Incident Reporting Policy
(N-038)

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Author (name & job title)	Oliver Sims - Corporate Risk and Incident Manager
Executive Director (name & job title):	Sarah Smyth - Executive Director of Nursing, Allied Health and Social Care Professionals
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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. Policy Statement

Humber Teaching NHS Foundation Trust places the health, safety and welfare of its patients/service users, staff and visitors high amongst its priorities and is committed to maintaining safe and secure conditions throughout the organisation. It will work closely with partner organisations, where the health, safety and welfare have shared ownership, to ensure co-operation at all levels. To achieve this, the Trust has put in place a clinical and managerial infrastructure to support incident management, from reporting an incident to learning lessons as well as implementing solutions to prevent further harm. This work is led and coordinated through the Patient Safety Team, but responsibility and accountability for incident management sits operationally with the Trust's clinical divisions. The Trust will ensure that the necessary resources are made available to support this infrastructure.

The Trust is committed to embedding a patient safety culture throughout the organisation to facilitate effective reporting, investigation and communication of all incident activity both internal and external to the Trust.

For an effective safety culture to operate, employees must be supported to report incidents that have occurred. As such, the Trust operates its incident policy in an open and fair way, adopting a no-blame culture. Action will only be taken against those individuals who have acted with reckless intent, have not followed Trust Policy or Practice Guidance, or have acted outside of their professional responsibilities. The Trust promotes a 'just culture' by which there is shared accountability that emphasizes fairness, transparency, and learning, particularly when patient safety incidents occur. The Trust acknowledges that mistakes are often systemic and focuses on improving processes and systems to prevent future errors, rather than solely blaming individuals. This approach encourages staff to report incidents openly and learn from them, fostering a safer environment for both patients and staff.

Trust staff must report all incidents, both actual and 'near misses', so that real opportunities for improvement and risk reduction are taken. To enable this to occur, staff must make themselves fully aware of this policy and the arrangements in place for the prompt and accurate reporting of incidents and the appropriate management of incidents. Professional staff should also ensure they comply with their own professional guidelines (e.g. General Medical Council, Nursing & Midwifery Council, Health and Care Professional Council) regarding the reporting and investigation of incidents.

2. Scope

This policy applies to all permanent (clinical and non-clinical) staff, locum, agency, bank and voluntary staff and students working within the Trust.

Effective reporting of incidents is key element of good governance and is essential in the delivery of safe, effective, caring, well-led and responsive services. This policy sets out the process for reporting and management of clinical and non-clinical incidents, accidents and near miss events reported via the electronic incident management system (Datix). The process includes the reporting of incidents, accidents, and 'near miss' events related to patients/service users, staff, volunteers, contractors and visitors.

3. Definitions

Contributory factors	Contributory factors are those things that contributed to or had an influence on the incident occurring.
Datix	The Trust's electronic incident reporting and risk management software system.
Duty of Candour	A statutory, professional and contractual requirement to be open, honest and transparent both within the Trust and with the family when a notifiable patient safety incident has occurred.

Harm	A negative effect (Health Foundation, 2011)
Incident	Any event or circumstance that resulted, or could have resulted, in unnecessary harm, loss or damage – such as physical or psychological injury to a service user, staff member or visitor, environmental or reputational damage to the Trust.
Initial Incident Review	A detailed incident report completed within 72 hours which assesses the incident in more detail identifies and provides assurance that any necessary immediate action to ensure the safety of those affected is in place.
Patient Safety Incident	A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.
Non-patient Safety Incident	A non-patient safety incident is any unintended or unexpected incident which could have or did lead to harm to a member of staff/contractor/visitor.
Near Miss	A near miss is defined as an unplanned event that did not result in injury, illness or harm but had the potential to do so. Only a fortunate break in the chain of events prevented an incident from occurring for example an injury or fatality. it is important that near misses are reported and appropriately investigated as the learning may prevent actual harm occurring to future patients, their families or staff.
Never Event	A nationally recognised category of incidents that could cause harm to people that should never happen and can be prevented.
RIDDOR	RIDDOR Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
Mental Health Homicide	Homicide committed by a patient in receipt of mental health services or recently discharged from services. The Trust's Standard Operating Procedure provides guidance to staff regarding the steps that need to be taken following the notification of an alleged homicide and can be found here: Standard Operating Procedure - Following Notification of a Mental Health Homicide SOP 22-015
PSII	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.
PSIA using Swarm Huddle methodology	Patient Safety Incident analysis is a review of care incorporating a meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely. It is a safe space, invitees only (those involved in incident, agreed by the Division/Patient Safety

	team). A report is produced to be shared with the patient / family / carer if requested.
AAR	After Action Review (AAR) is a method of evaluation that is used when the outcomes of an activity or event, have been particularly successful or unsuccessful.
MDT	A Multidisciplinary (MDT) approach supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/ or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability

4. Duties and Responsibilities

Chief Executive
The chief executive retains ultimate accountability for the health, safety and welfare of all service users, carers, staff and visitors; however, key tasks and responsibilities will be delegated to individuals in accordance with this policy. The chief executive will assure the Trust Board that this policy is acted on through delegation to the appropriate business units and committees.

Director of Nursing, Allied Health and Social Care Professionals
The director of nursing will ensure that this policy is acted on through delegation of responsibility for the development and implementation of the policy to the appropriate directors and committees. The director of nursing will ensure the policy; procedure and guidelines comply with UK law requirements. The director of nursing will also ensure the policy and procedures are monitored and reviewed formally through the appropriate forum, e.g. Quality and Patient Safety Group.

Divisional Clinical Leads and Divisional General Managers
The divisional Clinical Leads and General Managers will ensure that this policy is acted on through a process of policy dissemination and implementation in collaboration with Trust senior managers. They will support their staff through making provision for appropriate training and also in making adequate resources available to fulfil the requirements of this policy. The Clinical Leads and General Managers will review and interpret aggregated data on incidents to inform the management of risk.

Senior Managers, Managers and Clinicians
Senior managers, managers and clinicians will ensure all staff within their area of responsibility are informed about the contents of this and other associated policies and procedures and will apply this policy and procedure in a fair and equitable manner. They are responsible for ensuring that robust arrangements are in place for all incident types including this which may attract public, or media interest categorised as notifiable incidents. They will support their staff through making provision for appropriate training and also in making adequate resources available to fulfil the requirements of this policy and will review and interpret aggregated data on incidents to inform the management of risk.

Employees
All employees will comply with this and any other associated policies and procedures.

Clinical Risk Management Group
The Clinical Risk Management Group (CRMG) will ensure that this policy is disseminated and applied across the Trust. The CRMG will identify and take the necessary action and reporting in respect of all PSIIs, PSIAs and mortality reviews in line with the Patient Safety Incident Response Framework (PSIRF) and the Trusts policies. The CRMG will review and interpret incident reports, investigation reports and aggregated data on incidents to inform risk.

5. Procedures Relating to the Policy

The Trust's procedures on reporting adverse incidents are detailed in the following sections:

5.1 Reporting an incident

Any incident or near miss on Trust premises, or involving Trust staff must be reported within 24 hours using the online incident reporting system (Datix) available through the Trust Intranet or via the link below:

Report an Incident | Humber Teaching NHS Foundation Trust

The staff member who first becomes aware of an incident should:

- Ensure immediate actions are taken to prevent further harm.
- Report the event/incident to their line manager (or senior member of staff on duty).
- Consider whether any equipment, devices, medications or notes involved need to be secured (if in doubt please seek advice from your line manager).
- Report the incident electronically via the intranet or electronic shortcut on the Datix incident reporting system, within 24 hours following the incident.
- Provide a clear and factual description of the circumstances of the incident.
- Avoid recording opinion; the incident description should be factual.
- Avoid using abbreviations unless they are explained in the first instance.
- Ensure that the specialist services commissioner is notified within 24 hours using the 24-hour notification form and the email copied to HNF-TR.IncidentReporting@nhs.net. Details of reportable incidents can be found in Appendix 3.
- Ensure that CQC statutory reportable incidents are notified correctly. Details of CQC statutory reportable incidents can be found in Appendix 4.
- Inform the patient/service user and/or their relatives as soon as possible of the incident, advise of any treatment that may be necessary, and any subsequent investigation required.
- Ensure the clinical team looking after the patient/service user is informed.
- Ensure that any incident involving a patient/service user, and the action taken, is recorded in the patients' healthcare record.

An event may only be recognised as an incident sometime after it has occurred. In such cases the member of staff to whom such evidence comes to light must report the incident as described above within 24 hours of discovery.

The Datix Web system has been set-up using mandatory fields to collect all relevant information based on the type of incident reported to facilitate appropriate decision making regarding the level of investigation required.

The Datix Web system has been set-up to provide automatic email alerts to appropriate managers each time an incident is reported.

5.2 Incident Report Requirements

The following requirements must be addressed when reporting an incident:

- All persons involved in the incident must be clearly identified on the incident report (i.e. individual patient/service user/staff/student member(s) adversely affected, staff involved in the incident itself, and witnesses to the incident).
- The 'Person in Charge' at the time and place of the incident must notify their service/senior manager/senior professional lead of all actual or suspected PSIIs / PSIAs which are deemed to be serious enough to require immediate attention as per the Patient Safety Incident Response Policy.
- 'The Person in Charge' at the time and place of incident must contact the on-call manager if the incident occurs out of normal working hours.

- If a member of staff is concerned about the appropriateness of completion of an incident form, they should contact the Patient Safety Team for advice by email HNF-TR.IncidentReporting@nhs.net.

5.3 Patient Safety Incidents

A patient safety incident is defined as 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.' All patient safety incidents should be reported and managed in accordance with this policy.

Patient safety incidents will be reported through the Patient Safety Incident Form held on the Datix system which can be accessed through the Trust intranet or the following link:
Datix: Humber NHS Foundation Trust - Patient Safety Incident Form

5.4 Non-Patient Safety Incidents

A non-patient safety incident is defined as 'any unintended or unexpected incident which could have or did lead to harm to a member of staff/contractor/visitor.' All non-patient safety incidents should be reported and managed in accordance with this policy.

Non-patient safety incidents will be reported through the Non-Patient Safety Incident Form held on the Datix system which can be accessed through the Trust intranet or the following link:

Datix: Humber NHS Foundation Trust - Non-Patient Incident Form

5.5 RIDDOR Reportable Incidents

Health and safety incidents where members of staff have been injured can sometimes meet the requirements for reporting under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) requires employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences that may have resulted in death, major injury or dangerous occurrence.

Where such an incident has occurred, a non-patient safety incident form should be completed on Datix and the RIDDOR reportable field completed to enable further investigation. Major injuries and accidents resulting in an absence of more than seven days (including days not normally worked) or where the employee cannot fulfil their normal range of duties will be reportable using the link on the system to the RIDDOR forms that MUST be completed within 15 days to the Health and Safety Executive (HSE) by the manager of the area concerned.

Authors are required to download a copy of the RIDDOR form at the point of submission and once an email has been received forward this to the Trust's Safety Team.

Datix: Humber NHS Foundation Trust - Non-Patient Incident Form

5.6 Medicines Management/ Medical Device Incidents

All incidents related to medicines or medical devices must be reported via the Trust incident reporting system.

The term 'medical device' covers all products used in healthcare for diagnosis, prevention, monitoring or treatment of illness or disability. The specified form for reporting of medicines and medical device incidents can be found below or accessed through the Trust intranet.

Datix: Humber NHS Foundation Trust - Medicine Management / Medical Device Incident Form

5.7 Safeguarding Incidents

When it is suspected that an individual that is not your patient is at risk of or has suffered significant harm, a safeguarding referral should be made as per the Trust Safeguarding Children and Adult policies,

and it must be reported via the Trust incident reporting system. A copy of the safeguarding referral form must be added to the incident record on Datix and must be forwarded to the Trust Safeguarding Team.

Where an incident relates to an allegation against a member of staff this must be reported as a Patient Safety Incident (5.3) and appropriately marked as an allegation, this will then be sent to the Trust safeguarding team for review under the Managing Concerns Against People in Position of Trust policy (N-004).

The specified form for reporting of safeguarding incidents where a child that is not your identified patient is at risk of or has suffered significant harm can be found through the following link:
Datix: Humber NHS Foundation Trust - Safeguarding Children Incident Form

The specified form for reporting of safeguarding incidents through the following link and the incident must be marked as safeguarding related at the point of submission:
Datix: Humber NHS Foundation Trust - Patient Safety Incident Form

5.8 Death of a Patient

In line with the National Quality Board guidance on Learning from Deaths the Trust will identify, report, investigate and learn from a patient's death. When a notification of a patient death has been received it must be reported via the Trust incident reporting system. The specified form for reporting of patient death incidents can be found below or accessed through the Trust intranet:

Datix: Humber NHS Foundation Trust - Death of Patient Form

In cases where the patient who has died has a diagnosis of a learning disability or autism, the death with be reported through the LeDer portal for consideration for a LeDer review.

In cases where the patient is a child the death must be reported to the Safeguarding Team as per the Child Death SOP 24-037. A patient safety review may take place alongside this however the reporting to the safeguarding team ensures reporting to the Child Death Overview Panel is completed, and a multi-agency response and review initiated.

5.9 Local Safety Huddles

Safety Huddles are a patient safety tool that can be used to enhance the safety culture within a clinical area, through the promotion of teamwork, multi-disciplinary communication, enhancing psychological safety and promoting civility and respect.

Safety Huddles are a brief (≤ 10 minutes), focused exchange of information about potential or existing safety risks which may affect patients, staff and any person accessing the healthcare environment. They are multidisciplinary, occur at the beginning of every shift and follow a three-point agenda.

A safety huddle is a proactive approach to clinical risk management and the reduction of harm which provides dedicated time for the multidisciplinary team to communicate and share critical information to promote safety. They also support a shared understanding of the situation and key risks regarding patient safety. Safety Huddles support shared situational awareness by providing an opportunity for team members to share vital information about a patient or their environment, to discuss, integrate, and make meaning of the information; therefore, clinical risks are more likely to be mitigated.

There are various types of safety huddle which are detailed below:

Daily Inpatient Unit Safety Huddles – used to support initiatives such as the reduction in the number of falls and associated admissions to acute providers and allowing for staff feedback and reflection. Inpatient unit safety huddles are also used in times of business continuity so Senior Management teams are aware of staffing/ patient demand and are supported to make difficult decisions as part of a multidisciplinary team in a safe and supported way.

Primary Care Safety Huddles – used to ensure the staff within Primary Care are supported to ensure

effective communication in the provision of safe, high quality patient care and ensure staff safety, that staff are aware of their roles and responsibilities in the implementation of an effective safety huddle handover, staff are able to identify high risk and monitor trends especially around key areas of capacity /demand and patient safety. Primary care safety huddles are also used in times of business continuity so Senior Management teams are aware of staffing/ patient demand and are supported to make difficult decisions as part of a multidisciplinary team in a safe and supported way.

Community Services Safety Huddles – used ensure the staff within all community services teams and community inpatient units are aware of the importance of effective communication in the provision of safe, high quality patient care and ensure staff safety, that staff are aware of their roles and responsibilities in the implementation of an effective safety huddle handover, staff are able to identify high risk patients and monitor trends especially around the 4 key harms – pressure ulcers, CAUTIs, VTE and falls. Community Services safety huddles are also used in times of Business Continuity so Senior Management teams are aware of staffing/ patient demand.

5.10 Information Governance Breach Reportable Incidents

Incidents where an information governance breach may have occurred can sometimes meet the requirements for reporting under the General Data Protection Regulation (GDPR) as implemented by the UK Data Protection Act 2018. This places a duty on all organisations to report certain types of personal data breach within 72 hours to the relevant supervisory authority.

Where such an incident is thought to have occurred, a patient safety incident form (where patient data is concerned) or a non-patient safety incident form (where staff or visitors' data is concerned) should be completed and the information governance reportable field completed to enable further investigation. Please include as much detail as possible about the incident and type of data involved and any action that has been taken to remedy the IG Breach. Advice can be obtained from the Information Governance Department.

5.11 Incident Grading

All incidents reported will be graded in terms of the level of harm caused. Reporting of degree of harm is intended to record the actual degree of harm suffered by the patient, member of staff or member of the public or organisation (i.e. organisational reputational damage). Explanation of the incident grading categories used within the Trust can be found below:

Near miss	Any patient safety incident that had the potential to cause harm but was prevented and so no harm was caused.
No harm	Impact not prevented – any incident that ran to completion, but no harm occurred to people or the organisation.
Low	Any incident that caused minimal harm, to one or more persons/the organisation requiring extra observation/minor treatment/minor management actions to be undertaken.
Moderate	Any incident which caused significant but not permanent harm or short-term harm, to one or more persons or the organisation that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, transfer to another area or short-term management actions required.
Severe	Any incident that appears to have resulted in permanent harm or long-term harm one or more persons; significant management actions required in relation to minimising organisational reputation risk.
Death	Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Further guidance in relation to level of harm for reported patient safety incident can be found at the following link: Learn from Patient Safety Events (LFPSE) Level of Harm Guidance

If information is received subsequent to submitting an incident report which may affect the grading or description of events (e.g. injuries or damage subsequently detected, or deterioration in patient/client's condition) this must be recorded on Datix, either by the incident handler (manager) or reported to the system administrator, by contacting contact the Patient Safety Team by email HNF-TR.IncidentReporting@nhs.net who will amend the record accordingly.

5.12 Supporting Staff Involved in an Incident

Staff may suffer high levels of stress immediately after an incident. It is imperative, to maintain both staff wellbeing and service user safety and support staff throughout the process. Following an incident where a member of staff has been affected, the line manager should provide support and consider follow up action that may include:

- Formal/informal debriefing and support of staff individually or as a group
- Make staff aware of services provided by Occupational Health and the staff counselling service
- If the staff member is unable to attend work as a result of the incident, the absence should be managed in accordance with the Trust's Policy on Managing Attendance at Work.

5.13 Raising Concerns

There are times at which service users do not feel confident in the care and treatment they are receiving. At these times service users may report incidents or alleged incidents. Whilst the incident reporting process should be used in the first instance, service users, families and carers can also be advised to use the complaints reporting process by contacting the Trust's Complaints and Feedback Team on 01482 303930 or via email hnf-tr.complaints@nhs.net to raise concerns about care and treatment received.

If staff members have concerns, there may be occasions when they do not have the confidence to report issues directly through their line management structure. In these instances, staff should be aware that the Trust has a system in place to support individuals to be able to safely speak up. If staff do not feel that they can raise an issue with a member of the management team they can contact the Freedom to Speak up Guardian on 01482 389135 or via email HNF-TR.SpeakUp@nhs.net.

For further information please refer to the Trust Freedom to Speak Up (Raising Concerns) procedure which can be accessed at this link.

If the incident you want to report refers to sexual misconduct at work and you feel you cannot raise through line management or via Datix, staff can report these types of incidents via the '**Report it'** hnf-tr.reportithumber@nhs.net. Reports will be addressed as identified in the Sexual Misconduct Policy.

5.14 Duty of Candour

Every day people are treated safely within the Trust, however occasionally things can go wrong, and people are harmed within the organisation or people harm themselves, which can result in moderate, severe harm or death. It is important that when incidents occur that healthcare staff communicate openly with the patient and or relatives/carers.

The Trust seeks to promote a culture of openness, which is a pre-requisite for improving patient safety and the quality of healthcare systems. There should be a timely investigation into all moderate harm, or above incidents. The patient and where appropriate their family or carer must be verbally notified of the incident and investigation as soon as practically possible by a nominated Trust representative.

For further information, please refer to the Trust Duty of Candour Policy which can be accessed at this link.

5.15 Incident Review Daily Meeting / Corporate Safety Huddle

The incident review meeting is held daily (Monday-Friday). The meeting is attended by the senior representatives from the patient safety team and Trust clinical divisions, as well as representatives from safeguarding team as well as a range of other professionals.

The role of the IR meeting is to:

- Review all patient safety incidents submitted over the preceding 24 hours (72 hours following weekends). The incident severity level and category are reviewed and where required amended in line with Learning from Patient Safety Events (LFPSE) guidance.
- Identify any incidents which have resulted in significant harm to a patient/service user or third party, a death resulting from a patient safety incident, an incident which has resulted in a significant injury to a staff member, an incident which may result in organisational/reputation damage/media interest, or any significant ongoing or unmitigated risks to patient or staff safety and escalate for further review to the Deputy Director of Nursing, Allied Health Professionals and Social Work Professionals.
- Commission the completion of initial incident review reports for completion within 72 hours

5.16 Investigating Reported Incidents

Incident reports submitted on-line will automatically be forwarded to the allocated handler (manager) for review. The manager reviewing the incident report should ensure that all relevant information has been accurately recorded. The Datix investigation should be brief and specific. If a more thorough investigation is required into the incident this will be decided via escalation through the CRMG.

5.17 Investigation Process

- Incidents will be allocated a 'handler' on Datix, who will be the line manager of the incident reporter and will have responsibility for investigation of the incident and closure.
- If a Handler is of the view that they should not have responsibility for management of an incident, they should liaise with the appropriate manager to seek agreement for them to take on the role of handler and reallocate the incident accordingly.
- Some investigations will require input from two or more service areas, or from specific departments, and in these cases, managers should decide together how they are going to proceed.
- Medicine-related incidents are reviewed by the medication safety officer. Actions carried out by the line managers of the persons reporting medicine related adverse incidents are reviewed.
- Information governance-related incidents are reviewed by the Information Governance Team and subsequently scored against the breach assessment grid to identify if notification to the Information Commissioners Office is necessary.
- Further enquiries, investigations and actions will be carried out when necessary to mitigate against the risk of similar incidents.
- Any specific actions including required timescales will be directed by the statutory or regulatory body the incident has been reported to.
- The handler will complete this initial investigation process within 10 days of the incident being reported on Datix.

The appropriate handler for investigation will be determined by the level of harm.

Near Miss	• Datix incident review and necessary investigation completed. • Investigation and incident completion will be undertaken by team member/team manager responsible for incident investigation on the ward/unit/team or with professional responsibility for individual who reporting the incident.
No harm	• Datix incident review and necessary investigation completed. • Investigation and incident completion will be undertaken by team member/team manager responsible for incident investigation on the ward/unit/team or with professional responsibility for individual who reporting the incident.

Low	• Datix incident review and necessary investigation completed. • Investigation and incident completion will be undertaken by team member/team manager responsible for incident investigation on the ward/unit/team or with professional responsibility for individual who reporting the incident.
Moderate	• Datix incident review and necessary investigation completed. • Investigation and incident completion will be undertaken by team manager/service manager responsible for incident investigation on the ward/unit/team or with professional responsibility for individual who reported the incident. • Alternatively, should the incident be deemed significant following review, it will be referred for consideration to escalate to a PSIA/PSII investigation. • Statutory Duty of Candour would also apply to incidents of moderate severity, where the person affected/ family would be invited to participate in the investigation process, given a verbal and written apology following the incident and met with to discuss any investigation findings when available.
Severe	• If on review by the Incident Review daily meeting, the incident will be escalated to the Deputy Director of Nursing, Allied Health Professionals and Social Work Professionals for further review and for appropriate learning methodology to be identified. • Incident may require investigation as an PSIA or PSII as per the Patient Safety Incident Response Policy and assigned for investigation by the service manager responsible for the area in which the incident occurred or for the staff involved in the incident or assigned to another experienced senior member of Trust staff for investigation. • Statutory Duty of Candour would also apply to incidents with severity, rating of severe, where the person affected/family would be invited to participate in the investigation process, given a verbal and written apology following the incident and met with to discuss any investigation findings when available.
Death	• If on review by the Incident Review daily meeting, the incident will be escalated to the Deputy Director of Nursing, Allied Health Professionals and Social Work Professionals for further review and for appropriate learning methodology to be identified. • In circumstances where incidents are found to have directly resulted in death, a PSII will be undertaken as per the Patient Safety Incident Response Policy and Procedure and will be assigned to and the service manager responsible for the area in which the incident occurred or for the staff involved in the incident or another experienced senior member of Trust staff. • Duty of Candour would also apply to incidents resulting in death, where the family/carers of the patient would be included in the investigation process and given a verbal apology following the incident and met with to discuss any investigation findings when available. • All reported deaths are reviewed on a weekly basis by the Clinical Risk Management Group to determine that the applied level of harm is correct, and that appropriate action has been taken. Where required CRMG can commission Initial Incident Reviews to further investigate reported deaths, the findings of which are then considered by the group to determine any further learning methodology should be undertaken.

5.18 Witness Statements

Witness statements (please see Appendix 2) may be provided by anyone who witnesses the incident. Statements must be signed and dated. Original statements should be forwarded to the Patient Safety Team, using email address HNF-TR.IncidentReporting@nhs.net with the incident report form or later if this is not possible.

5.19 Patient/Client Records

Patient/client record entries relevant to the incident should be retained within the patient/clients' records. Copies of any relevant entries should **not** be attached to the incident entry held on the Datix system.

5.20 Datix Incident Management

Managers/handlers may amend incident reports if there are errors or inadequacies in the report provided, for example:

- The description of the incident is factually incorrect
- The description of the incident does not provide adequate information
- There are grammatical/typographic errors
- Names of service users or staff have been included in free text fields

Any material amendments (e.g. description of incident) must be discussed and agreed with the member of staff who reported the incident. N.B: The Datix system has an audit trail function which identifies amendments made, when and by whom.

Following completion of the incident investigation, staff charged with investigation of incidents must access Datix and review the initial level of harm rating and amend, as necessary, to reflect more accurately the impact of the incident on the individuals concerned or the organisation. It is essential that 'action taken to prevent recurrence', 'lessons learned', and incident closure is recorded on Datix.

Any manager with open investigations into incidents that are overdue on Datix will receive a weekly reminder email until the overdue investigation is completed.

Open incidents awaiting review / closure on the Datix system are reported on monthly to the Trust's Operational Delivery Group where they are monitored at divisional level. Responsibility for closure of incidents not closed by the Corporate Safety Huddle remains with the relevant clinical area where the incident occurred and outstanding incidents should be overseen by divisional governance arrangements to ensure timeliness of incident management.

5.21 Learning, Feedback and Support for Staff

Disseminating Learning/Feedback

The investigation of incidents and 'near misses' must be thorough and comprehensive to ensure causes are identified and remedial action taken. It is important that the Trust learns from incidents that occur, and the follow actions must be taken at relevant levels within the organisation to ensure learning from incidents is appropriately disseminated:

Divisions	Must ensure that they have a system in place to identify and share learning, for example, by including this issue as a standing item on the agenda of ward/department/sub-directorate and directorate governance meetings.
Divisional Teams	Must review incidents as part of their internal governance arrangements so that they can work together to consider how to improve systems and processes. Where Trust-wide learning has been identified, it is the responsibility of the member of staff leading the investigation to ensure that this is communicated to the appropriate managers/departments.
Senior Managers	Communication and notification of incidents across the Trust can be produced from Datix and will be provided to senior managers on a regular basis. Teams are also encouraged to access this information.
Incident Reporters	The staff member who has led the incident investigation must ensure that appropriate feedback is provided to the person who reported the incident, and any other staff involved (bearing in mind any staff confidentiality issues). Staff who may have been involved in an error should be provided with appropriate

	support. Where a system error has been identified, staff should be advised of action being taken to improve systems to prevent recurrence.
Working Groups	Working groups with corporate responsibility for specific areas of risk will also consider incident reports relevant to their area of responsibility to review trends and recommend and monitor action required.

5.22 Types of Learning Responses / Review Tool

Learning Review method	Objective	Indications for use	Decision making Forum/ Person
Initial Incident Review (72 hr report)	A staff debrief to ascertain rapid gathering of facts and areas of immediate safety actions and learning ensuring that urgent action is taken to address risks. Report produced	All incidents where information is required to understand what happened and any area of learning	Daily Safety Huddle with approval from Divisional Clinical Lead/ General Manager/ Deputy Director of Nursing and/or Assistant Director of Nursing, Patient Safety and Compliance Oversight through CRMG and appropriate specialist groups ie Pressure Ulcer Review and Learning group (PURL), Reducing Restrictive Interventions Group RRI
After-action review	A structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions: 1. What is expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt?	Can be used to generate insights from the different MDT perspectives to look at positive outcomes as well as incidents	Daily Huddle Ward Managers Modern Matrons Clinical Leads
Patient Safety Incident investigation (PSII)	Where an in-depth review of a single patient safety incident or cluster of incidents is required to understand what happened and how.	Initial Incident Review/Swarm Huddle indicates: Complex incidents (Multiple teams involved/teams external to the trust) Multiple system failures requiring a coherent report and critical analysis external to the team involved Nationally mandated investigations i.e. Never Events	Director of Nursing Medical Director

Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review	Complex incidents involving patient or group of patients	Clinical Lead Responsible Consultant
Swarm Huddle	Investigation using SEIPS framework and a swarm approach. The Swarm Huddle is designed to be initiated after an event and involves an MDT discussion. Staff "swarm" to the site to gather information about what happened and why it happened as soon after the incident as possible and decide what needs to be done to reduce the risk of the same thing happening in the future	Any incidents where: • following receipt of the Initial Incident Review more information is required. • Incidents where following receipt of the DATIX an urgent meeting with those affected is required i.e. cannot wait for a 72hr briefing due to significant immediate/ ongoing patient safety concern	Daily Huddle and approval via Deputy Director Nursing/ Assistant Director of Nursing, Patient Safety and Compliance Oversight by CRMG
Case record/note review e.g.structured judgement review/ Mortality review	To determine whether there were any problems with the care provided and areas of good care provided to a patient by a particular service. (To identify the prevalence of issues; or when patients/families/carers or staff raise concerns about care.)	Thematic review of incidents and other information indicates potential care delivery concerns. Mortality reviews- no immediate care delivery problems but a review of the records is required to identify if care was delivered in line with expected standards.	CRMG/ QPAS
Thematic review	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. The 'top tips' document provides guidance on how to approach a thematic review	Incident data analysis indicates an emergency theme	Quality and Patient Safety Group/ EMT

6. Training

All staff are introduced to incident reporting as part of the Trust Corporate Induction and a rolling programme of Datix training is provided by the Patient Safety Team along with individual support as required.

7. Dissemination and Implementation

This policy will be disseminated by the method described in the Document Control Policy (C-003). Training will be available for all Trust employees via the Patient Safety Team to support the implementation of this policy. The implementation of this policy requires no additional financial resource.

8. Monitoring and Compliance

The Clinical Risk Management Group (CRMG) will monitor the compliance with this policy.

9. References / Related Trust Documents

9.1 Legislation

Data Protection Act (1998)
Mental Capacity Act (2005)

9.2 National Guidance

NHS Improvement Revised Never Events Policy and Framework
Patient Safety Incident Response Framework (PSIRF)
NHSi A Just Culture Guide Guidance Documentation
National Advisory Group on the Safety of Patients in England (2013) A Promise to learn - a commitment to act - improving the Safety of Patients in England
DH (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
CQC Essential Standards on Quality & Safety
CQC (2016) Learning, Candour and Accountability
DH (2006) Safety First
DH (2008) High Quality Care For All: NHS next stage review final report
DH (2006) Memorandum of Understanding – Investigating Patient Safety Incidents involving unexpected death or serious harm: protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive
Health and Safety Commission (2013) Management of Health and Safety at Work Regulations
Health and Safety Executive (2013) Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

9.3 Trust Policies / Procedures

Patient Safety Incident Response Policy
Patient Safety Incident Analysis Using Swarm Huddle Methodology
Duty of Candour Policy and Procedure
Freedom to Speak Up (Raising Concerns) Procedure
Managing Sickness Absence Policy
Medicines Optimisation Policy
Safeguarding Adults Policy
Safeguarding Children Policy
Sexual Misconduct Policy
Safety Huddle Guidelines

Appendix 1 – Document Control Sheet

This document control sheet, when presented for approval/ratification must be completed in full to provide assurance. The master copy of the document is to be held by the Policy Management Team.

Document Type	Policy		
Document Purpose	This policy sets out the process for reporting and management of clinical and non-clinical incidents, accidents and near miss events reported via the electronic incident management system (Datix).		
Consultation:	Date:	Group / Individual	
list in right hand columns consultation groups and dates -	March 2019	Health and Safety Team / Patient Safety Team / IG Team	
	August 2022	Clinical Risk Management Group	
	August 2022	QPaS	
	July 2025	CRMG	
	July 2025	Patient Safety Team / Safeguarding	
	August 2025	Patient Safety and Practice Development Lead	
Approving Body:	QPAS	Date of Approval:	18 September 2025
Date of Board Ratification:	N/A (minor amends)		
Training Impact Analysis:	None [X]	Minor [ ]	Significant [ ]
Financial Impact Analysis:	None [X]	Minor [ ]	Significant [ ]
Capacity Impact Analysis:	None [X]	Minor [ ]	Significant [ ]
Equality and Health Inequalities Impact Assessment (EHIIA) undertaken?	Yes [X]	No [ ]	N/A [ ] Rationale:

Document Change History:			
Version Number	*Type of Change (full/interim review, minor or significant change(s))*	*Date*	*Details of Change and approving group or Executive Director* ***(if very minor changes as per the document control policy)***
1.0		*March 2017*	*Initial draft*
1.1		*April 2017*	*Additional Information*
2.0	*Minor*	*May 2017*	*Updated incident grading*
2.1	*Review*	*July 2019*	*Clarified reporting process requirements* *Further details regarding RIDDOR reportable incidents* *Further details regarding Safeguarding Children incidents, Information Governance breaches and death of a patient* *Details regarding the daily Incident Review Meeting*
2.2	*Review*	*Aug-22*	*Reviewed with minor changes* *Approved QPaS (director sign off - 18-Aug-22)*
3.0	*Full Review*	*July 2025*	*Full review with minor amends.* *Updated Datix links, Added reference to PSIRF and definitions for associated learning methodologies etc…,Added reference to LFPSE and removed reference to NRLS. Changed into new policy format and completed EHIIA. Raising concerns, practice capability, death of patient and Safeguarding incidents section updated in conjunction with Head of Safeguarding. PSIRF, huddle and level of harm sections in conjunction with Patient Safety and Practice Development Lead.* *Approved at QPaS (18 September 2025).*

Appendix 2 – Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document of Process or Service Name: Incident Reporting Policy (N-038)
2. EHIIA Reviewer: Oliver Sims, Corporate Risk and Incident Manager – oliver.sims@nhs.net)
3. Is it a Policy**,** Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
This policy sets out the process for reporting and management of clinical and non-clinical incidents, accidents and near miss events reported via the electronic incident management system (Datix).
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	How have you arrived at the equality impact score? • who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	No age group is adversely affected by this policy.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	No group with a disability is adversely affected by this policy.
Sex	Man/Male, Woman/Female.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Marriage / Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Pregnancy / 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 person unfavourably because they are breastfeeding.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.

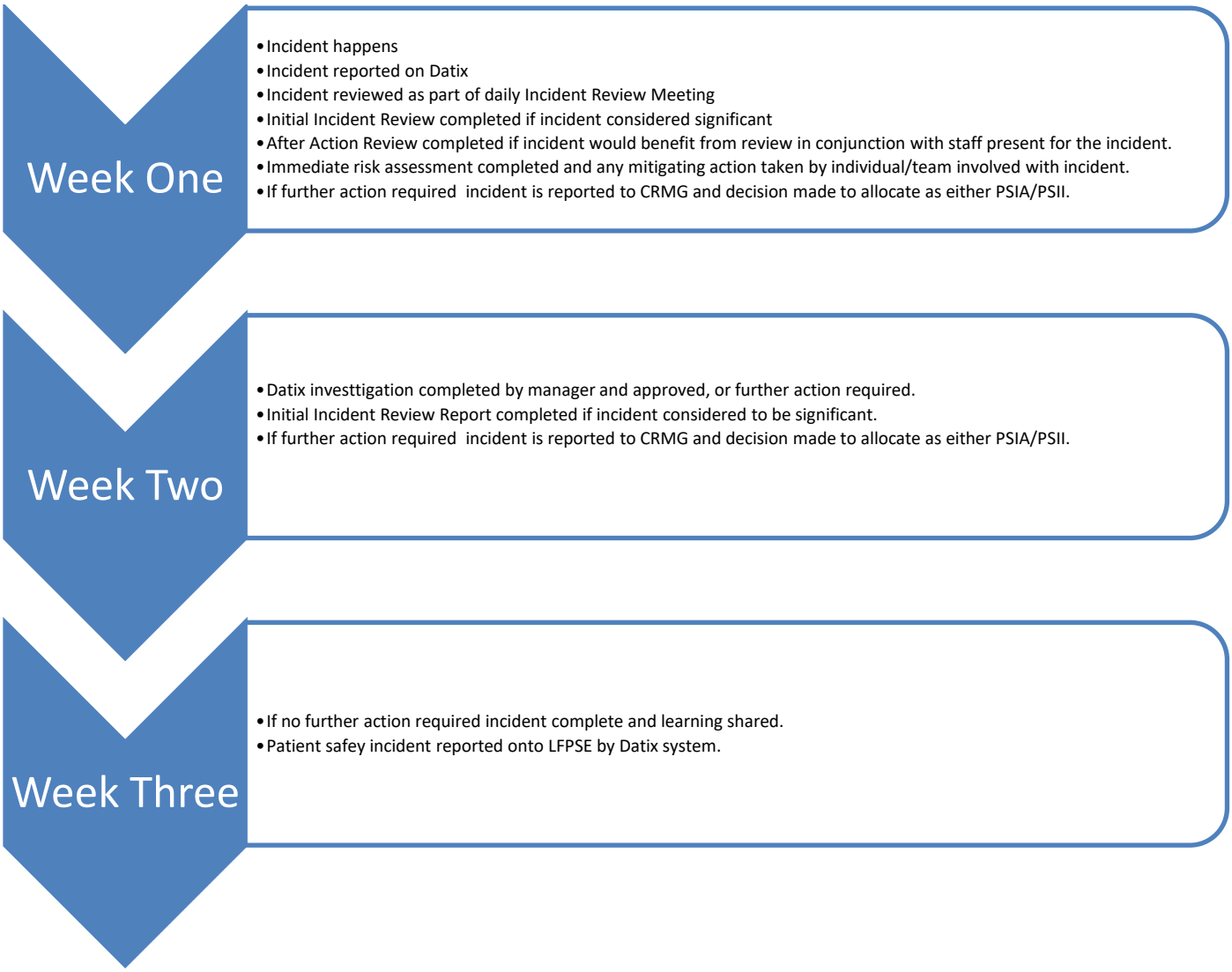
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	
	• People who experience homelessness	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
	• Drug and alcohol dependence	Neutral	
	• Vulnerable migrants	Neutral	
	• Gypsy, Roma and Traveller communities	Neutral	
	• Sex workers	Neutral	
	• People in contact with the justice system	Neutral	
	• Victims of modern slavery	Neutral	
Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.

Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted	Neutral	Review of the policy has taken place to ensure no group is adversely affected by the policy.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above This policy will be adapted system-wide within the Trust and is applicable to all members of staff. The details within the policy will be applied unilaterally across the organisation. Review of the policy has taken place to ensure no group is adversely affected by the policy.	
EIA Reviewer: Oliver Sims	
Date Completed: 29/07/2025	**Signature:** O. Sims

Appendix 3 – Incident Flowchart



Appendix 4 – Witness Statement

Witness Statement

Name		**Date of Incident**	
Job Title		**Web/NYR/PSII/PSIA number (if known)**	
Type of Incident			
What Happened? *Provide a description of the incident you saw, who was involved, who was also present and what happened, including who did what and where the incident happened.*			
Signature		**Date**	

Appendix 5 – Specialist Commissioning Reportable Incidents

Specialist Commissioning Reportable Incidents

A1	Escape	A detained patient escapes from a unit/hospital if he or she unlawfully gains liberty by breaching the secure perimeter that is outside the wall, fence reception or declared boundary of that unit.	A full patient and perimeter check has been completed and patient is unaccounted for.
A2	Abscond involving force or weapons.	Abscond where a patient unlawfully gains liberty during escorted leave of absence outside of the perimeter of the originating hospital by breaking away from the custody/supervision staff.	Patient uses force/violence/weapons against escorts/public to effort absconding
A3	Hostage taking	An individual/group is held by captor(s).	Within or external to the unit/hospital.
A4	Serious sexual assault	This may include an allegation of rape, where genital, oral or anal penetration by part of accused body or by an object using force and without the victim's consent.	Where it is immediately reasonable to determine that a sexual assault has/may have taken place necessitating immediate police forensic and investigative involvement. Safeguarding issues to be implemented.
A5	Major concerted indiscipline	A disturbance involving two or more patients resulting in violence, damage or destruction.	E.g. Sit-in protest involving violent behaviour, group assault, barricade where multiple patients may be involved etc.
A6	Roof top disturbance	Where more than one patient is on the roof for any length of time **or** where one patient is on the roof for over 30 minutes.	
A7	Major fire	Major fire leading to widespread loss of property or considerable spread of fire from source of ignition.	Requiring action from the fire service to control.

A8	Major loss of service	Unplanned loss of buildings or services or loss of service causing major disruption.	Loss of ability to maintain security and/or deliver patient care.
A9	Major key compromise	The permanent or long-term compromise of any personally allocated or centrally controlled security key.	E.g. the loss or of staff personal security keys that results in the need for total or partial re-locking of the service.
A10	Death	Unexpected or expected.	Where potential suicide, homicide or as a result of a known or unknown physical condition.
B2	Abscond where harm ensues	A patient unlawfully gains liberty during escorted leave of absence outside the perimeter of the originating unit/hospital by breaking away from the custody/supervision of staff.	A clear attempt at evading escorting staff where control of the escort is lost and the patient remains at liberty. Whilst at liberty the patient engages in behaviour that results in harm to self and/or others or significant property damage.
B7	Serious fire	Fire at any part of the hospital that causes serious damage.	Serious damage that requires action from the fire service. May cause some disruption to service provision but not requiring the removal of patients
B8	Serious disruption to service	The partial loss or significant restriction of buildings or services.	Where temporary additional operational controls or contingency/business continuity plans are required. This would include any incident serious enough to require the assistance of any external agency (e.g. the police).
B10	Key making	Evidence of attempts to make any type of key	
B11	Attempted suicide	An attempt which has been assessed by clinical staff as genuine by a patient to take their own life.	Where, as a consequence, the patient may require a significant level of local intervention and/or may require medical treatment outside the hospital perimeter.
B12	Serious self-harm where serious injury is sustained	Where it has been assessed that there was not a deliberate attempt to commit suicide but where deliberate self-injury has been caused to the body requiring significant intervention or medical treatment.	Where the patient immediately requires a significant level of local intervention and/or requires medical treatment outside the hospital perimeter.

B13	Serious assault	Assault with weapon or attack where there is the clear potential to seriously injure or endanger life.	Where, as a consequence the victim may require a significant level of local intervention and/or may require medical treatment outside the hospital perimeter.
B14	Serious accident or injury	Any event that results in injury or ill health or harm.	Where, as a consequence the injured person may require a significant level of local intervention and/or may require medical treatment outside the hospital perimeter.
B15	Unexplained serious injury	Serious injury to a patient which cannot be readily explained.	Where, as a consequence the patient requires a significant level of local intervention and/or requires medical treatment outside the hospital perimeter.
B17	Weapon making where serious threat is posed	The discovery of weapons or evidence of weapon manufacture where serious threat is posed.	Weapons may be 'home-made' or otherwise
B18	Security breach	A serious failure of perimeter security or a failure of internal security where patient(s) have taken advantage of that failure.	E.g. where a perimeter gate is left unlocked although there is no breach or where an internal security door is door left open and a patient gains access.
B20	Serious allegations against staff where there is sufficient evidence to warrant investigation.	Any serious allegation against staff related to their behaviour or care of patients where there is sufficient evidence to warrant investigation.	May include allegations of abuse or neglect, fraud or inappropriate behaviour requiring further investigation.
B21	Serious medication error	Wrongful administration of medication which has a significant impact on the patient and has the potential either to do irreparable harm or to be life threatening.	Patient requires medical treatment or intervention or is hospitalised.
B22	Serious breach of confidentiality	Breach of patient or organisational confidentiality.	Where this is done either intentionally or unintentionally.
B23	Loss of data	Loss of clinical and/or organisational information.	Where no back up exists or where the information is physically lost and may fall into the public domain.

B24	Serious or unexplained outbreaks of healthcare acquired infections	Serious or unexplained hospital-acquired infection.	Including MRSA, Clostridium difficile, hepatitis infections which are contracted within the hospital or outbreaks of infection.
B25	Abscond or absent without official leave (awol)	• Any abscond or absence without leave when that absence occurs over midnight on any day. • Any abscond or absence that causes the clinical team significant concern.	Services should report the incident as soon as possible after the incident is noted but not to the detriment of taking necessary actions to deal with the incidents on a practical level. Only one notification is required to report a notification that extends over more than one day.
B26	Near miss	A near miss is defined as any incident where the contributory causes are serious and under different circumstances may have led to serious injury, major permanent harm or unexpected death without actual harm occurring.	Near miss incidents should be linked to the definitions specified as 'serious' in this document and offer services the opportunity to learn.

Appendix 6 – Incidents that Require CQC Statutory Notifications

Incidents that Require CQC Statutory Notifications

Events that require Statutory Notification	How we notify CQC	Other actions required (and responsible team)
Under 18 Admission Any under 18 admitted to an adult in-patient unit **Uunder 18 presenting at the 136 Suite, Miranda House)**	• Unit to contact Governance Team who will complete CQC notification form HNF-TR.CQC@nhs.net *Under 18 presenting at the 136 Suite, Miranda House do not need CQC notification, but the Governance team must be informed via the in-house form*	**Unit or Team** • Datix to be completed in usual manner ensuring coded under Admission/Admission of minor • Safeguarding to informed via email and verbal phone call to ensure aware **Governance Team** • Log information on notification tracker and ensure relevant managers informed
AWOL Any patient going AWOL from Secure Services * please note if patient has returned immediately this can be completed on the same notification	• CQC to be notified via the CQC Portal (Governance Team) • Contact HNF-TR.CQC@nhs.net and the Governance Team will assist with notification	**Unit or Team** • Datix to be completed in the usual manner **Governance Team** • Log information on notification Tracker and ensure relevant managers informed
AWOL Return Any return of AWOL from Secure Services	• CQC to be notified via the CQC Portal (Governance Team) • Any queries contact HNF-TR.CQC@nhs.net and the Governance team will assist with notification	**Unit Staff** • Notify the Trust Governance Team **Governance Team** • Log information on notification tracker and ensure relevant managers informed
Death of Detained Patient Any death of a detained/CTO/DOLs patient	• CQC to be notified via the CQC Portal by MHLT (group log in) unless notified through LFPSE • Any queries contact HNF-TR.CQC@nhs.net and the Governance Team will assist with notification	**MHL Team Staff** • Send notification reference through to HNF-TR.CQC@nhs.net • Datix to be completed in usual manner **Governance Team** Log information on notification tracker and ensure relevant managers informed
DOLs	• MHLT to complete DOLs application and forward to CQC	**MHLT** Inform Governance team via HNF-TR.CQC@nhs.net **Governance Team** Log information on notification tracker and ensure relevant managers informed

Events that require Statutory Notification	How we notify CQC	Other actions required (and responsible team)
Other Deaths Certain deaths of persons using the service	• CQC will be notified via the LFPSE system • Datix to be completed in usual manner which will populate LFPSE notification	**Team/Unit/Ward** Datix to be completed in usual manner **Datix Team** Notify HNF-TR.CQC@nhs.net when Datix uploaded to LFPSE **Governance Team** Log information on notification tracker and ensure relevant managers informed
Allegations of Abuse	• CQC will be notified via the LFPSE system • Datix to be completed in usual manner which will populate LFPSE notification	**Team/Unit** Datix to be completed in usual manner **Datix Team** Notify HNF-TR.CQC@nhs.net when Datix uploaded to LFPSE **Governance Team** Log information on notification tracker and ensure relevant managers informed
Events that Stop the Service Events that stop or may stop the service from running properly	• CQC will be notified via the LFPSE system • Datix to be completed in usual manner which will populate LFSPE notification	**Team/Unit** Datix to be completed in usual manner **Datix Team** Notify HNF-TR.CQC@nhs.net when Datix uploaded to LFPSE **Governance Team** Log information on notification tracker and ensure relevant managers informed
Serious Injuries Serious injuries to people who use the regulated activity	• CQC will be notified via the LFPSE system • Datix to be completed in usual manner which will populate LFPSE notification	**Team/Unit** Datix to be completed in usual manner **Datix Team** Notify HNF-TR.CQC@nhs.net when Datix uploaded to LFPSE **Governance Team** Log information on notification tracker and ensure relevant managers informed

Appendix 7 – ICB notifiable patient safety incidents escalation process

Datix

- Patient safety incident identified and is reported on the Trust risk reporting system (DATIX).

Daily Huddle

- The Corporate Daily Huddle to review patient safety incidents and determine if additional review via IIR is required. For those incidents requring an IIR follow next steps.

Clinical Risk Management Group (weekly)

- IIR received and reviewed at CRMG.
- CRMG to consider if the IIR meets the thresholds for escalation to the ICB as outlined in the Escalation of Significant Patient Safety Incidents/Events briefing note:
  - **Where there is, or is likely to be, MP, ministerial, political or media attention**
  - **NHS executive interest**
  - **Involvement of multiple national bodies**
  - **The issue(s) span(s) multiple regions**
  - **Where the ability of a provider to operate as normal may be reduced**
  - **Where significant numbers of patients are affected and where particularly vulnerable patients are affected.**

Executive meeting

- All incidents considered to met the threshold will be escalated for discussion at the weekly Executive meeting.

Patient Safety Specialist

For incident meeting the threshold, the HTFT nominated Patient Safety Specialist (or delegated other) to complete and return the **NHS England North East & Yorkshire Escalation of Significant Patient Safety Incidents/Events escalation template** and return to **hnyicb.patientsafety@nhs.net**

ICB Patient Safety Team

ICB Patient safety team to review and return to **england.NEY-investigations@nhs.net**

(Flowchart - Sept 2025 Version 1)