injury, damage or loss (e.g. defective equipment or flooring, inadequate or absent safety controls, deviation from safe working practice etc)
Adverse Incident	In the context of CCG and its locus of (statutory) responsibilities, this covers all types of non-clinical incidents e.g. security incidents such as theft, suspicious behaviour, deliberate damage to property, or violent incidents where a physical or verbal challenge to someone's safety or well-being is made (i.e. threats or assaults). An adverse incident is any incident, event or circumstance that did lead, or could have led, to unintended harm; or produces unexpected or unwanted effects; or incurs a loss to the individual or CCG.
'Near Miss'	Any incident that did not result in injury, ill health, property damage or loss, but had the potential to do so.
Serious Incident (SI) **a.k.a.** **Serious Incident Requiring Investigation (SIRI)**	In clinical environments: an accident or incident when a patient, member of staff or member of the public suffers serious injury, major permanent harm, unexpected death - or the risk of death or serious injury - on premises where care is provided, or whilst in receipt of healthcare. In non-clinical environments: any event where actions of NHS staff are likely to cause significant public concern; or any event that might seriously impact upon the delivery of service plans, and/or may attract media attention, and/or result in litigation, and/or may reflect a serious breach of standards. Any incident must be notified to the relevant bodies; the CSU's Risk Managers will undertake reporting / management through the STEIS system.

National Reporting & Learning System (NRLS)	Prior functions of the National Patient Safety Agency (NPSA) have transferred to NHS England, which operates NRLS to improve patient safety by reducing the risk of harm through error. NHS Provider organisations are obliged to report patient safety adverse incidents through this system. CCG staff incidents are not required to be reported here as no direct care is provided by the CCG.
Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (RIDDOR)	The CCG also has a legal duty to comply with reporting of certain categories of injuries, diseases etc to the Health and Safety Executive. Additionally, the Care Quality Commission (CQC) and the National Health Service Litigation Authority, (NHSLA) both seek evidence relating to incident reporting procedures.

Incident Reporting Process

- **Single Incident Report Form**

The CCG utilises a single incident form for all types of incidents. The form is attached at Appendix One.

In the vast majority of cases it will only be necessary for staff to complete this one form, making reporting less onerous and keeping within the CCG's philosophy of simple reporting.

The form will be available to all CCG Senior Managers and Heads of Service, and will also be kept in a place where they are easily accessible by any member of staff (shared Network drive and CCG Members Area website).

The individual completing the form should take particular care to record only **known facts** and not to assign fault or blame, as the form is a legally-disclosable document.

- **Grading the Severity of Incidents**

The incident form contains a matrix that is designed to help staff 'grade' the incident. The general approach to completion of this mirrors the CCG's Risk Management procedure for ascertaining the relative level of risk in standard risk assessments.

Therefore the matrix is in two parts: (a) actual impact, in terms of how harmful the incident was; and (b) the probability of recurrence: i.e. could the same thing happen again. The overall grading of the incident is obtained by multiplying the impact score by the probability score. Further definitions are provided in Appendix Two.

CCG Managers can be assisted in the grading of incidents by the Head of Performance & Governance. Any Incident Reporter completing the grading matrix at the time of the incident is expected to have been suitably informed by CCG Managers to enable them to do so.

Actual Impact		***Probability of Recurrence***	
Insignificant / No Injury	1	Rare (doubtful will ever happen again)	1
Minor / Short Term	2	Unlikely, but possible	2
Moderate / Semi-Permanent Injury	3	Possible: i.e. may recur occasionally	3
Major / Permanent Injury	4	Likely, but not a persistent issue	4
Catastrophic / Death / Destruction	5	Almost Certain	5

The grading will determine the speed / level of investigation and CCG management response required. For this purpose, incidents will be classified according to their grading as follows:

Low Risk	Moderate Risk	Significant Risk	High Risk	Serious Incident (SI / SIRI)
0 - 3	4 - 8	9 - 15	16 - 20	20+

Accordingly, this Policy is divided into two parts to facilitate the necessary level of investigation. The first covers reporting arrangements for incidents graded below 20; the second covers arrangements for reporting / responding to SIs / SIRIs at 20+.

For low-risk / low-graded incidents, it is expected that any necessary investigation and staff feedback will have been completed at the time of submission of the Incident Report Form.

For higher-risk incidents, it may be necessary for Investigating Managers to submit the form, but to record on it that an investigation is being undertaken. Details of the outcome of the investigation should then be forwarded to the Head of Performance & Governance upon its completion.

Investigating Managers will ensure that appropriate action is taken at the time of incident. Such action may include referring the affected staff member to Occupational Health, reviewing risk assessments, removing equipment from service or taking witness statements.

The grade of the incident will determine the level of action needed. Witness statements will always be needed for an incident graded 20 or above, and may be needed for some graded 16 – 20.

Disciplinary Action

Fear of disciplinary action may deter staff from reporting an incident. The Governing Body is committed to not enacting disciplinary action as part of the response to incident reporting.

An *"Incident Decision Tree"* (Appendix Three) can be used by CCG Managers to help them give consideration to the alternatives to disciplinary action and to help them to think about systematic and organisational issues in error management.

This can be used by any Manager dealing with staff involved in an adverse incident, and in turn by any employee.

Investigation under CCG disciplinary procedures may take place when:

- ✓ There is a repeated similar occurrence involving the same individual
- ✓ The incident results in a police investigation
- ✓ In the view of the CCG, the action causing the incident is removed from acceptable practice
- ✓ There is a failure to report an incident in which a member of staff was either involved or about which they were aware

When considering allegations of misconduct arising from errors, East Staffordshire CCG will take great care to distinguish between those cases where the error was the result of reckless or incompetent practice, or was concealed; and those that resulted from other causes, such as serious pressures of work and where there was immediate, honest disclosure.

Staff Responsibilities

All CCG staff must comply with this Policy. They may also refer to the Whistleblowing Policy which recognises the right of CCG employees to disclose information reasonably and responsibly in the public interest to a third party, and to be protected against retribution or dismissal.

The range of concerns that staff may raise under this Policy include the following:

- Unsatisfactory standards of business practice or fraudulent activity
- Ill treatment of a staff member
- Practices relating to health and safety at work
- Any attempt to 'cover up' any act or omission

(1) Accountable Officer (AO)

The AO is accountable to the Governing Body for ensuring implementation of this Policy.

(2) CCG Senior Managers / Directors

Identify individuals with responsibilities for the process of investigation within their Directorate / Team. They will also ensure that there is a system for monitoring actions initiated as a result of incidents and that there is an appropriate method of communicating this to their responsible staff.

They will ensure that wherever possible, the principles of openness and fairness will be applied to incident reporting (exceptions will be where acts or omissions are malicious, criminal or constitute gross or repeated professional misconduct).

(3) CCG Line Managers

Line Managers are responsible for maintaining staff awareness regarding incident reporting and of this Policy and Investigation Procedure. This will also extend to ensuring awareness of affiliated policies, such as the Whistleblowing Policy, and of their scope.

They will agree with their staff the essential core areas for reporting of incidents, including "Near Misses" and concerns; and will ensure adequate supplies of reporting forms are available for the purposes of reporting these.

They will ensure that an appropriate investigation (including any further root cause analysis or subsequent investigation) is carried out according to the grading of the incident. Any noted high-risk areas must be reported directly to a CCG Senior Manager / Director or to the Head of Performance & Governance to enable discussion at the appropriate Committee.

They will also ensure that completed Incident Report forms are forwarded to the Head of Performance & Governance, within the timescales specified in Part Two; and will ensure that staff, especially individuals reporting the incident, are explicitly provided with feedback following investigation.

Line Managers will also be required to take appropriate action to prevent further recurrence. Where other actions need to be taken, e.g. to comply with RIDDOR reporting, these are to be taken promptly and must be advised by the quickest practicable route (expected to be via the CSU).

(4) Individuals

Individual employees need to be aware of the requirements of this Policy in relation to the reporting of near misses and adverse incidents, to ensure that they report these, either themselves, or through their Line Manager or other responsible person. All individuals must adhere to the specified CCG principles of confidentiality; and will be expected to report anything of concern.

They will complete the Incident Report form and will give the incident an initial grading according to its severity (this will help their Line Manager to ascertain the level of investigation and action required). This will then be passed to their Line Manager (or in their absence another responsible person) for investigation / action and signature.

In any case of physical assault, these must be reported to the Head of Performance & Governance for onward reporting to the CCG's Local Security Management Specialist (LSMS). After consultation with their Line Manager, individuals will consider whether to report any physical assault to the Police – failure to do so could adversely affect any claim for compensation under the Criminal Injuries Compensation Authority Scheme.

(5) Head of Performance & Governance

The Head of Performance & Governance will provide advice and support, when requested in relation to incidents; and will maintain the incident-logging system for reported incidents. If necessary or appropriate, incidents may be re-graded following investigation.

They will ensure that an appropriate investigation into each incident has been carried out, and will undertake additional information gathering to answer specific incidents wherever necessary. Routine scanning of all incidents will be conducted in case of any possible future litigation claim.

In conjunction with Line Managers, they will ensure that actions are taken as necessary to comply with mandatory external reporting requirements such as RIDDOR (Health & Safety Executive).

Where information has been received from an incident report that poses a potentially harmful or hazardous effect on staff health & well-being, this will be cascaded to staff immediately where the information directly affects or is relevant to them.

If the information is deemed to be something that others would benefit from knowing, and in doing so could prevent an occurrence, the Head of Performance & Governance will ensure that CCG staff receive relevant feedback (in an appropriate forum) on the outcome of suggested actions, or investigations. This will help facilitate organisational sharing and learning from incidents received.

Beyond routine information sharing in this context, the Head of Performance & Governance will also provide regular incident summary reports, containing both qualitative and quantitative data, to:

- ✓ The Governing Body (bi-annually);
- ✓ The Quality Committee (quarterly incidents report);
- ✓ The QIPP, Finance & Performance Committee (quarterly Information Governance incidents).

In addition ad hoc reports will be provided to other groups / individuals as requested.

(6) Commissioning Support Unit (CSU)

The Staffordshire CSU will be co-responsible under the terms of contracted support activities for ensuring that arrangements are in hand for the following incident-related areas:

(a) LSMS and Counter Fraud & Security Management Service (CFSMS) for any security incidents and especially those involving physical assault;

(b) Serious Incident (SI) reporting from and to the relevant stakeholders and commissioned Providers within given timescales;

(c) Information Governance Team, jointly with the Head of Performance & Governance, for any CCG HQ lapses in information security (see Appendix Four for details);

(d) Health & Safety: subject to review, the focal point for all Health & Safety incidents will be outsourced to external commissioning support organisations, providing advice to the Head of Performance & Governance when requested.

(e) The CSU may ultimately also become responsible, under terms of the procured services, for the provision of a supporting e-system to record CCG-reported incidents (as opposed to a local database and storage / management system) – the CSU currently processes SIs / SIRIs on behalf of the CCG under the terms of their contract, but not lower-level adverse incidents: it is possible that the mechanisms outlined in this Policy regarding reporting and confidentiality arrangements may alter as a result;

Incident Analysis and Learning Lessons

The reporting and investigation of incidents is only one part of the total picture if such a process is to lead to positive improvement in the working lives of CCG employees. Information contained in the report and investigation forms needs to be amalgamated to systematically identify trends from any root cause analyses and system failures identified.

This is a dynamic process where all employees have the opportunity to report incidents and near misses with the intention of learning and influencing positive change within the CCG.

Aggregated incident reports will be produced for CCG sub-committees, and will include:

- The total numbers of incidents reported
- Categories / Causal Factor Groups: top 3 themes' numbers of incidents
- Comparison to previous reporting period / trend analysis as appropriate
- Common outcomes and lessons to be learned / changes in practice made

A report will be submitted to the Committees outlined on the previous page, in accordance with that Committee's Business Cycle (but generally on a quarterly basis).

Learning the lessons organisation-wide will be at the heart of all incident investigation if the CCG is to identify root cause(s) and any organisational systems failures, which have contributed to it. Where changes in practice occur following an investigation, where appropriate an alert will be issued to staff and to any other relevant organisations.

The effectiveness of this Policy and compliance with the various requirements outlined above can satisfactorily be monitored by the normal incident reporting processes outlined. However these will be further enhanced by:

- ✓ Staff survey to establish whether staff involved in an incident feel supported
- ✓ Feedback from any Incident Reporting / Risk Management training events
- ✓ Ensuring improvements are implemented and lessons learned are shared widely with staff
- ✓ Minutes from Quality Committee
- ✓ Quality Committee and CCG Governing Body summary reports

Confidentiality

Incident Reports may contain sensitive information and must be treated as confidential. Once entered onto the CCG's incident database, hard copies will be stored in a secure file.

Where an incident involves an external agency, the CCG may send a copy of the Report to that body. In such cases, the Reporter's name etc will be removed. Other identifiable details will only be passed on if a specific investigation into an event is required (as opposed to using a general issue or trend), and with the explicit consent of the individual concerned.

Media Enquiries

These must be referred to the Chief Operating Officer or Accountable Officer in the first instance. CCG staff should not, without the prior approval of the Accountable Officer, make any comment and should deal with the caller courteously: i.e. *"I am sorry I am unable to comment at this present time, but if you would like further information, please contact the CCG's Chief Operating Officer"* (or if it is out of hours, the on-call Senior Manager / Director)

PART TWO: Reporting and Investigation Arrangements for Incidents (grading < 20)

- ***How do CCG Staff report?***

(1) When an incident or near miss occurs, an Incident Report form should be completed with the relevant factual details and will record the initial grading which has been given to the incident;

(2) Any information given to staff or the public relating to the incident should be documented and any relevant witness statements should be collected;

(3) Statements should be legible, signed, dated and timed (the Incident Investigation Procedure gives guidance for writing statements);

(4) The form should then be passed to a senior member of staff or Line Manager, in order for an initial investigation to be carried out;

(5) The form should then be forwarded to the Head of Performance & Governance within 3 days of the incident occurring, if possible;

(6) In some instances, depending on the nature and grading of the incident, a more in-depth investigation may be required (e.g. incidents graded 'significant' / 'high' – additional guidance on techniques is provided in the Incident Investigation Procedure).

- ***What should be reported?***

Any adverse incident which gives rise to, or has the potential to produce unexpected or unwanted effects, or incurs a loss to the individual (i.e. staff or others) or the CCG, should be reported.

However, the fundamental principle to follow is that staff should report anything which causes them concern or anything that is unexpected or unintended. This includes all "near misses" that could translate into full incidents – **if in doubt, fill a form out**.

The following list is intended as a (not exhaustive) guide for the main types of incidents or "near misses" that would fall into the definition above:

(a) A criminal matter: i.e. theft from a vehicle whilst on the CCG car-park (the owner has the right to report directly to the Police, then to follow-up this up with an incident report);

(b) Staff injured whilst at work;

(c) Acts of violence / aggression including, where appropriate, verbal abuse and harassment that could be construed a criminal matter;

(d) Incidents occurring to others, e.g. visitors and contractors either whilst on CCG property or as a result of the work of the CCG;

(e) All incidents involving suspicious persons, or potential criminal / security matters, whether accidental or criminal, or any damage to CCG or an individual's property;

(f) Racial Incidents;

(g) Lone Worker or other supervision issues (e.g. working beyond personal competency levels);

(h) Concerns about policy and procedures that are not sufficiently implemented or integrated into practice that give rise to the potential for standards to fall below expected levels;

(i) System failures: e.g. equipment provision / maintenance / training;

(j) Lack of a policy or lack of a system for (identifying) policies dissemination: i.e. being able to have sight / obtain policy, or a lack of knowledge about what the supporting system is;

(k) Training issues: e.g. updates, quality, availability of training;

(l) Communication failures;

(m) Information Governance (IG) incidents.

- ***Why investigate?***

All incidents or "Near Misses" have a risk potential and should therefore be reviewed by the relevant Line Manager. A more-detailed investigation may be necessary and other, internal or external parties may need to be involved, especially where impartiality is required.

Every incident will require an assessment to establish the cause. This will range from minimal investigation where the underlying cause is well-known and already being addressed through other means, or the incident has been risk-assessed and is as low as it can be; through to SIs / SIRIs, which will give rise to a full / immediate investigation.

This is called *'Root Cause Analysis'* (RCA) and is the process necessary to ascertain the true cause of a problem, and the actions necessary to eliminate it, by determining:

- What the purpose of an investigation is (its timelines, focus)
- What happened
- How and why it happened (applying the *"Five Whys"* technique of RCA)

These need to be established in order for appropriate action to be taken to prevent future occurrences, and so that the CCG learns from the experience and improves Risk Management.

While it is recognised that human error may sometimes be the main cause, or a major contributory cause of incidents, the root cause is often a more complex series of factors, which have been lying dormant, or have been tolerated and have come together to allow the event to occur. Unless incidents are investigated to identify these, any improvement action aimed solely at individual practice is unlikely to be successful in preventing recurrence of that type of event.

All staff must feel confident to report incidents and safety issues. Staff must also believe that the information they provide will be used to improve the safety and quality of the working environment for staff and visitors. It will be necessary to:

☑ *Determine the sequence of events leading to the incident and what was managed well*
☑ *Determine the human, organisational + job factors that gave rise to the incident or condition(s)*
☑ *Identify the root causes*
☑ *Initiate short-term action to eliminate the immediate causes*
☑ *Establish a longer-term programme to correct the underlying factors*

The investigation will not:

☒ *Seek to apportion blame nor to exonerate people without due cause*
☒ *Be designed to set a legal defence*

- ***Who should investigate?***

This will depend on the nature of the incident, but will certainly involve the relevant Line Manager and may involve senior CCG personnel. Other experts (e.g. CSU Health + Safety Manager / HR Dept, NHS PropCo Facilities & Estates), will be consulted as necessary.

In the event of an incident of a criminal nature, the Police will be informed at the earliest opportunity for immediate investigation, if necessary, before the completion of an Incident Report. Any member of staff who is asked for a written report has the right to support (from a person of their choice or professional support through their union).

- ***How to investigate***

(Full guidance is provided in the Incident Investigation Procedure in Appendix Five)

The severity grading of the incident will determine the speed / level of investigation and management response that is needed. If there is a significant lapse, then conditions may change and memories may become clouded. For this reason, the time-frames applied to investigation completion will be as follows:

SIs / SIRIs: graded 20+ and high-risk incidents: graded 16-25	**Within 45 days**
Significant risk incidents graded: 10-16	**Within 20 working days**
Moderate event or moderate risk incidents: graded 4-9	**Within 15 working days**
Minor event or low risk incidents: graded 3 or below)	**Within 3 working days**

The majority of incidents will fall into the low to moderate categories. Teams should ensure that they monitor these incidents accordingly and ensure that remedial actions recommended have been acted upon and are working.

Low-risk incidents are simple events to be dealt with by the individual and/or Line Manager in charge at the time. The amount of information required is likely to be entirely contained within the incident reporting form. This type of event will be reviewed using quarterly incident reports. The frequency of this type of event should be given careful scrutiny.

Moderate-risk incidents may require more detailed planning, but management is likely to remain within the Team. The Incident Form will usually be a sufficient record of any findings, but more detail will be required than for low-risk incidents. The investigation will include what actions are required to reduce or remove the risks, and any underlying causes, organisational, environmental, team or individual. RCA should be considered for incidents that trigger external investigations.

Significant incidents are likely to have, or could have, a significant outcome. They will require more-detailed investigation – an RCA approach is strongly recommended. A suitably-trained person within the Team in which the incident occurred should lead the investigation. The Team should identify their own system for appointing a Lead Investigator, who will ensure other parties are involved as necessary.

A written report will be expected. Such incidents require certain considerations when determining the level of investigation needed. Where a major event (e.g. permanent injury) or catastrophic harm has occurred, the relevant CCG Senior Manager / Director, with the support and advice of the Head of Performance & Governance, should appoint an Investigative Team. The Investigation Report and improvement strategies identified should be presented to / monitored by the CCG Quality Committee.

It is recognised that not all events resulting in major or catastrophic harm are as a result of human or system failure. In these cases, the Line Manager notified of the event should satisfy themselves that there is no need to progress to full RCA by considering the information available about the event and asking simple questions to ascertain if there were any factors meriting closer inspection.

PART THREE: Reporting and Investigation Arrangements for Incidents (grading > 20)

These incidents require a rapid follow-up and will be incidents where the outcome is, or could foreseeably have been death, very serious injury, serious criminal activities, serious service disruption: e.g. serious financial loss, major defects of IT equipment, the capacity of the CCG or where an incident or individuals involved is likely to attract media attention / public concern.

- ***Immediate actions***

Staff immediately involved should assess the potential risks and any action(s) required at the time, bearing in mind the following factors:

- Maintaining a safe environment
- Privacy / Dignity of those affected
- Maintenance of the scene as far as is reasonably practical

- ***Who to notify***

A CCG Senior Manager must be notified as soon as possible, either the one responsible for the Team in which the incident occurs, and/or the Accountable Officer.

Third Party investigation could be required if there is a high probability of litigation, insufficient expertise within the CCG, the need to eliminate bias or if there are political considerations.

In these situations, a Statutory Authority or External Agency / Adviser may need to be notified: e.g. the Police, Coroner, Health & Safety Executive, NHSLA or NHS England, depending upon the nature and type of event. The likelihood and scope of this requirement will be considered at the outset of the investigation and specified by the notified Director.

The Director involved will be responsible for ensuring that:

- ✓ An Incident Investigation Team is established as necessary
- ✓ The staff member is informed prior to the media
- ✓ The CCG approach to Media Relations is adhered to
- ✓ The CCG Major Incident Plan requirements are enacted (if the event warrants it)
- ✓ The relevant staff are interviewed, and any witnesses identified
- ✓ All relevant information is collected
- ✓ Witness statements are collated (ensuring legibility and that they are signed, dated / timed)
- ✓ RCA processes are followed as necessary and as soon as practicably possible
- ✓ Solutions are determined and an action plan drawn up to prevent recurrence
- ✓ Completion of an Incident Report form occurs at the first opportunity or within 24 hours
- ✓ Update reports are provided to the Accountable Officer
- ✓ The CCG Chairman is notified
- ✓ The CSU are informed of any SIs / SIRIs

- ***Notification***

CCG staff must be notified as soon as possible about Serious Incidents involving them. It is also essential that any information given be based solely on the facts known at the time. CCG staff should be informed of any new information that might emerge as an Incident Investigation is undertaken, and that they will be kept up-to-date with the progress of this.

The method / person responsible for this will vary according to the type of incidents, but all communications and information given out, and the method, must be documented in the incident record. The process of communicating with staff or individuals will also be expected to follow ‘Duty of Candour’ (being open) guidance to the NHS.

- ***Records***

Contemporaneous records should be maintained efficiently and confidentially in a designated file. The maintenance and security of records will be the responsibility of the person managing the incident. They should ensure that all actions, communications and witness statements are clearly written, dated, timed and signed.

- ***Debriefing***

When a SI / SIRI occurs, CCG staff involved may also require emotional support and advice. All Managers will formulate arrangements for ensuring that their staff receive the

necessary support to prevent harmful effects in the longer term. This includes initial feedback, plus ongoing support throughout and beyond any investigation as required. This includes counselling services offered by Occupational Health or Trade Unions, as relevant.

- ***Incident Review***

Immediate Review – the relevant Manager will initiate an initial report / briefing paper for review by senior personnel, containing:

- A summary of the incident, including identification of the immediate causes
- An appraisal of evidence available
- An initial action plan including details of how immediate needs of others will be met
- The identify of staff directly involved in the incident
- Arrangements for the taking of statements from all those involved in the incident

The relevant Manager will also ensure that records and reporting for statutory requirements (e.g. RIDDOR), are maintained as appropriate.

In ensuring that the appropriate support arrangements are in place for affected people within their Teams, Managers should also consider any potential human error or competence issues.

Where potential disciplinary actions may need to be considered, if felt appropriate, use of the Incident Decision Tree (Appendix Three) will help Managers consider the alternatives to disciplinary action and help them think about systemic or organisational issues.

Post Incident Review - the relevant Manager will generate the Incident Investigation Report, Recommendations and an Action Plan. These must be easy to follow and clearly present the salient points. The final report must be confidential, and all staff names and details should be anonymised. The final report should include the following:

- Executive Summary: factual elements relating to the event (background description)
- Descriptions investigation scope (purpose, timeframe and methodologies)
- Summary of the root causes: e.g. presentation of RCA components
- Analysis and Findings
- Learning Points (what will be done, when and who will be responsible for it)
- Summary of proposed actions / recommendations (including any rationale)
- Any resource requirements for implementing these
- Evaluation Plan for checking the effectiveness of corrective actions

Note:

Recommendations must be focused on addressing root causes or fundamental issues associated with the incident i.e. those things that once addressed will prevent the problem from recurring. Recommendations should make explicit reference to where it is thought responsibility lies for considering or acting on the recommendation (including any supervisory and training issues). Recommendations should also include some indication of the risk of doing nothing.

APPENDIX 1 – Incident and "Near Miss" Reporting Form

If the event is serious it should be reported immediately by phone					
			Incident No.		
REPORTER		**PERSON INVOLVED**			
Name		**Name** (if different)			
Job Title / Grade		**Address** (if this is a report of an accident to a member of staff, their home address must be shown)			
CCG Dept / Team		**Contact Number**			
Contact Number		**D.O.B** (if not CCG staff)			
		Gender (please circle)	**Female**	**Male**	
		Status (please circle)	**Staff**	**Visitor**	
			Contractor	**Other**	
Incident Type: non-clinical / accident to staff / violence or aggression to staff / fall					
Health & Safety Executive reportable?		**Yes**	**No**		
Was this a "Near Miss"?		**Yes**	**No**		
Incident Date		**Time** (24-hr clock)			
Exact Location of Incident: site or address					

What happened (Facts only to be recorded, not Opinions): include the names of all affected / involved people and any factors that contributed to the Incident / "Near Miss"; use a continuation sheet if necessary

Injury details (if applicable)	
Immediate actions: inc. First Aid (if applicable)	
Were there any witnesses; if so, who?	

HOW HARMFUL WAS THIS INCIDENT?

(a) Actual Impact Score	**Tick**	***Staff Absence***	**Tick**
Insignificant / No Injury = 1		**None: immediate return**	
Minor / Short Term = 2		**1 Hour+ but < 1 Day**	
Moderate/Semi-Permanent Injury = 3		**1 – 3 Days**	
Major / Permanent Injury = 4		**More than 3 days**	
Catastrophic / Death = 5		**Other**	

(b) Likelihood of Recurrence Score	**Tick**	**OVERALL GRADING = Score (a) x Score (b)**	
Almost Certain = 5			
Likely but not persistent issue = 4		**0 - 3 = Low Risk**	**4 - 8 = Moderate Risk**
Possible: may recur occasionally = 3			
Unlikely, but possible = 2		**9 - 14 = Significant Risk**	**15+ = High Risk**
Rare: not expected for years = 1			

Signed	
Date	

Line Manager to complete for all Incidents / Near Misses by (after investigation)	
Why did this incident / near miss happen (e.g. failure of processes / missing procedures?)	
What action has already been taken?	
What further action is recommended or proposed?	
Any other comments	
Please tick this box if there are any Adult / Children's Safeguarding issues involved with the incident / near miss	
Signed	
Print Name	
Contact Number or Email	
Date	

How to use this form

- This form should be freely available to everyone working with the CCG
- It can be completed by any member of staff but should be signed by the Line Manager
- Use this form to report anything which causes you concern
- Events resulting in injury or serious harm should always be drawn immediately to the attention of your Line Manager

On completion this form should be sent to the Head of Performance & Governance: Edwin House, Second Avenue, Burton upon Trent, Staffordshire, DE14 2WF

NO BLAME STATEMENT – COMPLETION OF THIS FORM WILL NOT LEAD TO DISCIPLINARY ACTION, EXCEPT WHERE ACTS / OMISSIONS ARE MALICIOUS OR CRIMINAL, OR CONSTITUTE GROSS OR REPEATED PROFESSIONAL MISCONDUCT

APPENDIX 2 – Definitions for Assessing Incident Impact (actual or potential)

Description	Individuals / Staff	Environment	Service	Quality	Litigation
Insignificant	No injury;	Nil;	No disruption;	Nil;	Nil;
Minor	Short-term injury < 7 days absence;	Contained incident;	Slight delay to schedule (hours);	Complaint possible / low risk;	Low - HSE action unlikely;
Moderate	Semi-permanent injury > 7 days absence (RIDDOR-reportable *);	Contamination; Reportable incident; COSHH limits are exceeded; Partial / temporary evacuation of area; Damage to property requiring significant repair;	Delay to service (days); National targets not achieved for a limited period;	High complaint potential;	Possible;
Major	Permanent Injury / disability / ill-health;	Potentially-reportable to: - HSE (dangerous occurrence) - Local Authority (contamination of area) - Dept of Health - PHLS (infection risk) - Police; Major equipment / power failure; Major fire; Significant structural damage;	Major disruption; National targets not achieved for a lengthy period;	SUI; Significant fraud or security incident; High potential for complaint; Potential for independent review;	High risk;
Catastrophic	Fatality;	As above;	Long-term major disruption; National targets not achieved for a significant period;	Expected complaint / judicial review;	Expected litigation;

**** External reporting of RIDDOR-reportable incidents (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations, 1995) to the Health & Safety Executive:***

It is a legal requirement for the CCG to report some work-related accidents, diseases and dangerous occurrences to the Health & Safety Executive (HSE). Accidents to members of staff which cause fatal or specified injury must be reported to the HSE by the quickest-practicable means (normally telephone). In practice, the requirements of RIDDOR, especially those for specified injuries, dangerous occurrences and diseases are fairly complicated.

The person responsible for reporting is defined by the regulations as the *'employer'* or *'the person for the time being having control of the premises in connection with the carrying on by him of any trade business or other undertaking (whether for profit or not)'*. In practice, this will be the person in charge at the time of the incident. If circumstances are such that some other person has to complete the report, the Head of Performance & Governance must be sent a copy.

All incidents from the list below can be reported online to the HSE, using a downloadable form that should be completed by the responsible persons. The form will then be submitted directly to the RIDDOR database, and the CCG will receive a copy for local records keeping purposes.

- *Report of an injury*
- *Report of a dangerous occurrence*
- *Report of an injury offshore*
- *Report of a dangerous occurrence offshore*
- *Report of a case of disease*
- *Report of flammable gas incident*
- *Report of a dangerous gas fitting*

http://www.hse.gov.uk/riddor/report.htm

A telephone service remains for reporting **fatal and major injuries only** – the Incident Contact Centre (ICC) on 0845 300 9923 - opening hours Monday to Friday 8.30am to 5pm.

If a member of staff has an accident at work which does not lead to fatal or specified injury, but is incapacitated for work for more than three consecutive days (including days which would not have been working days), then a report must be submitted as per the above paragraph.

In addition to this, certain dangerous occurrences will need to be reported in the same way. These include the failure of lifting equipment, the collapse of buildings or structures and the escape of a dangerous pathogen.

If an employee suffers from an occupational disease and their work involves certain activities and the responsible person (Line Manager) has received a statement prepared by a Registered Medical Practitioner diagnosing the disease; then the responsible person must ensure a report is completed.

Any records relating to reportable injuries / diseases / dangerous occurrences must be kept for 3 years after the date of the event.

The following incidents are reportable if they arise out of, or in connection with, work-related duties:

- ✓ Accidents to staff resulting in death, major injury or where they are unable to carry out their normal duties for more than 7 days (this includes acts of physical violence to staff)
- ✓ Accidents to a visitor, suffering an injury and being taken to hospital
- ✓ An employee suffering a work-related disease
- ✓ A dangerous occurrence

Examples (this list is not exhaustive):

MAJOR INJURIES:

Fractures (except to fingers, thumbs or toes); amputation; dislocation of shoulder, hip, knee or spine; temporary or permanent loss of sight; chemical / hot metal burn to the eye or penetrating injury to the eye; electric shock leading to unconsciousness or needing resuscitation or admittance to hospital for more than 24 hours; acute illness requiring medical treatment or loss of consciousness following absorption / inhalation / ingestion or exposure to a biological agent; any other injury leading to hypothermia, heat-induced illness or unconsciousness, or which requires resuscitation or admittance to hospital for more than 24 hours.

REPORTABLE DISEASES:

Occupational dermatitis; occupational asthma; hepatitis; tuberculosis; legionellosis; tetanus; infections attributable to work with biological agents; occupational cancer; certain musculoskeletal disorders.

DANGEROUS OCCURRENCES:

These are any events which may not have resulted in a reportable injury, but which had the potential to cause significant harm.

- ***Other Incident Reporting Definitions***

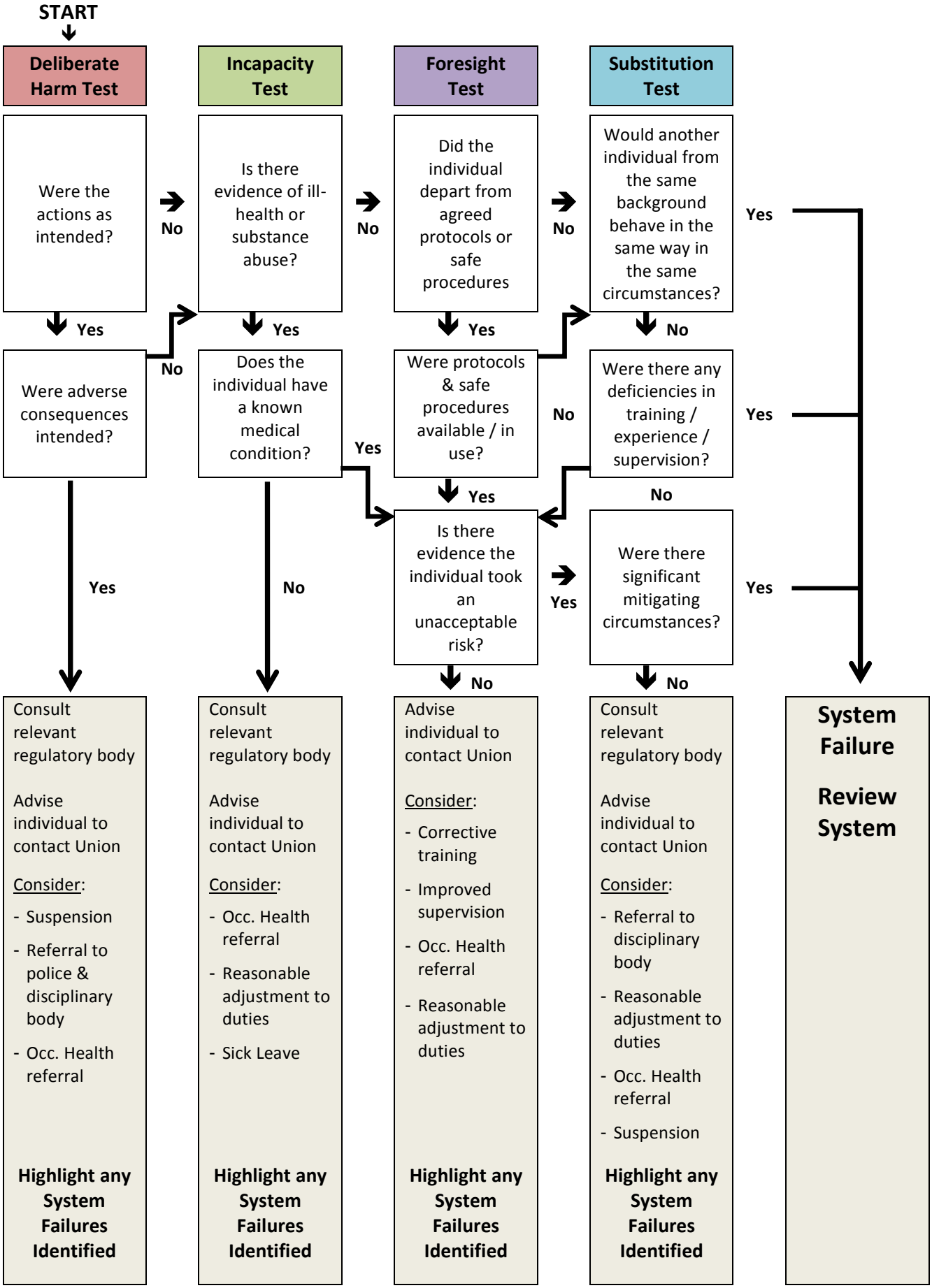
(a) All incidents of physical assault must be reported to the NHS Security Management Service. The Head of Performance & Governance will undertake this reporting in conjunction with commissioned services provided by the Commissioning Support Unit. CCG staff should ensure that any incident of abuse, either non-physical or physical, is reported using the CCG incident reporting process.

(b) Where any SI / SIRI is likely to result in significant litigation against the CCG (a potential claim over £250,000) a preliminary analysis should be carried out by the relevant Director, Line Manager and Head of Performance & Governance. Where necessary, the NHS Litigation Authority (NHSLA) should be notified of the incident, along with the preliminary analysis as soon as possible, usually before a claim is made.

(c) Any chemical incidents need to be notified to the Public Health England – Chemical Hazards & Poisons agency.

(d) All Estates defects and failures must be reported to the NHS Property Services Ltd (PropCo): Midlands and East Regional Director, NHS Property Services Ltd, 01223 597 500.

APPENDIX 3 – NHS Confederation / NPSA "Incident Decision Tree" for CCG Staff + Managers



APPENDIX 4 – Information Governance (IG) Incidents

Any Information Governance (IG) incident involving the actual or potential loss of personal information that could have a significant impact on individuals should be considered as serious. This applies irrespective of the media involved (electronic and paper records).

The CCG has robust IG policies in place to ensure that its staff are aware of their obligations and how CCG systems manage IG incidents. These include appropriate notifications within and outside of the organisation, especially those involving data loss or breaches of confidentiality. Where incidents occur out of hours, arrangements are in place to ensure on-call Directors are informed of the incident and take action to inform the appropriate contacts.

Consideration should always be given to informing patients when person-identifiable information about them has been lost or inappropriately placed in the public domain. All CCG staff should review any public statements made, particularly those in response to any incoming requests under the Freedom of Information Act 2000.

All IG-related incidents should be completed in the same way as others, in terms of forms to be completed and processes to consider. However for onward reporting of these, a new functionality has been added to the national IG Toolkit to facilitate the reporting of IG incidents and Serious Incidents Requiring Investigation (SIRIs).

CCGs have a responsibility to report SIRIs to the Department of Health (DH), and historically this was through Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), but as these establishments no longer exist as of April 2013, it must be ensured that the DH are kept informed.

The system provided within the IG Toolkit will allow IG incidents to be recorded and assessed to determine the severity of the incident; and dependent upon the severity, the system will automatically notify the Health & Social Care Information Centre (HSCIC), DH and the Information Commissioners Office (ICO).

From June 2013, all organisations processing health and adult social care personal data are required to use the IG Toolkit Incident Reporting Tool to report Level 2 IG SIRIs to the DH, ICO and other regulators.

Local incident management and reporting tools (including Strategic Executive Information System - STEIS) can continue to be used for local purposes, but notifications of IG SIRIs for the attention of the DH and the ICO must be communicated using the IG Incident Reporting Tool with immediate effect. Any CCG IG incident forms should be passed on to the Head of Performance & Governance, who is registered to use the IG Toolkit.

Access to the incident reporting tool is not limited to IG Toolkit users though. As administrators for CCG Toolkits, the CSU's IG Team will be able to provide any member of CCG staff with access to the incident reporting tool as an 'Incident Reporting Tool User'. In any period of absence of Head of Performance & Governance, the IG Team should be contacted (contact details are provided in the CCG's IG policies and procedures) that all staff have access to.

All information recorded under a 'closed' IG SIRI on the IG Toolkit Incident Reporting Tool will be published quarterly by the HSCIC, therefore it is important that the content recorded in the incident report does not include any information that would not normally be provided or published by the CCG if it had been requested under the Freedom of Information Act.

In addition, a new publication has been released by HSCIC: *"Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation"*.

The full document is available on the CCG's shared network drive, or on request from the Head of Performance & Governance. This document outlines how information should be recorded in the IG Toolkit Incident Reporting Tool, the process for incident management and the revised scales for assessing the severity of IG incidents.

A summary of the key points of the guidance is as follows:

Whilst there is no simple definition of a serious incident, as a guide:

- ✓ Any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and/or the Common Law of Confidentiality
- ✓ This includes unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy
- ✓ Such personal data breaches which could lead to identity fraud or have other significant impact on individuals

All CCG staff should be encouraged to report IG SIRI "near misses", as these and suspected incidents can also be recorded on the IG Toolkit Incident Reporting Tool, because lessons can often be learnt from them and they can be closed or withdrawn when the full facts are known.

- All staff should know to whom they should report and escalate suspected or actual IG SIRIs
- All organisations should already have in place an Incident Response Plan (IRP) covering Disaster Recovery, Business Continuity and the development of effective Communications Plans; it is recommended that this checklist is incorporated into the IRP
- Organisations should enter details of initial findings, within 24 hours of becoming aware of the incident, onto the Incident Reporting Tool
- When assessing the severity of an IG incident, there are two influencing factors – scale and sensitivity. Every incident can be categorised as level:

1. Confirmed IG SIRI but no need to report to ICO, DH and other central bodies
2. Confirmed IG SIRI that must be reported to ICO, DH and other central bodies

- The loss or theft of removable media (including laptops, removable discs, CDs, USB memory sticks, PDAs and media card formats) upon which data has been encrypted to the approved standard, is not a SIRI unless you have reason to believe that the protections have been broken or were improperly applied
- Incidents classified at IG SIRI level 2 need to be detailed individually in the CCG annual report in the format provided in Table 1 of the guidance
- Incidents classified at severity level 1 should be aggregated and reported in the annual report in the format provided in Table 2 of the guidance
- Incidents rated at severity level 0 need not be reflected in annual reports
- The CCG's Annual Governance Statement should, in the description of the risk & control framework, explicitly include how risks to information are being managed / controlled; any incidence of an IG SIRI should be reported as a significant control issue (for the avoidance of doubt these are those incidents with a severity level 2)

APPENDIX 5 – Incident Investigation Procedure

This Procedure details how to decide the level of investigation required and the action to be taken by the CCG's Investigation Team or the person investigating the incident, complaint or claim. The aim of this process is to identify and record the direct, contributory and root causes of the incident, complaint or claim. The information obtained can then be analysed, and common causes and trends highlighted. Appropriate preventative action can then be taken to avoid a recurrence.

- **Definitions**

Direct Cause is defined as the immediate cause, which triggered the incident.

Contributory Cause is defined as a cause, which contributes to the incident, but which by itself would not have caused the incident.

Root Cause is defined as the underlying cause to which the incident can be ultimately attributed, and which if corrected will prevent recurrence.

- **The Investigation Team**

This will be required to be established for all high-risk SIs / SIRIs, where it is good practice for the investigation to be undertaken by more than one person.

- **The Investigation Process**

The Investigation Team Lead should ideally have been trained in incident investigation and Root Cause Analysis (RCA) techniques *. Other members of the Team may include a person with specialist knowledge about an aspect of the event, and someone who knows nothing about the specialty involved in the event (i.e. someone who can act impartially).

** RCA is the process of examining what happened, in order to establish how / why it happened and should result in preventative measures to ensure that it does not happen again and that risks are mitigated. It involves the following steps:*

- *Outlining the sequence of events*
- *Finding and recording each pertinent event*
- *Avoiding any judgment, blame or attribution*
- *Identifying why the incident, complaint or claim occurred: causation*
- *Identify how the incident occurred: system faults, active errors, latent conditions*
- *Identify situational factors: distractions, circumstances, and triggers for latent failures*

Incident investigation will normally comprise the following processes. Initially, the following prompts should be considered to see if they contributed to the outcome of the event in question:

- Was there anything about the task / procedures involved?
- Was there anything about the way the team works together or perceives each other's role?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training / education of staff in relation to their competence to manage the event when it occurred?
- Was there anything relating to communication systems, between individual staff, departments, or electronic communications?
- Was there anything about the availability or quality of any guidance, policies or procedures?
- Was there anything about the CCG's strategy, its objectives and priorities?

If you answer "No" to all of these questions, it is acceptable not to investigate further. If you have answered "Yes" to any of these questions, some degree of RCA of the incident is recommended, even if a decision is taken not to review the whole event. The following should then be undertaken by the Investigation Team Lead:

- ✓ Preserve any direct evidence from the scene
- ✓ Chart the event with current knowledge ("Event Chart")
- ✓ Gather documentary and other evidence
- ✓ Revise the Event Chart
- ✓ Arrange and carry out interviews
- ✓ Identify, and then analyse, causal factors
- ✓ Decide on options for improvement and obtain costs
- ✓ Produce an Incident Report
- ✓ Ensure implementation of improvement plans

By taking into account the above, the investigation should highlight where there are areas of poor performance / practice or the need for change in practice, system failures or violation of procedures.

- **Investigating the Incident**

For all SIs / SIRIs and highly-scored incidents, the investigation should take the form of an Incident Review Meeting to ensure that the event is reviewed through a team approach to:

- Present a full chronology of events
- Identify and priorities the critical issues that need to be explored further
- Explore the critical issues for contributory / influencing factors and root causes
- Generate a series of recommendations and learning objectives
- Acknowledge and commend good practice / actions in mitigating the incident's seriousness
- Foster a positive learning environment

***Step One*: identify the scope of the incident and collect complete information**

All material facts relating to the incident must be gathered as soon as possible after it. In determining what to collect, the facts leading up to as well as the incident itself must be considered.

For complex events it is only by starting at the point that the incident occurred and then working backwards that the "start point" for the incident can be identified. Investigators will find it helpful to consider information from a range of sources including:

- ✓ The people involved in or witnessing the event
- ✓ The place or environment in which the event took place
- ✓ The equipment or objects involved in the event
- ✓ The paperwork related to the event
- ✓ Widely-held beliefs about normal work processes, relationships and adequacy of leadership

All staff / visitors / contractors involved in the event must be identified and informed an investigation is taking place. They must be informed that their assistance in investigating the incident would be appreciated and that the purpose is to identify areas where systems failed rather than to focus on human error. All witnesses should be interviewed along with the "affected" person if possible.

All staff involved in catastrophic incidents must be advised of the availability of confidential support and counselling; and told they can have a friend or union representative with them during interviews. The CCG will ensure that ongoing support to staff is provided wherever necessary.

All staff involved in, or witness to, the event must be asked to make a full record of the incident (including events leading up to and following the incident) as soon as possible after the event.

Appropriate statements should be taken from witnesses and from those involved in the incident. They should be of appropriate format and scope, in order to fully inform uninvolved or lay people of the facts as they relate to the incident. Statements comprised of opinion should be avoided and only the known facts should be recorded (in the first person format). Each statement must include the incident reference number, be dated and signed by the witness, and they must be clear that it could be disclosable, so they should be happy as to its content. Therefore the final paragraph of the statement should read: *"This statement is true to the best of my knowledge and belief."*

Where applicable, investigators should visit the environment where the incident took place, preferably before any changes are made and note the layout. A sketch of the area and its layout may be useful particularly if annotated with the location of persons involved in the incident, and other witnesses to the incident. Photographic evidence of the environment can be invaluable.

Any piece of equipment involved in the incident should be immediately removed and preserved as evidence. It is also important to elicit custom and practice in the workplace in which the incident occurred. The information obtained can help shape the context in which risk factors exist.

Step Two: map the information (the "Narrative Chronology")

A timed record of events should be obtained, as they took place in chronological order. Dates and times should be recorded, along with a narrative stating what happened.

"Time-Person Grids" are valuable mapping tools if there is a need to clarify where various people were during the incident:

Type of Staff	**9.00 am**	**9.15 am**	**9.30 am**
A	With person X	In office	With person X
B	In office	In office	In office
C	At coffee	In office	In day room
D	With person Y	In kitchen	With person Y

When mapping the incident information:

- Try to avoid moving into analysis: i.e. problems and contributory factors
- Choose one or more tools
- Use the written chronology and statements provided
- Identify any gaps in data collection
- Identify any unconfirmed information requiring verification

Step Three: problem identification and prioritisation

As you map the chronology of events you will generate questions to which you will need answers. Some of these will be issues relating to the chain of events and issues of clarification, others will be "why" questions as you try to understand how the event happened.

The fact-based questions can be answered with relative ease by going back to the people involved in the incident. The "why" questions are harder to answer and may require the involved parties to get together with the support of the Investigation Team to explore the unanswered questions.

Step Four: Root Cause Analysis (RCA)

Easy-to-use RCA tools include:

- **Brainstorming / Brain-writing**

Brainstorming is a familiar technique that can be used to assist the group to identify the issues that need further exploration. A disadvantage is 'group think', especially if there is a strong character within the group.

There are no right or wrong answers and the trick is not to allow any in-depth exploration during the process. A Facilitator must record ideas as they are spoken. This tool can be used when the team wants to do any of these things:

- ✓ Identify all the contributory factors
- ✓ Generate a list of problem areas that can be improved
- ✓ Identify possible consequences stemming from problem being analysed

Brain-writing is essentially the same, except that it allows the group to generate ideas anonymously and in a short timeframe. A group of people writes down ideas individually on index cards or paper. At the end of a set period of time (10-15 minutes) the ideas are collected by a Facilitator, mapped on a flipchart, organised into groups and prioritised for exploration. Brain-writing is best used when:

- ✓ The anonymity of participants needs to be protected
- ✓ There are a few dominant group members
- ✓ Complex ideas are expected

- **The "5 Why's"**

This is used to delve deeper into a problem asking "why" for each primary cause identified, then asking "why" again in response to each answer until there are no more causes forthcoming. It is best suited for exploring simple non-complex problems.

As a brief rule of thumb, it usually takes about five rounds of asking "why?" to identify the root cause of a problem, but you may need to ask more or less than five times. You can only investigate one cause at a time using this method and it is better to follow each identified cause to its end before investigating another.

- **Fishbone Diagrams**

Draw a long horizontal arrow on a sheet of paper; and at the head of the arrow write the problem to be explored. Spines are then added to the arrow, and each spine is given a classification label representing the main areas under which you want to explore the contributory factors to the identified problem. It is suggested that the following classifications be used to explore the problem.

- Individual (staff member), team and social factors
- Equipment and work conditions
- Task / process
- Communications
- Education and training
- Strategic management

The easiest way to identify the influencing factors for each problem identified is to consider each classification in turn and identify whether or not there were any issues of influence that map under it.

Not all influencing factors are negative. You could also identify positive factors that reduced the impact the identified problem had on the incident. This is particularly true of "near miss" incidents. These should be recorded as well as they can contribute to improvement strategies.

- **Identifying Causes + Effects**

A fundamental part of a Root Cause Analysis investigation is the identification of the influencing and causal factors that contributed to the event.

The investigation should consider the significance of the influencing or causal factors identified by the common categories in the table below, and use this to build appropriate improvement strategies.

Individual Factors	That the individual(s) involved have as unique to them: e.g. fatigue, stress, experience
Team Factors	These predominantly involve team communication issues and leadership
Communication Factors	Do verbal, non-verbal or written communications contribute to poor performance or occurrence of the event
Task Factors	Those that support and aid the safe / effective delivery of a process: e.g. procedures, clinical guidelines, protocols

Education & Training Factors	These influence the availability and quality of training programmes to support competence
Equipment Factors	Factors relating to the safety and operation of equipment
Working Conditions	Those which affect an individual's ability to function at optimum levels in the workplace
Organisational Factors	These are factors that are either inherent or embedded within the organisation. Often these factors are latent and only come to light when an adverse event occurs

***Step Five*: Generating the Incident Report, Action Plan and Recommendations**

The expected minimum content of the report is covered within the "Incident Review" section of the main Incident Reporting Policy (pages 13-14).