NHS
Herts Valleys
Clinical Commissioning Group

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document which guides practices when submitted to the appropriate committee for consideration and approval.

	Yes/No/ Unsure	Comments
Title of Document		Incident Reporting and Management Policy
Could this policy be incorporated within an existing policy?	No	
Does this policy follow the style and format of the agreed template?	Yes	
Has the front sheet been completed?	Yes	
Is there an appropriate review date?	Yes	
Does the contents page reflect the body of the document?	Yes	
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	No	
Are all appendices appropriate and/or applicable?	Yes	
Have all appropriate stakeholders been consulted?	Yes	
Has an Equality Impact Assessment been undertaken?	Yes	
Is there a clear plan for implementation?	Yes	
Has the document control sheet been completed?	Yes	
Are key references cited and supporting documents referenced?	Yes	
Does the document identify which Committee/Group will approve it?	Yes	

Plans for communicating policy to – staff; practice membership; public (as appropriate)	Yes	Via the HVCCG intranet and weekly bulletin

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Alan Warren	Date	21st April 2015
Signature			

Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Executive Team	Date	21st April 2015
Signature			

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Incident Reporting and Management Policy

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1.	**INTRODUCTION**
1.1	This policy underpins the Clinical Commissioning Group (CCG) risk management framework and sets out the systems, processes and accountability within the CCG for the reporting, investigation and management of all incidents and near misses, whether clinical, non-clinical or of a serious nature including Serious Incidents (SIs) and any required external notifications. By adopting this policy, the CCG aims to improve the organisation's ability to: • Commission high quality, safe and accountable health services • Minimise risk to patients and members of the public and • Ensure a safe working environment for staff whilst maximising the resources available. As a commissioner, the CCG procures a range of services, some of which are large and complex. The CCG is committed to complying with legislation and NHS standards that require the CCG to have robust systems and processes in place for the reporting, investigation and management of all incidents and near misses which occur as part of the day to day organisational business. As an NHS commissioning organisation, the CCG aims to learn and share the lessons learnt and improve its internal systems and processes, which underpin and support its statutory organisational and commissioning responsibilities. By adopting this approach, the CCG will improve its ability to commission high quality patient care, ensure a safe environment for staff and effectively utilise its resources. The CCG recognises that incident reporting is a fundamental tool of risk management in that it provides an opportunity to collect vital information about incidents to gain a better understanding of the underlying factors, system failures, errors or events that have occurred or had the potential to occur causing harm, loss, injury or damage. The CCG endeavours to improve its commissioning by embedding risk management and incident reporting into all areas of its business functions to ensure that lessons learnt lead to improvements within its commissioned health care services and/or organisational functions.
1.2	Serious Incidents **-** the CCG and all providers commissioned by the CCG will work in line with national requirements set out in the Serious Incident Framework (March 2015) http://www.england.nhs.uk/?s=serious+incident+guidance The CCG is required to report all internal SI's to NHS England. All providers

	including non-NHS providers (including any organisation or person that is accountable to the CCG through contracting and commissioning arrangements), are expected to report all serious incidents (including Never Events, and serious health-care associated infections) directly to their commissioners
2.	**PURPOSE**
2.1	The purpose of this policy is to ensure that all members, staff and/or contractors working for or on behalf of the CCG are aware of their duties when reporting, investigating or managing incidents. It applies to all incidents, whether they involve commissioned services, patients, carers, visitors, staff or members of the public; and includes property, premises, assets, information or any other aspect of the organisations business. It gives direction and organisational regulation so that managers are aware of their duties in the approval, management and investigation of incidents, and key personnel are aware of their duties of reporting incidents to external bodies as appropriate. This policy aims to: 1. Ensure that all staff respond and learn from incidents. 2. Ensure that all incidents are reported in a timely manner. 3. Ensure that all staff contributes to the identification of risk by reporting incidents and near misses, thus allowing preventative controls to be put in place. 4. Ensure that all SIs are investigated in a timely, efficient and effective way. 5. Ensure compliance with national reporting requirements. 6. Ensure the CCG has an open and honest approach to provider incidents affecting patients/relatives/carers, and a commitment to sharing lessons learned. 7. Ensure lessons learned from incidents and trends are shared across the organisation and fully acted upon by commissioned providers. 8. Enhance learning and development through the application of good performance management principles. For the purposes of this Policy, the term incident also refers to significant/adverse events.
2.2	**Culture of Openness** The CCG has an open and non-judgmental approach to the reporting of incidents. It is important that everyone within the organisation contributes to

	the reporting and learning process. The processes and procedures in this policy are not designed to apportion blame, but focus on the understanding of the root cause of errors and learning from them to avoid a further recurrence.
3.	**DEFINITIONS**
3.1	**Accident** – An unintentional event which can, but may not have caused harm. **[Clinical] Governance -** A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. **Culture -** Learned attitudes, beliefs and values that define a group or groups of people. **Employee** – An individual employed by the CCG directly or working on behalf of the CCG through a third party for a specific piece of work on a short/medium term basis. **Hazard** - Has the potential of something to cause harm to people or property. **Near Miss** - A situation during any activity that fails to develop further, whether or not as the result of intervening action, but carried with it the potential to cause harm (i.e. “it almost happened”). **Incident** - The term “incident” is used in this policy to refer to any event which gives rise to, or has the potential to, produce unexpected or unwanted effects involving the safety of patients, staff, contractors, visitors on CCG premises or employed by the CCG, or loss or damage to property, records or equipment which are on CCG premises or belong to the CCG. It therefore includes accidents, clinical incidents, deaths, security breaches, violence, and any other category of event which does or could result in harm. It also includes failures of medical or other equipment. **Investigation -** The act or process of investigating – a detailed enquiry or systematic examination. **Never Event** - A serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented. NHS England offers guidance on what constitutes a ‘Never Event’ and CCGs are required to monitor their occurrence within the services they commission. **Risk -** The chance of something happening that will have an impact on individuals and/or organisations. It is measured in terms of likelihood and consequences. **Risk Assessment** – The evaluation of risk with regard to the impact if the risk is realised and the likelihood of the risk being realised. **Risk Management** – All the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

	Risk Summit - A meeting of high-level leaders called to shape a programme of action, which is focused on sharing information willingly to help achieve a consensus about the situation under scrutiny and the actions required to mitigate the identified risks. **Root Cause Analysis (RCA) -** A systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened. **Serious Incident -** A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following: • unexpected or avoidable death of one or more patients, staff, visitors or members of the public; • serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm) • a scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population; • allegations of abuse; • adverse media coverage or public concern about the organisation or the wider NHS; • one of the core set of never events
4.	**ROLES AND RESPONSIBILITIES**
4.1	**Roles and Responsibilities within the Organisation** **Accountable Officer** The Accountable Officer has overarching responsibility for internal governance arrangements and managing providers responses to SIs and where appropriate for commissioning and co-ordinating SI investigations. **CCG Board** The CCG Board has overall responsibility for risk management and health and safety within the CCG. Through the reports and minutes from delegated sub-committees, the CCG Board must gain assurance that the process of incidents, complaints and claims investigations, and the learning and

application of lessons learned is working efficiently and effectively.

The CCG Board also receives quality and performance reports regarding all incidents and SIs, trends, and lessons learnt to ensure organisational learning and to prevent recurrence.

The CCG Committee with Responsibility for Quality
The CCG Board has established a sub-committee that reports to it and has delegated responsibility for:

- Reviewing statistical evidence for all reported CCG Incidents, SIs, complaints, Patient Advice & Liaison Service (PALS) and claims on a 6 monthly basis.
- Interpreting this data for trends analysis and assurance.
- Monitoring the feedback from external agencies on the incident reporting process.
- Ensuring all high and moderate risk graded incidents have an investigation completed within 60 days. This will be provided via the compliance report.
- Seeking assurance that the operational management of incidents within the CCG is both effective and efficient.

Chief Finance Officer
To provide specialist advice on the management of incidents

- To promote and encourage risk and incident reporting through awareness raising and training.
- To monitor the timeliness of reporting and raise awareness with senior leads/directors of issues.
- To conduct/facilitate root cause analysis on incidents as appropriate.
- To ensure all incidents with a risk rating of 8 and above are investigated appropriately, providing advice, guidance and facilitation when necessary.
- To identify themes and trends through the regular analysis of all reported risks and incidents to help support organisational learning.

Executive Team
It is the duty of all senior managers to ensure that all their staff comply with the incident reporting process and all of its associated procedures, and take appropriate action if this does not occur.

- To encourage a risk aware working environment, ensuring that senior leads are aware of their responsibilities
- To lead and support staff undertaking the investigation of incidents in accordance with the Policy.
- To ensure all incidents with a risk rating of 7 or less are managed appropriately and action taken to reduce the risk to its lowest level.
- To ensure all incidents with a risk rating of 8 and above are investigated appropriately, informing the Accountable Officer as

appropriate, in accordance with this Policy.
- To ensure lessons that are learned from risks and incidents are shared across the CCG.

The Nursing & Quality Team
The Nursing & Quality Team have the responsibility to:

- Ensure all staff using the Datix system are trained appropriately
- Implement this policy when appropriate for all internal serious incidents
- Inform the appropriate CCG lead and CCG Board or relevant Committee of reported incidents
- Inform all relevant external bodies of a SI if appropriate in accordance with their requirements
- Ensure lessons are learned across the organisation and by educating staff
- Ensure that incident data collection is complete and appropriate
- Inform the CCG Board and/or relevant sub-Committee of reported incidents according to their significance
- Inform NHS England of Serious Incidents in accordance with their incident reporting requirements
- Provide reports to relevant CCG Board sub-committees or groups
- Undertake quarterly analysis of aggregated incident data for inclusion in the Quarterly Report
- Ensure lessons are learned across the organisation
- Inform all external agencies of incidents as statutorily obliged

Risk Manager
Is responsible for reviewing and co-ordinating the implementation of this policy and keeping a corporate database of incidents.

Line Managers (Incident Approvers and Investigators)
- Must take immediate action where possible to prevent or reduce likelihood of recurrence of an incident
- Ensure that the Datix incident form is completed for all incidents
- Ensure local investigations are carried out to a satisfactory and prompt conclusion; upload findings, action plans and documentation relevant to the investigation
- Retain all appropriate records, materials and equipment involved in the incident
- Maintain all records on the Datix incident reporting system
- Comply with this policy and its reporting and management procedures
- Must inform their Senior Manager (or designated deputy) verbally, as soon as they become
aware, of a serious incident
- Must work with staff to take immediate action where possible to

	reduce likelihood of recurrence of any serious incident **All Staff** • Must comply with this policy and its reporting procedures and take all reasonable steps to minimise risks associated with incidents they report/witness. • Must inform their line manager or appropriate deputy, verbally as soon as they become aware of an SI • Take all reasonable steps to minimise risks following an incident and assist with any incident investigation • Retain all appropriate records, materials and equipment involved in an incident • Assist with any incident investigation such as providing written statements on request of an investigation manager. • To report risks, incidents and near misses in accordance with the policies and procedures of the CCG. • To participate with the investigation into an incident and any subsequent review.
4.2	**Consultation and Communication with Stakeholders** The following stakeholders have been consulted in relation to this policy: • HVCCG Exec Team • Human Resources • Local Counter Fraud Officer • Health & Safety Officer • Risk Manager • Head of Corporate Support • Business Intelligence & Information Governance • Head of Quality • Quality Systems Support Officer
5.	**CONTENT**
5.1	**Process for reporting Internal Incident** Incident reporting is a key element to promoting a safe culture and is a cornerstone of the wider risk management process within the CCG. An incident is any event that occurs or has the potential to occur which causes harm, injury, loss or damage to a patient, member of staff, or the CCG as an organisation. In general all employees must report: • Something that has happened that is contrary to the CCG's accepted standards of practice; • An accident in which an employee, contractor or member of the public

	has been, or could have been, injured; • An incident that places, or has placed employees, contractors, patients or visitors at unnecessary risk; • An incident that could put the CCG in an adverse legal or an adverse media interest position. • Data Loss All incidents must be reported by employees using the CCG's Datix web incident reporting system on the CCG intranet. Incident reporting must be undertaken in an accurate and consistent way, which will enable departments and management to action appropriately. When completing the Datix incident web form, it must be remembered that only factual statements must be made. Opinions must be omitted. Further guidance is available in Appendix A. All incidents reported to, or discovered by an employee, regardless of type or source should always be reported using the online Datix webreporting form or, if unavailable at the time of the incident, reported retrospectively using the following link which is also available on the HVCCG Intranet. https://hvccg-web01/datix/live/index.php?module=
5.2	**Types of incident include:-** **Health and Safety Incident**: An unplanned and uncontrolled event that has led to or could have caused injury, ill health, harm to persons, damage to equipment or loss. Examples of Health and Safety incidents and actions required are: • Accident: Where injuries have been sustained from an incident in the workplace (e.g. slip, trip, fall, etc.); • Environment: Where an incident occurs due to defects and failures in estates and facilities. **Occupational Health:** Any health compromise or illness directly work-related (e.g. Sharps injury, latex allergy, stress, disease, unsafe exposure to substances hazardous to health, infection control/inoculation, poisoning, physical injury, etc.). **Violence/Abuse/Discrimination:** Where any person is subject to the threat of, or to actual violence and/or verbal abuse or discrimination; the CCG is committed to the NHS Zero Tolerance Policy and encourages the reporting of these as a consequence.

	Fire Incident: Any incident involving a fire or any incident where the fire alarm sounds – including false alarms. Such incidents must also be reported to the CCG Fire Safety Officer, Senior Management and NHS Property Management Services as soon as possible after the incident has occurred. **Security or Data Security (i.e. Information Governance) Incident:** Any incident where a breach or a lapse of security or information governance is the dominating factor, e.g. theft or vandalism, premises window left open overnight, or data security incident, e.g. theft of a PC or potential/inadvertent or unauthorised disclosure of patient identifiable information. (Further guidance for information governance incidents can be found in Appendix 4) **Clinical/Patient Safety Incident:** Any unintended or unexpected incident that could have or did lead to harm (E.g. injury, suffering, disability or death – physical, psychological or social) for one or more persons receiving CCG commissioned/NHS-funded health care, (e.g. an occurrence, procedure or intervention, which has or could have given rise to actual injury, or to an unexpected or unwanted effect). **Events of negative/disruptive media Interest** If events cause media interest or have the potential to cause media interest
5.3	**Process for Managing Internal Incidents** When approving an incident, the following steps must be taken: • Approvers must decide what local action will follow the incident: 1. Green/Yellow graded incidents - no further action required, although a local investigation is required to take place and be included in the text of the initial incident report stating what immediate and or remedial actions have been taken. 2. Orange/Red – local investigation must take place, findings and action plans must be recorded on the incident system. Escalation may be needed if this is a particularly serious incident, meets SI criteria, or requires reporting to external agencies (see relevant section of this policy). 3. Action Plans must be updated until complete for all Orange and Red graded incidents, using the actions section of the incident reporting system. • If an investigation falls outside the local approver's managerial responsibility then communication with the Nursing & Quality Team or Corporate Support Team must take place to request an investigation by another area. This must be undertaken by using the communication/ feedback section of the incident reporting system. • The approver must ensure that all parts of the incident report form

	have been completed **legibly** and review the risk grading criteria before the form is approved. Incidents must be graded according to the grading criteria outlined in Appendix 3. If an incident report form is duplicated, local approvers should reject additional copies and note the reason for rejection in the appropriate box. If an incident report is produced inappropriately, they must be rejected and the employee informed of the correct procedures to follow. Please note that if an incident is 'rejected' on the Datix system a record of it will still be maintained. Where an incident has occurred and action has been taken to address the immediate issues; should further actions be required to prevent future recurrence, further action must be taken and recorded in the investigation section of the Datix incident reporting form regardless of the incident grading. Where there is difficulty or doubt about preventative action, this must be discussed with a member of the senior management team or the Corporate Support Team. Further guidance can be found in Appendix 2.
5.4	**Process for investigating internal incidents** As already specified at 5.3 of this policy, all incidents graded orange or red must receive a formal investigation, which must be recorded in the Datix system. When investigating an incident, one or more of the following must be included and documented: • Identify system failures/causes that led to the incident. • Identify corrective action required to prevent further recurrence or harm. • Where appropriate, obtain written statements from any persons involved in the incident or those who witnessed the incident (notes from interviews conducted and written statements must be uploaded into the documents section of the incident reporting system). • Action plans must be added into the 'Action' section of the incident reporting system, with details of the responsible person to implement the action and due dates. This must then be updated and monitored by the approver. • Retain all records and documents relevant to the incident. • Keep the staff informed at all times during the investigation and implementation of action plans. (**Please note that at any point in the investigation process the Investigating Manager may seek advice from Human Resources depending on the type of incident; this should be fully documented)**

	On completion of an investigation, the investigating manager should: Provide verbal feedback to personnel involved in the incident. • Ensure original documentation gathered during the investigation has been uploaded into the 'Documents' section of the incident report form. • Ensure the Datix system is updated with investigation findings and action plans. • Ensure actions are implemented and monitored within agreed timescales. • Consider wider sharing of the investigation outcome to ensure lessons are learned at team meetings, relevant committee/group or for inclusion in CCG reports. Further guidance can be found in Appendix 2.
5.5	**Learning Lessons** It is the responsibility of the individual directors and senior leads to ensure that lessons learnt from incidents in their areas of responsibility areas are identified and shared widely as appropriate, both within the CCG and its member practices. To support this; quarterly reports of the incidents that have occurred will be prepared by the appropriate body on behalf of the CCG and considered by the Executive Team for action as appropriate. Quarterly reports will also be prepared by the appropriate body on behalf of the CCG and considered by the appropriate committee to further support learning from incidents. • It is the role of the appropriate committee to ensure that recommendations for improvements are implemented to reduce risks. • It is important that lessons are learned and communicated to all staff across the CCG in line with the communications framework and . Communications Strategy and the Department of Health Report "Organisation with a Memory".
6.	**Serious Incidents**
6.1	**Serious Incidents (SI)** A degree of judgement is required when deciding to treat an incident as a SI and implement the SI procedure. A first indicator is when an incident has been graded as Red on the Datix system. Other indicators would be: • Any incident that is reportable to NHS England – as per their Serious Incident Framework (March 2015) http://www.england.nhs.uk/?s=serious+incident+guidance • A death or life threatening event involving an employee, visitor,

	contractor or other persons on CCG premises or conducting CCG work • Any incident which exposes the CCG, its employees or assets to potential or actual litigation • Any incidents significantly damaging to the reputation of the CGG, its employees or assets • Any major information governance incident or counter fraud incident (any major breach of corporate policies). In devising the SI procedure, the CCG has noted that depending on the nature of the SI, it may consider the need for a Serious Incident Team (possibly independent of the organisation) to investigate. Some Sis are multi-organisational, therefore it may be necessary to undertake joint SI Investigations or to ensure that other organisations are aware and updated on the CCG's investigation and that its findings and safety lessons are shared.
6.2	**Central Reporting of a Serious Incident** Where a Serious Incident has occurred and been submitted on Datix, employees must not assume that the incident report has been reviewed by the Nursing & Quality Team or senior management and must make a verbal report of the incident. If there is any doubt, a telephone call must be made for advice and support. Where an incident occurs out of hours, then the senior manager on call must be contacted who will provide assistance in determining the next action(s) and reporting the event to the Nursing & Quality Team when normal hours resume.
6.3	**Serious Incident Reporting and Investigation Procedure** The immediate priority in the case of SIs is to take steps necessary to secure the safety of CCG employees and other persons that may be involved in the incident. Subsequently, SIs should be reported and actioned as follows: 1. The Risk Manager or Head of Corporate Support (Monday to Friday during office hours) will inform the CCG Executive Leads or Accountable Officer immediately of any event and jointly take any remedial action necessary. The on-call Senior Manager (out of hours) will take any immediate remedial action necessary and inform the Risk Manager or Head of Corporate Support when normal office hours resume. 2. Comments or responses to the press or other media enquiries must only occur following discussion with the Executive Team (including Communications) and only after any patients, relatives or employees have been informed. 3. NHS England will be advised of the nature of the SI and that an investigation has commenced as soon as the SI is known and no later than within 72 hours of knowledge of the SI. The final report will be submitted

following completion of the investigation and no later than 60 working days following notification, unless unavoidable delays occur which must be discussed with NHS England. All reporting will be completed by reporting on the STEIS Serious Incident Reporting System and by telephone in accordance with the NHS England Serious Incident Reporting Protocol.

4. A SIT will be convened comprising of:

- A CCG Senior Manager
- Risk Manager or Head of Corporate Support
- Lead Manager (of affected area/department)
- Specialists as required (such as communications, information governance, counter fraud etc.)
- The membership of the team should also include representation from the areas affected, according to the nature of the incident.

5. The principle functions of the SIT are:

- Investigation of the SI to identify, as rapidly as possible, the facts and consequences, using Root Cause Analysis (RCA) methodology. A timeline will be produced based on the SI and if necessary written statements gained.
- Co-ordinate information, communication and press coverage as well as establishing efficient means of dealing with enquiries from press, media, relatives and members of the public.
- Organise appropriate counselling and support for employees affected by the SI.
- Production of an action plan designed to correct or limit the consequences, minimise the chance of recurrence in the future and allow lessons to be learned.
- Production of a preliminary and final written report in a timely fashion under the guidelines set out in this document.

6. An investigating officer (Lead Investigator) must be appointed to manage the investigation, gather the facts of the SI, co-ordinate all statements and documentation, keep contemporaneous notes of the investigation meetings and ensure that the timescales set out in this policy are adhered to.

(**Please note that at any point in the investigation process the responsible Director may seek advice from Human Resources on behalf of the Serious Incident Team (SIT), depending on the type of incident; this should be fully documented)**

7. Consideration will be given as to whether it is appropriate to report the SI to the relevant professional or statutory body (e.g. Nursing and Midwifery Council, General Medical Council, General Dental Council, Health and Safety Executive, Medicine and Healthcare Related Products Agency or National Patient Safety Agency) including the outcome of the SIT investigation.

6.4	**Process for Managing External (Provider) Serious Incidents** The principal accountability of all providers is to patients and their carers/families. This means that the first consideration following an SI must be the patient's welfare. They must be cared for, their health and welfare secured, and they must be fully involved in the response to the SI. Where a patient has died or suffered serious harm, their family must be similarly cared for and involved. Additionally, organisational accountabilities will underpin the response to SIs. Providers are accountable via contracts to their commissioners. The key organisational accountability for SI management is therefore from the provider in question to the commissioner. All service providers commissioned by the CCG, either as a co-ordinating commissioner or associate, have a requirement to report, investigate and monitor incidents (including SIs) as specified within contracts and legislation and this is detailed within *Serious Incidents Requiring Investigation June 2015.*
6.5	**Reporting to External Agencies** The CCG is responsible for ensuring incidents are reported in a timely manner to external agencies as detailed below and that safety lessons are shared. **Police** Incidents must be reported to the Police promptly when there is • Evidence or suspicion of criminal activity; • Evidence or suspicion that the actions leading to the incident were intended (such as fraud). The CCG Accountable Officer or Executive Director should always be consulted before the police are called where practicable. **NHS England** CCG SIs will be reported to NHS England by the Nursing & Quality Team via the electronic STEIS system. Investigation reports will be shared with NHS England on completion of the investigation and within their timescales of 60 working days (unless otherwise stated by NHS England). If this is not possible, NHS England should be notified as soon as possible including reasons for any delay. **Health and Safety Executive** Many incidents will be reportable to the HSE under the "Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)".

	The following are examples of reportable incidents under RIDDOR: • Incidents which result in an employee or a self-employed person (working for the CCG) dying, suffering a major injury, or being absent from work or unable to perform their normal duties for more than seven days. • Incidents which result in any person suffering an injury and being taken to hospital. • An employee or self-employed person suffering from a work related disease, such as asbestos exposure. The Corporate Support Team, on receipt or further investigation of an incident report, will undertake reporting to the HSE. **Medicines and Healthcare products Regulatory Agency** (MHRA) – If the CCG receives any information from members or providers involving a medical device or medication which gives rise to, or has the potential to produce unexpected or unwanted effects involving the safety of patients, users or other persons, such incidents will be reported, by the CCG and providers to the Medicines and Healthcare Products Regulatory Agency (MHRA) when they did or could have led to: • Death, life threatening illness or injury • Deterioration in health • The necessity for medical or surgical intervention • Unreliable tests results leading to inappropriate diagnosis or treatment.
7.	**MONITORING COMPLIANCE**
	The Accountable officer will oversee, on behalf of the governing body, a method for monitoring the dissemination and implementation of this policy. • A quarterly summary incident reports will be produced by the appropriate body on behalf of the CCG. This will be done using data from the Datix electronic system. Any inaccuracies in data input and/or incident grading will be drawn to the attention of the appropriate Committee for action. • Incident reporting trends will be monitored and analysed on behalf of the CCG by the appropriate body, support subsequent investigations and root cause analysis as requested by the CCG. • Copies of all completed root cause analysis reports and follow up activity will be monitored on behalf of the CCG by the appropriate body.
8.	**DISSEMINATION AND TRAINING**

	Once ratified, this policy will supersede all previous incident reporting policies and procedures. In order that this policy is disseminated and implemented correctly the following will occur after ratification: • The policy will be published on the CCG website and relevant links sent out via the communications and engagement department. • The CCG Induction training will incorporate this policy and attendees will be made aware of this procedure. • A dedicated training session will be provided for all staff who are identified as 'Local Approvers' May 2015 • Senior managers will make their staff aware of this policy at team meetings and when incidents arise. • Advice can be sought from the Corporate Support and Nursing & Quality Teams.
9.	**REFERENCES**
	• Health and Safety at Work Act 1974 • Management of Health and Safety at Work Regulations 1999 • Organisation with a Memory
10.	**ASSOCIATED DOCUMENTATION**
	This policy should be read in conjunction with other CCG policies, with particular reference to: • Serious Incidents Management National Framework April 2015 • Serious Incidents Requiring Investigation June 2015 • Health and Safety Policy • Lone Worker Policy • Information Security Policy • Risk Management Strategy and Procedure • Information Governance Policies/Procedures • HVCCG Anti-Fraud & Bribery Policy • Whistleblowing Policy

Appendix 1 – Guidance for Employees and Contractors

Any member of CCG staff can report an incident. Please remember to report an incident as soon as possible after the event. Access the DATIX incident form via the CCG Intranet page. A new Datix form will appear. Note: Mandatory fields are denoted by * and must be completed.

The Incident Form should be completed in line with the guidance below:

Incident Type:
Please select the relevant 'Type' of incident. When reporting an incident defined by the terms of this policy always select '**HVCCG Incident'**, which will appear in the drop down selection list.

Incident Category and Sub-category
Using the pull down menus select the most appropriate category and sub category to describe the incident (if you are unable to find the appropriate code please select the next most appropriate or contact the Corporate Services or Information Governance Team for guidance).

Incident Date:
On clicking the calendar button, a calendar will appear in the top left-hand corner of the screen. Click on the appropriate date to select.

Details of Incident (Description):
Description of Incident – Individual names and initials must not be entered in these free text boxes. The words 'patient' or the staff members 'job title' should be used instead of names to identify individuals. The description of the incident should be as detailed as possible, but based on facts only, personal opinion must be avoided at all times.

Action Taken
Patient and staff identifiers must not be used. Details of actions taken following the incident must be reported based on fact, personal opinions must be avoided. This is a mandatory field and must be completed.

Team and Location Exact
The appropriate team, locality or directorate should be selected in this section of the form plus the exact location of the incident (this may be the building and exact location for CCG incidents, such as Kitchen, Car Park, off site).

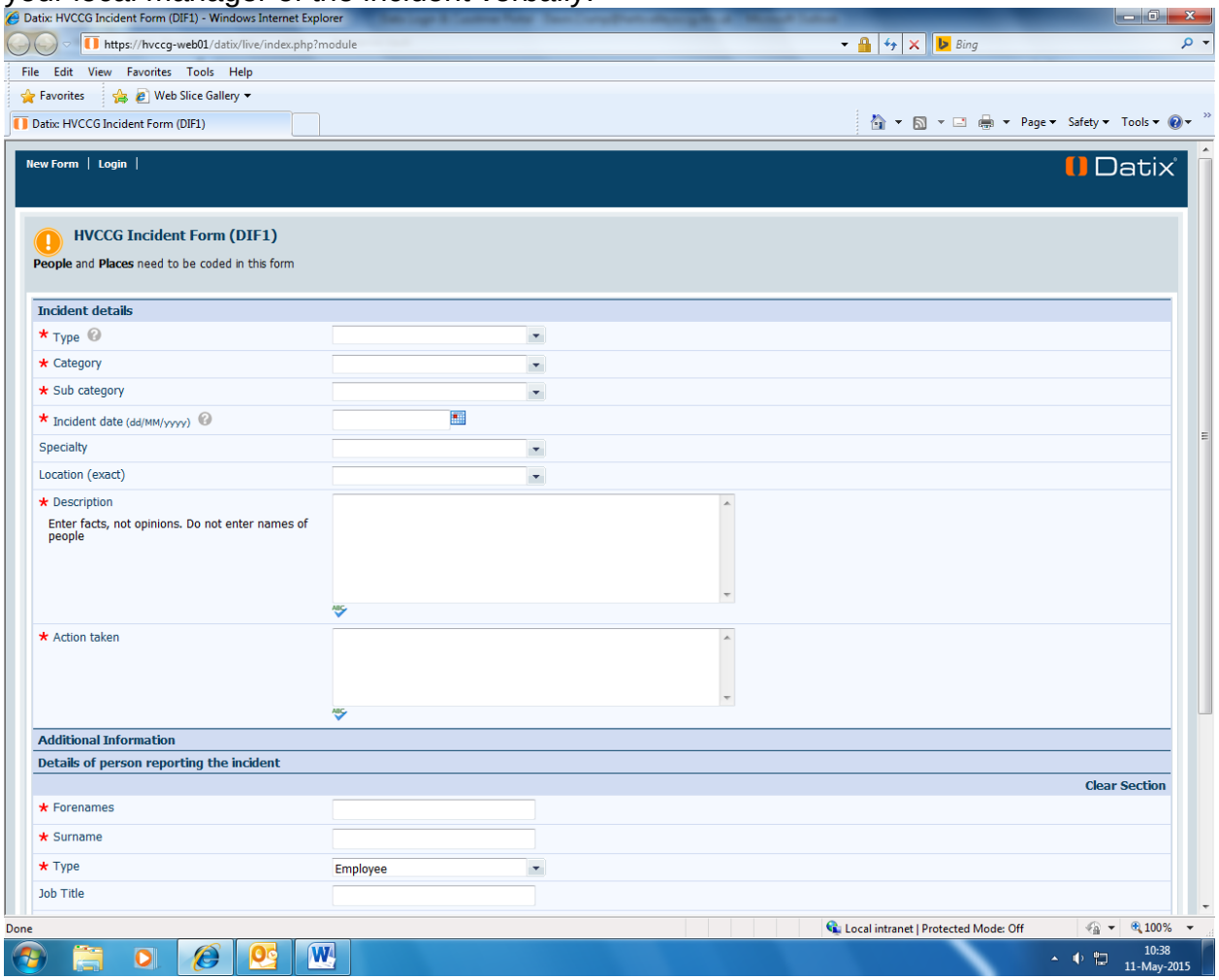
Incident Result and Severity:
Indicate in the Result box whether the incident resulted in harm, no harm or was a near miss. Indicate in the Severity box the degree of harm that was caused.

Documents:
You can upload any documents that were of relevance to the incident in this section. This is particularly helpful for investigating incidents and may include statements made by those affected.

Details of the person reporting the incident:
This section is to record your details in case we need to follow up on the information provided or during an investigation. You should provide your work contact details, including your NHS email address, which is used to acknowledge the incident form has been sent appropriately.

Responsible Manager:
Choose your manager's name from the drop down box. (if you are unable to find your manager, please select the next most appropriate senior person or contact the Nursing & Quality Team or Corporate Services Team for guidance)

Completion of Incident Report:
When the form is complete, click 'submit incident' at the bottom of the page. The form will not submit if any mandatory information is missing and a prompt will appear. An incident number will be generated which can be noted for future reference and used for requesting feedback. Additionally, the reporter has the option to print a copy of the information submitted. The appropriate incident approvers will automatically be notified of the incident. You must still inform your local manager of the incident verbally.



Appendix 2 – Guidance for Approvers and Investigators
Nominated managers review and approve incidents. All 'approvers' must have undertaken one to one training in the reviewing of incidents. This can be accessed by contacting the Nursing & Quality Team. Access to the system is only provided once training is complete.

On submission of an incident, an e-mail is automatically generated and sent to the nominated 'approver'. The incident must be reviewed in a timely manner. A five-day time frame has been set from the date the incident was reported through to final approval. This time-scale will be performance managed via the compliance report that is presented to the CCG's Governance Committee.

Approving and checking incidents:
The local approver must check that the following information is present, factual and accurate:

- What happened
- When it happened
- Where it happened
- Who/ what was involved
- What the outcome was and what immediate action was taken
- Ensure that staff/ patient names do not appear on the "description of incident" and the "immediate action taken", if they do, the names should be deleted and replaced with generic terms
- Ensure that the description and action taken fields are factual accounts, and not those of opinion.
- Check category and sub category are correctly coded
- Assign a grading and identify appropriate level of investigation. ***Note***: all orange and red incidents must be investigated formally within 30 days
- Look out for any patterns, trends or key issues
- Finally approve the incident and add a 'closed date'.

The approver has the facility to add/amend information as necessary to any of the fields. Any changes made will appear on the audit trail.

- The feedback facility can be used to email reporting staff with feedback on the outcome of the incident or if further information is required. The CCG advises approvers to try and respond to all incident reporters and create a culture of 100% feedback from incident reporting.

If the incident requires investigation:
Approvers are responsible for identifying incidents in need of investigation. These will be monitored and performance managed by the Nursing & Quality Team.
1. Green/Yellow incidents = no further action, but should be monitored locally for trends
2. Orange incidents = must be Investigated at a local level
3. Red Incidents = Does this require an internal Serious Incident investigation/procedure?

Where the investigation is outside your normal management responsibilities, you should use the communication and feedback section to inform the relevant investigator that another area needs to be informed.

Add lessons learned and further actions taken to the Investigation Section (which can be found on the left hand side of an incident form). Complete the investigator box dates and costs where applicable as well as the “Lessons Learned” and “Actions taken” fields with as much detail as possible.
Complete the action plan with who is responsible for each action and the timeframes given for the action to be completed. These should include actions undertaken to prevent or reduce the likelihood of recurrence.

You must also ensure that if further documentation has been produced as part of the investigation process, you retrieve the incident form and attach all of the documents e.g. RCA, C Diff, by clicking the document section and add a document.

APPENDIX 3 – Risk Grading

It is necessary to rate risk systematically using standard methodology, so that they can be placed into one of the three categories above. This allows prioritisation of remedial action. All incidents should be rated in 2 ways:

Assessment of Consequence

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

Assessment of Likelihood of Reoccurrence

The tool described here provides a simple way of rating the potential risk associated with hazards. It requires an assessment of rating the potential consequences and the likelihood of recurrence of harm from the hazard. (A hazard is anything that has the potential to lead to or cause actual harm, the risk is how likely the hazard will cause harm).

	LIKELIHOOD				
IMPACT	**Rare 1**	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost Certain 5**
Catastrophic 5	**5**	**10**	**15**	**20**	**25**
Major 4	**4**	**8**	**12**	**16**	**20**
Moderate 3	**3**	**6**	**9**	**12**	**15**
Minor 2	**2**	**4**	**6**	**8**	**10**
Negligible 1	**1**	**2**	**3**	**4**	**5**

Risk Assessment Levels

Colour	Overall level of risk	Score
Red	High	15 – 25
Amber	Significant	8 – 12
Yellow	Moderate	4 – 6
Green	Low	1 – 3

Appendix 4 – Information Governance Incident Procedure

An Information Governance or Information Security related incident relates to breaches of security and/or the confidentiality of personal information which could be anything from users of computer systems sharing passwords, to a piece of paper identifying a patient being found in the high street.

It could also be any event that has resulted or could result in:

- The integrity of an information system or data being put at risk;
- The availability of an information system or information being put at risk;
- An adverse impact, for example, embarrassment to the NHS, threat to personal safety or privacy, legal obligation or penalty, financial loss and/or disruption of activities.

Some more common areas of incidents are listed below but this list is not exhaustive and should be used as guidance only. If there is any doubt as to what you have found being an incident it is best to report it to the relevant person for this decision.

Breach of security

- Loss of computer equipment due to crime or an individual's carelessness;
- Loss of computer media, for example, CDs, memory sticks/USB sticks due to crime or an individual's carelessness;
- Accessing any part of a database using someone else's authorisation either fraudulently or by accident.

Breach of confidentiality

- Finding a computer printout with personal identifiable data on it in a public area;
- Finding any paper records about a patient/member of staff or business of the organisation in any location outside secured CCG premises;
- Being able to view patient records in an employee's car;
- Discussing patient and/or staff personal information with someone else in an open area where the conversation can be overheard;
- A fax being received by the incorrect recipient.

Information Governance Related Serious Incidents (SI)

There is no simple definition of an Information Governance incident. What may at first appear to be of minor importance may, on further investigation, be found to be serious or vice versa. Please see the link below "Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation" document for further details and examples.

IG Knowledge Base (Control + Click)

As a guide, any incident involving the actual or potential loss of personal information that could lead to identity fraud or have another significant impact on individuals should be considered as serious. This definition applies irrespective of the media involved and includes loss of both electronic media and paper records.

Categorising of the incident assists to distinguish the severity level of the Information Governance related incident and whether it is a SI or not. This is explained in later sections of this procedure.

Process for Reporting Information Governance Incidents
Staff must follow the above policy in order to report any incident. All Information Security/Information Governance incidents must be reported using this procedure only and no other method.

On receipt of the Herts Valleys Information Governance Officer being notified of incidents relating to Information Governance, the severity score is calculated according to the checklist contained within the "Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation (SIRI's)" (Health and Social Care Information Centre, June 2013, Version 2).

The HVCCG IG Team based at the CCG where the incident has occurred must be notified of all Information Governance/Information Security incidents. The immediate response to the incident and the escalation process for reporting and investigating of incidents will vary according to the severity level of the incident.

IG Toolkit Incident Reporting Tool
Where it is suspected that an IG SIRI (Serious Incident Requiring Investigation) has taken place by the Information Governance Lead, this will be logged on the IG Toolkit Incident Reporting Tool. This was mandated from 1st June 2013. The IG Incident Reporting Tool which can be found on the IG Toolkit website will play a key role in providing visibility/knowledge and encouraging collaborative partnership working amongst key stakeholders to find solutions for addressing issues. Key staff will also be formally notified (Accountable Officer, Senior Information Risk Owner, Caldicott Guardian and/other Directors) as an 'early warning' to ensure that they are in a position to respond to enquiries from third parties and to avoid 'surprises'.

Guidance on how to use the IG Incident Reporting Tool can be found by clicking the icon below:

IG Incident Reporting (Control + Click)

STEIS will also be used where an information governance incident is also an SI and the initial report should be made as soon as possible. STEIS should be regularly updated as appropriate.

Assessing severity of Information Governance Incident
The IG SIRI's category is determined by the context, scale and sensitivity of the incident. Every incident is categorised at the following levels:

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

A further category of IG SIRI is also possible and is to be used in incident closure where it is determined that it was a near miss or the incident is found to have been mistakenly reported:

0. Near miss/non-event.

If an incident is found to have either to have not occurred or the severity of the category has been reduced due to factors that were not planned for the incident will be recorded as a “near miss”. This will allow for the CCG to undertake a lessons learned exercise.

The process used to categorise an IG SIRI can also be found in the checklist guidance referenced earlier in this document.

Management and investigation of IG reported incidents

Incidents scored 0 - 1

For incidents that are scored 0 -1, senior members of staff in that area/department are responsible for the investigation of that incident and assessing the situation. The IG Team located in the CCG will be there to provide support and guidance and provide any additional information or training that may be required. It is integral that any action taken is to minimise the potential adverse effects of the incident and help to minimise the risk of the incident occurring in the future as this could result in a SIRI.

Incidents scored 2+

For incidents that are scored 2 and above the following action should be undertaken in conjunction with the IG Team within the CCG:

- Appoint an investigating Officer;
- Engage appropriate specialist help (IG, IT, Security, Records Management, HR);
- Where across the organisational boundaries coordinate investigations and incident management;
- Carry out a RCA;
- Ensure that all relevant rules in regards to interviews, evidence and preservation of evidence are followed;
- Document investigation and findings;
- Ensure that content is reviewed;
- Identify lessons learned.

For all incidents, it is important that the information that is held within the IG Incident Reporting Tool is relevant and up to date, therefore the CCG should be kept up to date of all developments. Please note that all information under a closed IG SIRI will be published quarterly by the Health and Social Care Information Centre, therefore it is essential that all the information recorded is appropriate and does not include information that would not normally be released under the Freedom of Information Act 2000.

APPENDIX 5 - INCIDENT TYPE

Incident Types	Examples
Health and Safety Incident:	An unplanned and uncontrolled event that has led to or could have caused injury, ill health, harm to persons, damage to equipment or loss. Examples of Health and Safety incidents and actions required are: • Accident: Where injuries have been sustained from an incident in the workplace (e.g. slip, trip, fall, etc.); • Buildings Incident: Where an incident occurs due to defects and failures in estates and facilities.
Occupational Health	Any health compromise or illness directly work-related (e.g. Sharps injury, latex allergy, stress, disease, unsafe exposure to substances hazardous to health, infection control/inoculation, poisoning, physical injury, etc.).
Violence/Abuse/Discrimination	Where any person is subject to the threat of, or to actual violence and/or verbal abuse or discrimination; the CCG is committed to the NHS Zero Tolerance Policy and encourages the reporting of these as a consequence.
Fire Incident	Any incident involving a fire or any incident where the fire alarm sounds –including false alarms. Such incidents must also be reported to the CCG Fire Safety Officer, Senior Management and NHS Property Management Services as soon as possible after the incident has occurred.
Security or Data Security (i.e. Information Governance) Incident	Any incident where a breach or a lapse of security or information governance is the dominating factor, e.g. theft or vandalism, premises window left open overnight, or data security incident, e.g. theft of a PC or potential/inadvertent or unauthorised disclosure of patient identifiable information. (Further guidance for information governance

	incidents can be found in Appendix 4)
Clinical/Patient Safety Incident	Any unintended or unexpected incident that could have or did lead to harm (E.g. injury, suffering, disability or death – physical, psychological or social) for one or more persons receiving CCG commissioned/NHS-funded health care, (e.g. an occurrence, procedure or intervention, which has or could have given rise to actual injury, or to an unexpected or unwanted effect).
Events of negative/disruptive media Interest	If events cause adverse or disruptive media interest or have the potential to cause media interest

CG Equality & Quality Inclusion Analysis Form

Step 1:

Name of 'Policy or function' – this may relate to:	
• Incident Reporting and Management Policy	• Purpose The purpose of this policy is to ensure that all members, staff and/or employees working for or on behalf of the CCG are aware of their duties when reporting, investigating or managing incidents. • Aims and Objectives . Ensure that all staff respond and learn from incidents. 2. Ensure that all incidents are reported in a timely manner. 3. Ensure that all staff contributes to the identification of risk, by reporting incidents and near misses, thus allowing preventative controls to be put in place. 4. Ensure that all SI's are investigated in a timely, efficient and effective way. 5. Ensure compliance with national reporting requirements. 6. Ensure the CCG has an open and honest approach to provider incidents affecting patients/relatives/carers, and a commitment to sharing lessons learned.

	7. Ensure lessons learned from incidents and trends are shared across the organisation and fully acted upon by commissioned providers. 8. Enhance learning and development through the application of good performance management principles.

Step 2:

Test for relevance:

- **Will this help to deliver one or more of the aims of the Equality Act 2010? No**
- **Will this have a potential impact on the nine characteristic groups and/or others as described in the guidance? Yes**

Does the above 'Policy' have any relevance to equality? **Yes** - It does if discrimination is reported as an incident and will be dealt with in line with our HVCCG equality objectives, policies and practives.

Policy provides the same guidance to all staff who may need to report an incident and will not have any particular impact on the nine characteristic groups.

If you have selected yes, please complete section 3-8 below.

Step 3:

Engagement, involvement and consultation undertaken N/A		PSED Due regard to:	1. Eliminating unlawful discrimination, harassment and victimisation			2. Advancing equality of opportunity between people			3. Fostering good relation between people			Please provide details of evidence considered, service, workforce, research (national or local), demographic etc. **N/A**
Internal	☐											
External	☐											
Provide details		**Equality Characteristic Groups**	**-ve**	**N**	**+ve**	**-ve**	**N**	**+ve**	**-ve**	**N**	**+ve**	
		Age										
		Disability										
		Gender										
		Gender Reassignment										

	Marriage & Civil Partnerships										
	Pregnancy & Maternity										
	Race or Ethnicity										
	Religion or Belief										
	Sexual Orientation										
	Other groups (please list)										

Key: +ve = positive impact, -ve = negative impact, N = no impact

Step 4

Engagement, involvement and consultation undertaken		Quality				Please provide details of evidence considered, service, workforce, research (national or local), demographic etc.
Internal	☐					
External	☐	**Patient/Programmes**	**-ve**	**N**	**+ve**	
		Patient Experience – will it: Impact on the experience of patients and service users? Impact on patient choice?				**Potentially yes**
		Patient Safety – will it: Impact on safety? Impact on preventable harm? Impact on the risk of healthcare acquired infection? Impact on clinical workforce capability, care and skills?				**Potentially yes**
		Clinical effectiveness – will it: Meet evidence based practice/NICE				**Potentially yes**

		guidance? Impact on clinical leadership? Include systems for monitoring clinical quality supported by good information?				

Step 5:

Have you identified any gaps or potential negative impact from the above? If yes, please state: No			
Do you plan any further engagements? **Yes ☐ No ☐✓**		**Do you require further information or data to complete the analysis/actions?** **Yes ☐ No ☐✓**	
Any actions to be undertaken (including mitigation) regarding the negative impact:			
Action	**Outcome**	**Lead**	**Date for completion**
Monitor equality data of incidents reported where appropriate			
Any changes made as a result of this assessment?		YES ☐	NO ☐✓
Please provide brief description of changes			
Risk Manager will monitor/review incident reporting information in relation to 9 equality characteristic groups as appropriate, annually.			

Following information (internal use only)

Step 6: Key individuals

Analysis conducted by:	**Lead Name:**	Job Title:	Contact Details:
Dawn Crump	**Dawn Crump**	**Interim Risk Manager**	**01442 284044**

Other key contributors involved:			

Step 7:

Conclusion and/or recommendations:
This policy is about systems and process of collating, reporting and managerial response to incidents. Lessons learnt from such incidents amy on occasions highlight an equality diamension which will be responded to in line with our equality policy.

Step 8:

Date form completed: **17 April 2015**	**Clinical/Managerial approval:**	**Job Title/Directorate:**	**Date:**	**Signature:**
Does a Committee or Senior Leadership Team need to be informed about this IEQA? **Yes ☐ No ☐✓**		**Do you need to undertake monitoring/review** **Yes ☐ No ☐ If yes, date of Review: April 2016**		**Date of publication: May 2015**
Completed copy to be forwarded to Quality Team (name) Jan Norman				

Questions to consider when carrying out an EQIA

In completing the EQIA you may find our annual publication of equality information along with local health inequality data from our website and/or intranet useful, as well as Hertfordshire County Council and National charities and EHRC.

When completing this EQIA please consider the following in a proportionate and relevant way:

Equality monitoring

- In line with our legal obligations, you may wish to consider how you will monitor our service users and/or workforce data by the nine equality characteristic groups.

Access to services and information

- If an eligibility criteria is applicable, please ensure that this is not discriminative unless it can be justified.
- Please consider if our buildings are physically accessible to everyone or would some people such as those with a physical disability encounter barriers? If so, what mitigation steps have you undertaken?
- In some cases information about our policies, and/or publications may need to be available in Braille, large print, easy read or on a tape or in a different community language. Do images in our publications reflect the diverse population that we serve?

Respect, dignity and cultural awareness

- Please consider that our policies always treat service users, carers, members of the public and staff with respect and dignity and that, where appropriate, we take account of people's beliefs, languages and dietary needs.

Definitions of the relevant protected characteristic groups:

Age

Definition: Age refers to a particular age group.

If your service is open to people of all ages, how will you make sure it is used by people of all ages?

Disability

A person has a disability if they have:

a) A physical or mental impairment, and
b) The impairment has a substantial and long term adverse effect on the person's ability to carry out normal day to day activities

Race

Race includes:

a) Colour
b) Nationality
c) Ethnic or national origins

How will you make sure that people from a wide range of ethnic backgrounds use your service? (NB you may find it helpful to look at this section alongside the section on Religion and Belief as the actions are closely related).

Religion or Belief

a) Religion means any religion and a reference to religion including a reference to a lack of religion
b) Belief means any religious or philosophical beliefs and a reference to belief includes a reference to lack of belief

Sex

Definition: A reference to a person who has a particular protected characteristic is a reference to a man or to a woman.

Sexual orientation

Sexual orientation means a person's sexual orientation towards:

a) Persons of the same sex
b) Persons of the opposite sex, or
c) Persons of either sex

Gender reassignment

A person has a protected characteristic of gender reassignment if the person is proposing to undergo/is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex, by changing physiological or other attributes of sex.

Pregnancy and maternity

Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Marriage and civil partnership

A person has the protected characteristic of marriage and civil partnership if the person is married or is a civil partner.

Public Sector Duty regarding social/economic inequalities

An authority to which this section applies must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage.

Quality considerations

- Patient Safety:
  - provision of information, data quality improvement, clinical coding,
  - serious incidents, incidents, never events, complaints, PALs enquiries
  - medicines management
  - equipment management
  - safe environment
  - management of Healthcare Associated Infections (HCAI)

- Clinical effectiveness of care:
  - NHS Outcomes Framework: how will the business case impact on the delivery of the five domains?
    - Preventing people from dying prematurely
    - Enhancing quality of life
    - Helping people recover from episodes of ill health or following injury

- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm:
    - standards applied by relevant professional bodies i.e. mandatory training, qualifications, CPD, revalidation & accreditation, CRB
    - Compliance with regulatory bodies
    - Compliance with relevant guidance / appraisals from NICE
    - Application of national standards and outcome measures
    - Participation in relevant clinical networks, national and local clinical audit programmes
    - Service development and improvement

- Patient experience:
    - How is the service user engaged in planning and service design?
    - How are they listened too?
    - How do they get feedback on the service
    - How do we ensure equity of access equality and non-discrimination?