



INCIDENT MANAGEMENT POLICY: NEAR MISS INCIDENTS ADVERSE EVENTS SUI IG SERIOUS INCIDENTS

BADGER GROUP
Badger House
121 Glover Street
Birmingham, B9 4EY

Destroy All Previous Issues

This document is the property of Badger and must not be reproduced, published or used by any third party without prior written authorisation from Badger.

Contents

- 1 INTRODUCTION1**
- 2 AIM.....1**
- 3 CATEGORIES OF ADVERSE EVENTS1**
 - 3.1 INCIDENTS 1
 - 3.2 SERIOUS INCIDENT 2
 - 3.3 MAJOR INCIDENTS 3
 - 3.4 CLINICAL ENQUIRIES..... 3
 - 3.5 COMPLAINTS 4
 - 3.6 PROFESSIONAL CONCERNS..... 4
- 4 INCIDENT MANAGEMENT4**
 - 4.1 GOVERNANCE STRUCTURE 4
 - 4.2 REPORTING PROCESS..... 4
- 5 NO BLAME CULTURE 5**
- 6 PATIENT CONFIDENTIALITY 6**
- 7 INFORMATION GOVERNANCE RELATED SERIOUS INCIDENT REQUIRING INVESTIGATION (IG SIRI) 6**
- 8 RELATIONSHIP WITH OTHER BADGER POLICIES 6**
- 9 APPENDIX 1 - CONSEQUENCE/IMPACT RATING 7**
- 10 APPENDIX 2 – PROCEDURE FOR THE INVESTIGATION OF SERIOUS UNTOWARD INCIDENTS (SUIS) 9**

DOCUMENT CONTROL

Document Storage

Location: p:\ops team\central policies & procedures - development - word docs\cg - clinical governance policies\cg-02 - incident management policy v5.0.docx

Version Control Log (Only last 3 versions, earlier versions can be found in the appropriate Archive directory for the document)

Version	Date	Author	Description of Changes
V4.2	Jan 2019	S Barnes	Removal of HSCIC Guidance in 7, NHS Digital added
V4.3	April 2022	S Barnes	Reviewed, Minor changes
V5.0	October 2023	J Carey	Merged with G01

Approval

Version	Name	Position	Signature	Approved Date
V1.0	Dr Fay Wilson	Medical Director		Jan 2010
V2.0	Executive Team			Jan 2014
V5.0	SMT	Heads of Department		Nov 2023

Glossary

Term	Description
SMT	Senior Management Team

1 INTRODUCTION

Badger Group is committed to the delivery of a safety culture which is open and transparent and in which all staff proactively identify, assess, report and manage risk. Badger acknowledges that incident reporting is a vital part of minimising risk to patients, staff, visitors, contractors and the organisation. Any incident, whether resulting in an unintended or unexpected event that could have led to or did lead to harm or damage, must be reported. This enables the organisation to learn from near misses, incidents and serious incidents (SI), to manage risks and improve safety.

This policy covers all incidents and near misses both clinical and non-clinical. Staff can report incidents without fear of prejudice for doing so as long as the information provided is done so in good faith. Incident reports must be focused on the facts of the event and the consequences of the incident.

It incorporates and encourages:

- A unified mechanism for reporting and analysis when things go wrong.
- A more open culture, in which errors or service failures can be reported and discussed.
- Mechanisms for ensuring that, where lessons are identified, the necessary changes are put into place.
- A wider appreciation by all staff of a systematic approach in preventing, analysing and learning from errors and near misses.
- A system for ensuring the organisation is prepared to report incidents externally.

In order to improve safety and minimise risk, the organisation is committed to being open and learning from mistakes.

2 AIM

The aim of this policy is to support a safety culture in which all employees proactively identify, report and manage incidents through the implementation of this Policy. (Including Serious Incidents)

The objectives ensure that:

- Staff know how to report an incident
- Staff are aware of their responsibilities in incident and SI management
- Incidents are thoroughly investigated
- Incidents are assessed in terms of risk to patients and staff
- Staff receive appropriate support and advice
- Managers feedback findings of investigations
- Actions are taken to reduce risk of reoccurrence
- Learning is shared across the organisation
- Learning is shared externally where appropriate
- Badger complies with regulatory, legislative and statutory requirements

3 CATEGORIES OF ADVERSE EVENTS

3.1 Incidents

An unintended or unexpected occurrence or event that could have led to, or did lead to, harm or damage. It includes events which:

- May have caused harm to patients, staff and visitors
- May have caused harm to property or equipment
- May have caused harm to reputation

- May have caused financial harm
- May have had the potential to cause harm but this has been averted
- May indicate that change is needed to maintain quality of patient care

This definition covers all areas including patient, client or visitor injury, together with adverse patient or client incidents; fire, theft, fraud incidents of violence and aggression including verbal, physical, significant loss or damage; assault and employee accidents.

Incidents are adverse events reported by staff or others within or outside the organisation, relating to services provided by Badger or those provided by other organisations.

3.2 Serious Incident

The NHS England Serious Incident Framework 2015 identified a serious incident as events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. There is no definitive national list of specific events/ incidents that constitute a Serious Incident and local lists should not be created as this can lead to inappropriate management of an incident.

Please note: As outlined in the NHS patient safety strategy, in August 2022 the NHS published the new Patient Safety Incident Response Framework (PSIRF), which will replace the current Serious Incident Framework. There will be a 12-month period where organisations prepare for the transition to PSIRF, which we expect to be completed by Autumn 2023.

However, there are some circumstances in which a Serious Incident MUST be declared.

3.2.1 Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death¹ of one or more people, including: suicide/self-inflicted death; homicide by a person in receipt of mental health care within the recent past²
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: the death of the service user; or serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern-day slavery where: healthcare did not take appropriate action/intervention to safeguard against such abuse occurring³, or where abuse occurred during the provision of NHS-funded care

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded care caused/contributed towards the incident.

¹Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice.

²This includes those in receipt of care within the last 6 months, but this is a guide and each case should be considered individually - it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.

³This may include failure to take a complete history, gather information from which to base care plan/treatment, assess mental capacity and/or seek consent to treatment, or fail to share information when to do so would be in the best interest of the client in an effort to prevent further abuse by a third party and/or to follow policy on safer recruitment.

3.2.2 Never Event (NE):

The Department of Health (DoH) identifies what incidents are 'Never Events'. All these are defined as serious incidents although not all Never Events necessarily result in serious harm or death. There is a published list of Never Events available as well as a frequently asked questions document to assist with understanding 'Never Events'.

3.2.3 An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues:

- Property damage; Security breach/concern; Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population; Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS); Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or Activation of Major Incident Plan (by provider, commissioner or relevant agency)

3.2.4 Major loss of confidence in the service

Including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

3.2.5 A 'Near Miss'

A 'Near Miss' may also constitute an SI because the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. Deciding whether or not a 'near miss' should be classified as a serious incident should therefore be based on an assessment of risk that considers:

- The likelihood of the incident occurring again if current systems / process remain unchanged; and
- The potential for harm to staff, patients, and the organisation should the incident occur again. This does not mean that every 'near miss' should be reported as a serious incident but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.

3.3 Major Incidents

These are very serious incidents that typically include more than one organisation for example may involve multiple casualties (e.g. from communicable disease outbreaks, terrorist activity, explosions, serious transport accidents) and devastating loss of healthcare facilities (e.g. major fire in premises, massive fraud). Procedures for managing major incidents are included in the Badger Disaster Recovery Plan.

3.4 Clinical Enquiries

Clinical enquiries are queries made by healthcare professionals or associated staff about the clinical management of individual patients. Clinical enquiries are managed by senior clinicians under the oversight of the medical director, usually on the basis of documentary evidence only and usually within a timescale of two working weeks.

3.5 Complaints

Complaints are made by patients or their representatives when they are dissatisfied with the care they have received. Complaints may be received directly, via commissioners, via other providers or via the patient feedback system. See Badgers Complaint process QC-02 for details of complaint handling.

3.6 Professional Concerns

A professional concern is a concern raised about a clinician, which relates to their fitness to practise, for example misconduct, health conditions or poor performance. Professional concerns are acknowledged within three days and investigated by the medical director. Time scales are variable depending on the nature of the concern and a response (which may be an interim response) will be made within ten working days.

4 INCIDENT MANAGEMENT

Reporting of concerns is one element of governance that can be used by all members of staff to highlight difficulties that have arisen. Incidents may relate to clinical matters, or organisational issues, and may be apparently minor or serious events, but the overriding principle is that any event that affects patient or staff safety is important. All staff are encouraged to use the reporting mechanism to alert the governance team to problems that have arisen. These can then be reviewed and investigated where necessary. This review will assist the governance team to identify areas where there is potential risk for patients or staff and engage with managers to rectify the problem.

4.1 Governance Structure

The Governance Team will comprise:

1. An Associate Medical Director (AMD) who is responsible for reviewing all incidents and is responsible for investigating clinical incidents
2. A Head of Department or deputy designated by the AMD, who reviews and investigates non-clinical incidents
3. The Clinical and Management Support Officer who provides administrative support

This team reports to the Chief Executive Officer (CEO).

4.2 Reporting Process

1. Report the Incident

Report incidents, using the Incident Reporting forms (IG-F-001 - Incident Report Form) available on Aadastra, Web Communications, Badger Standard Forms, Information Governance Forms.

Incidents should be reported within 48 hours of the initial incident occurrence to ensure Badger can respond in a timely manner.

The detail of the incident should be completed as clearly as possible, along with the relevant Aadastra case number if applicable. Incident reports should be submitted to the Quality & Compliance department at Glover Street and these will be reviewed on a on a daily basis by a member of the governance team and escalated to the responsible AMD, who will distribute them to the relevant team member.

2. Acknowledging the Incident

The Clinical and Management Support Officer will send an acknowledgement within 7 working days of receipt. Potentially serious incidents are fast tracked for investigation.

3. Incident Investigation & Grading

All incidents require some level of investigation in order to identify the underlying causes of how and why the incident has occurred. The level of the investigation will depend upon the degree of harm to the patient/carer/relative or staff member and the risk of future harm. For this reason, all incidents require a likelihood / consequence grading (See Appendix 1). If an incident scores 20 or more, it will be handled as a Serious Incident Requiring Investigation (SIRI). The procedure for management of a SUI is documented at Appendix 2

All incident investigations must commence immediately if safe and legal to do so. Identifying the root cause of a problem rather than the 'underlying cause' is an essential part of the process of investigating serious incidents. It provides an opportunity to identify actions required to eliminate the risk of the incident occurring again, and make a positive impact to on-going quality and safety of care.

At the start of the process of investigation, issues that require an immediate specific risk assessment may be highlighted to identify the current risk and actions required to minimise the immediate risk. This may need escalating to senior managers to consider logging in their local risk register via the appropriate risk owner.

All incidents are discussed at a monthly incident review meeting with the Clinical Incident Investigator/Associate Medical Director, and allocated for investigation according to categories: clinical, operational, safeguarding etc. The time frame for completion of the process i.e. investigation, feedback to the incident team, and a response to the reporting individual, is 45 working days.

4. Record Keeping

Details of incidents will be entered into the incident log and copies of all documents, correspondence and evidence will be held in the Incident file that shares the corresponding Incident reference code to maintain an accurate audit trail.

5. External Reporting

Certain incidents reaching a threshold need to be reported externally to agencies for example: (non-exhaustive list).

- Health and Safety Executive (HSE) under RIDDOR regulations.
- Information Commissioner Officer (ICO) relating to data breaches
- Care Quality Commission (CQC) in line with regulations
- Integrated Care Board (ICB) when incident affects service provision or significant patient safety
- The emergency services such as the Police when a crime has been committed or alleged or there is an immediate risk to life
- Professional bodies such as GMC, NMC to report regulatory issues

6. Learning and sharing knowledge

All Incidents are discussed on a weekly basis within the Senior Management Team Meetings. Incidents are summarised and analysed quarterly internally at the Board Performance Group and Externally at the ICB Quarterly review. Reports are made to the monthly Clinical Management Group for discussion along with learning points and associated actions.

5 NO BLAME CULTURE

Badger is committed to developing and encouraging a reporting culture amongst staff that is free from an assumption of blame. To this aim, no disciplinary action will result from the reporting of incidents, mistakes or near misses, except in the cases of gross misconduct, criminal or malicious activities (including malicious reporting), clinical negligence and continual violations. All reports will be dealt with in a confidential manner and where necessary the names of the originators of the report will remain confidential. However, if as a result of an investigation, evidence of professional misconduct or negligence is identified, then the disciplinary procedure may be invoked.

6 PATIENT CONFIDENTIALITY

It is important to remember that throughout any investigation patient confidentiality must be maintained at all times in line with the Information Governance policy. Breaches of patient confidentiality will be recorded, and an Incident form completed. For any email correspondence containing Patient Identifiable Information Data (PII) the following policies must be adhered to:

- IG13 – Guidelines for Transferring PII (PII) & Sensitive Category Data
- IG37 – Email policy

7 INFORMATION GOVERNANCE RELATED SERIOUS INCIDENT REQUIRING INVESTIGATION (IG SIRI)

It is essential that all IG SIRIs which occur in Health, Public Health and adult Social Care services are reported appropriately and handled effectively. Commissioned services are subject to the same requirements to report data breaches to the Commissioner of the service and directly through the guidelines in the NHS Digital guidelines.

Potential IG incidents will be assessed in accordance with this Adverse Events Policy (CG-02) and if proven to be an IG SIRIs will be reported via the DSP Toolkit: <https://www.dsptoolkit.nhs.uk/Help/incident-reporting>

8 RELATIONSHIP WITH OTHER BADGER POLICIES

It is important that other policies are referred to in conjunction with this policy, including:

- Health & Safety Policy – H&S01
- Risk Management Strategy & Policy – RM01
- Complaints Policy CG02

9 APPENDIX 1 - CONSEQUENCE/IMPACT RATING

All incidents should be graded 1 to 25 by multiplying a “Consequence/Impact” rating of 1 to 5 with a “Likelihood” rating of 1 to 5 (Table 1)

TABLE 1

			Consequence/Impact				
			Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Likelihood	Rare	1	1L	2L	3L	4M	5H
	Unlikely	2	2L	4M	6M	8M	10H
	Possible	3	3L	6M	9M	12H	15H
	Likely	4	4M	8M	12H	16H	20E
	Almost Certain	5	5M	10H	15H	20E	25E

L= Low risk M = Medium risk H = High risk E= Extreme risk

TABLE 2 – ESTIMATING LIKELIHOOD

Score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	<1%	1-5%	6-20%	21-50%	>50%
	Cannot believe this will ever happen	Do not expect it to happen but is possible	May occur occasionally	Will probably occur but it is not a persistent issue	Likely to occur on many occasions

TABLE 3 – ESTIMATING CONSEQUENCE/IMPACT

Risk Area	Insignificant - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
1. GOVERNANCE/ INSPECTION/ AUDIT & POLICY COMPLIANCE	Minor non-compliance with standards. Minor recommendations	Non-compliance with standards. Recommendations given	Reduced rating, Challenging recommendations. Non-compliance with core standards, legislation	Low rating Enforcement action HSE intervention. Critical report. Major non-compliance with core standards, legislation	Zero Rating Prosecution. Severely critical report. Loss of contract
2. CLINICAL/ CARE SERVICE ISSUE/ OUTCOME/ EXPERIENCE	Clinical/care service issue but no service user dissatisfaction or mismanagement of patient care.	Clinical/care service issue with minimal service user dissatisfaction. Service loss <3 days experience readily resolvable. 1-2 people affected	Clinical/care service issue with moderate service user dissatisfaction, mismanagement of service user care, service loss < week. 3-15 people affected.	Clinical/care service issue with serious mismanagement of care. Misdiagnosis/ poor prognosis. Increased level of care >15days. Moderate number affected-16-50.	Totally unsatisfactory Clinical/care service issue with dire mismanagement of care. More than 50 people affected
3. HEALTH & SAFETY. HARM/ INJURY Physical/ psychological	No Injury. Total compliance with health and safety legislation No legal action	Minor Injury requiring first aid, less than 3 days off work. Possible legal action Partial compliance with health and safety law.	Moderate Injury requiring hospital admission. RIDDOR reportable Partial compliance with health and safety law Probable legal action via civil law	Major Injury requiring long-term treatment or community care intervention. Long term sickness. Non-compliance with health and safety legislation. Up to £20,000 fines, court appearance. Definite criminal and or civil law action	Death/ Permanent injury/damage/harm, long term incapacity, disability. Prosecution, over £20,000 fines, imprisonment. Non-compliance with health and safety legislation Definite criminal and civil law action
4. WORKFORCE e.g. staffing levels, training, performance, attendance, turnover etc	Short term reduction in staffing or skill mix, covered by colleagues. Reduces quality and/or productivity	On-going reduction in staffing or skill mix, covered by colleagues or short term unable to be covered. Reduces quality and/or productivity	Late delivery of objectives. Postponement of appointments. Failure to meet waiting times. Failure to meet training requirements	Failure to deliver projects. Unsafe staffing levels. Incident or Near miss serious incident as a result of staff levels or skills.	Failure to meet national targets. Failure to deliver functions of Badger. Serious incident as a result of staffing level or inadequate training
5. COMPLAINT/ LITIGATION	Locally resolved complaint	Justified complaint peripheral to service user care	Justified complaint involving lack of appropriate care. Litigation probable. Below excess	Multiple justified complaints Claim above excess level	Multiple claims or single major claims. Unlimited damages
6. REPUTATION/ PUBLICITY	No adverse publicity or loss of confidence in Badger	Local Media - short term minor loss of confidence and effect on staff morale	Local Media - long term effects on public relations Moderate loss of confidence in Badger and significant effect on staff morale	Widespread adverse publicity. National Media < 3 days Major loss of confidence in Badger	National media > 3 days. MP concern-questions in House. Major loss of confidence Viability of Badger threatened

10 APPENDIX 2 – PROCEDURE FOR THE INVESTIGATION OF SERIOUS UNTOWARD INCIDENTS (SUIS)

MANAGEMENT

1 INITIAL STAGE

1.1 Immediate Action

Immediate action is required by any member of staff discovering what may be a SUI, whether on Badger premises or elsewhere (e.g. Treatment Centre, hospital premises or patient's home.) The initial response may include calling the emergency services (e.g. ambulance for collapsed patient) or calling for assistance and / or the police (e.g. in the case of serious assault). The Team Leader should be notified as soon as possible by telephone.

1.2 Scene preservation

Once immediate hazards have been controlled to prevent risk to all on site, it is vital that the scene of the SUI be preserved until it has been inspected. The most senior member of staff present should ensure complete records are completed within the Adastra system, including referral to, or involvement of other agencies. Written reports should also be requested from all staff present at the time of the incident to ensure an accurate, contemporaneous account accompanies the incident form.

1.3 Initial Notification to Senior Management Team (SMT)

The Team Leader will as soon as possible notify the On-Call Manager, and duty Associate Medical Director who will escalate the incident to the Medical Director, Chief Executive, Executive Chair as required. The Team Leader will initiate processes to deal with patients at the location involved, for example arranging to divert any additional patients to an alternative Treatment Centre, confirming these arrangements on the shift report and / or the incident report.

The CEO will ensure other relevant agencies are involved (e.g. Badger Board, commissioners, Local Authority, other providers, NHS England etc.) within 24 hours.

1.4 Care of Staff

Following an incident where staff may be distressed or traumatised, appropriate support and debriefing will be provided. A senior manager may provide this in the first instance and is responsible for liaising with the Workforce Department of Badger if professional help is required.

2 REPORTING

2.1 Initial Reporting

Following notification to the Senior Management Team, the SUI must be reported to the respective Commissioner ideally within 24hrs of the incident occurring and no more than two working days. The information provided to the Commissioner must include: -

- The date the incident happened
- The category – Incident, near miss etc. (see 3.2 of Incident Management Policy for guidance)
- The grade (see section 6 below for further details of grading)
- Direct contact number of reporting officer
- A summary of the incident – if there is a lack of information known at the point of reporting it is necessary to indicate this to prevent a request for further information
- The immediate steps taken to safeguard patient and staff safety

2.2 Statutory reporting

It will be the responsibility of the CEO to report SUIs (e.g. to the Police, Health and safety Executive, Social Services) and if appropriate to inform professional regulatory bodies. Badger's insurance and indemnity providers should be informed as appropriate.

In the case of a death of a patient whilst using the Badger service, a 'Notification of Death' form must be completed and submitted to the CQC.

2.3 SUI Report

A full investigation will always be required: this may include statements from staff, review of clinical records by the Associate Medical Director or Group Medical Director, compilation of an initial report, and identification of any remedial action required. In all cases this information will be presented to, or collated by the Group Medical Director, who retains overall responsibility for managing SUIs, and will produce a formal report.

2.4 Media Attention

It will be the responsibility of the Associate Medical Director to notify the Badger CEO of SUIs where there is potential for media interest as soon as possible. The CEO will act as spokesperson for Badger, and if appropriate will notify the Board members and other parties.

3 INVESTIGATION

3.1 The CEO will appoint an Investigating Officer within 48 hours of the SUI occurrence.

3.2 The Investigating Officer should obtain written statements from staff and others involved, or provide summarised interview notes where written statements are not possible. The Investigating Officer must advise any member of staff to be interviewed that they are entitled to be accompanied by a colleague or professional representative.

3.3 The Investigating Officer must ensure that he/she:

- Is in receipt of background information to the incident
- Has a clear understanding of how the incident happened and the events leading up to it
- Is aware of what communications have been had with patients/relatives and professional staff when there is a question of fitness to practice
- Takes a root cause analysis approach
- Establishes whether there was a failure to follow procedures, or whether the procedures are flawed
- Considers any alternative course of action that might have prevented the incident – i.e., recommendations for action
- Highlights any discrepancies in the evidence
- Is in receipt of information about any remedial action that has taken place

3.4 An interim report will be provided by the Investigating Officer to the CEO within five working days of the initial reporting, with a copy being provided to the relevant commissioner and the Board of Directors.

3.5 The investigation should be completed within fifteen working days of the incident. If this is not possible, the Investigating officer will provide a weekly report to the CEO detailing progress, including reasons why the investigation is taking longer than usual.

3.6 The Investigating Officer will present a factual report to the CEO within fifteen working days of the incident.

3.7 A feedback exercise with the local team will take place within fifteen working days of the receipt of the Investigating Officer's report.

- 3.8 A review will be undertaken by relevant members of the executive team to consider potential litigation and risk and this will be forwarded to the CEO.
- 3.9 A final report with agreed action plans is to be provided to the relevant commissioner within 45 working days from the date the incident was initially reported.

4 FEEDBACK

The CEO should ensure an appropriate senior manager leads a feedback exercise with relevant members of the local team.

- 4.1 Purpose of feedback exercise:
- To consider the Investigating Officer's report
 - To discuss recommendations made
 - To ensure that lessons are learned.

4.2 Conduct of exercise

The exercise should be designed to ensure on-going support for staff. It will normally take the form of a discussion session. Confidentiality must be respected and the session should not be about apportioning blame although professional accountability may be discussed.

The session should include:

- A summary of the systematic analysis of the SUJ, having used a root cause analysis approach
- Consideration of the Investigating Officer's report and recommendations
- Formation of an action plan with measurable outcomes and timescale for review, and/or congratulating staff on their appropriate actions. (This may include changes in procedures, training and development needs etc.)

- 4.3 After the feedback exercise the senior manager will within two working days send a copy of the action plan to the CEO for discussion and agreement by the executive team. It may be appropriate at this time to share the outcome of the process with the patient / next of kin, taking into account confidentiality and potential liability.

5 IMPLEMENTING CHANGES AND SHARED LEARNING

The Senior Management Team will be responsible for sharing lessons learned from the investigation throughout Badger wherever appropriate. A report should be considered by the Clinical Management Group of Badger.

The Senior Management Team will be responsible for implementing any changes as a result of the investigation and for monitoring the action plan.

6 GUIDE TO GRADING OF A SERIOUS UNTOWARD INCIDENT

Grade 0	<p>Notification only – it is unclear if a SUI has occurred, the Commissioner must be updated with further information within three working days of a grade 0 being notified.</p> <p>If within three working days, with the agreement of the Commissioner it is found not to be a SUI, it can be downgraded to an Untoward Incident (UTO) and managed accordingly. If a SUI has occurred, it will be re-graded, with the agreement of the Commissioner as a Grade 1 or 2 and clearly recorded that it has been upgraded.</p>
Grade 1	<p>Examples</p> <ul style="list-style-type: none"> • Drug errors leading to severe harm or death • HCAI outbreak • Grade 3 and 4 pressure ulcer • Poor discharge planning causes harm to patient • Unavoidable/unexplained death • Mental health –attempted suicides of our patients • Data loss and information security (DH criteria level 2)
Grade 2	<p>Examples</p> <ul style="list-style-type: none"> • Homicides following recent contact with mental health services • Serious or intentional harm to patients • Maternal deaths • Child protection • Accusation of physical misconduct or harm is made • Data loss and information security (DH criteria levels 3 -5) • Never Events • Avoidable Serious Incidents