Policy for the Investigation, Analysis and Learning from Incidents, Complaints and Claims

Please be aware that this printed version of the Policy may NOT be the latest version. Staff are reminded that they should always refer to the Intranet for the latest version.

Purpose of Agreement	Process for investigating all incidents, complaints and claims, and ensuring that a systematic approach to the analysis and organisational learning of these events is in place and undertaken.
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Amendments Summary

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date

Review Log

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
V2	August 2016	Tracy Beck	Policy Steering Group	Update the policy. Page 4 Para 2.1.1 Para 2.2 Para 2.2.6 Para 2.2 9 Para 3 Para 3.4 Para 3.5 Para 3.7 Para 4.1 Para 4.2 Para 5.5.1 Para 5.5.1.1 Para 5.5.2.1 Para 5.5.2.3 Para 5.5.3.1 Para 6.1 Para 6.5 Para 7.3.1 Para 7.3.3 Para 9 Para 10.9 Para 10.23 Para 10.24 Para 10.26 Para 10.27 Para 11.1 Para 12.3 Para 12.8 Para 13.3.2 Para 13.3.3 Para 13.3.4 Para 14 Para 15.2 Para 15.4 Para 15.6
V3	April 2020	Mark Hopkinson	Policy approved as part of the Covid-19 review of policies	Overarching Emergency Statement added and expiry date extended to March 2021.

SUMMARY OF POLICY

This revised Policy presents the procedure for investigating all incidents, complaints and claims, and ensuring that a systematic approach to the analysis and organisational learning of these events are undertaken. The policy explains the processes adopted by the Trust to ensure that the organisation learns through sound analysis and that practice is changed to reflect the lessons learned

Learning from experience is critical to the delivery of safe and effective services in the NHS. The systems and processes which operate in the Trust must be designed to minimise risk and therefore each incident or near miss must be looked upon as a learning opportunity. The Trust is committed to a systems approach to learning, achieving improvements into the organisation's culture and practice.

Learning and making improvements from adverse events, particularly incidents, complaints and claims can happen at a local level, corporate and across the wider health community.

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Staff are expected to adhere to the processes and procedures detailed within this policy. During times of national or 'Gold command' emergency Solent NHS Trust may seek to suspend elements of this policy in order to appropriately respond to a critical situation and enable staff to continue to work in a way that protects patient and staff safety. In such cases Quality Impact assessments will be completed for process changes being put in place across the organisation. The QIA will require sign off by the Solent NHS Ethics Panel, which is convened at such times, and is chaired by either the Chief Nurse or Chief Medical Officer. Once approved at Ethics panel, these changes will be logged and the names/numbers of policies affected will be noted in the Trust wide risk associated with emergency situations. This sign off should include a start date for amendments and a review date or step down date when normal policy and procedures will resume.

1. INTRODUCTION & PURPOSE

1.1 The purpose of this policy is to set down the process for investigating all incidents, complaints and claims, and ensuring that a systematic approach to the analysis and organisational learning of these events are undertaken.

1.2 The policy explains the processes adopted by the Trust to ensure that the organisation learns through sound analysis from incidents, complaints and claims and that practice is changed to reflect the lessons learned.

2. SCOPE & DEFINITIONS

2.1 SCOPE

2.1.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation in line with Solent NHS Trust's Equality, Diversity & Human Rights policy.

2.2 DEFINITIONS

2.2.1 **Adverse incident:** an adverse incident is any unexpected / unintended incident, occurrence or accident which could result in injury / harm / unnecessary risk, adverse legal or media position, loss or damage of property / assets, or financial loss to a patient, visitor, member of staff or the Trust. Please refer to the *Trust Incident Reporting Policy* for examples.

2.2.2 **Claim**: a claim for compensation in respect of adverse incidents, which led to personal injury, injury claims from staff or public, employer's liability claims, occupier's liability claims, judicial reviews, human rights claims, fire or general damage.

2.2.3 **Complaint:** an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a response. There is no difference between a 'formal' complaint and an 'informal' complaint. Both are expressions of dissatisfaction', The Patient's Association, 2013.

2.2.4 **Duty of Candour** – a statutory requirement has been introduced to ensure health care providers operate in a more open and transparent way. The regulation for Duty of Candour applied to health service bodies from 27 November 2014. It will be extended to all other providers from 1 April 2015, subject to Parliamentary process and approval.

2.2.5 **High Risk** Incidents - A High Risk incident is an incident which the Trust considers to be of high

risk, but which do not meet the full criteria of a SIRI. The level of investigation and monitoring is comparable with the SIRI process, with the option to reclassify if SIRI criteria is established.

2.2.6 **Harm**: an injury (physical or psychological), disease, suffering, disability or death. In most instances, harm can be considered to be *unexpected* if it is not related to the natural course of the patient's illness, treatment or underlying condition, or the natural course of events if harm occurs to other than a patient

2.2.7 **Investigation**: a detailed inquiry or systematic examination.

2.2.8 **Near miss**: an incident that had the potential to cause harm but was prevented, by action or good fortune, resulting in no harm.

2.2.9 **Risk Management System** - Ulysses Safeguard: The web-based incident management system.

2.2.10 **Root cause analysis (RCA):** a well recognised way of investigating incidents, claims and complaints, which offers a framework identifying what, how and why the event happened. It is then possible to use analysis to identify areas for change, develop recommendations and look for new solutions.

2.2.11 **Serious Incident (SI):** In incident that occurred in relation to NHS-funded services and care resulting in unexpected or avoidable death, serious harm, threat to the organisation's ability to continue to deliver healthcare, allegations of abuse, adverse media coverage or the occurrence of a 'Never Event'. Please refer to the *Trust SIRI Policy* for examples

3. ROLES AND RESPONSIBILITIES

3.1 The **Chief Executive and the Trust Board** has ultimate responsibility for all aspects of risk management and governance, including the management of incidents, complaints and claims. This includes ensuring that suitable arrangements are in place for the systematic investigation, analysis and improvement, both locally and corporately. This involves ensuring services are adequately resourced to comply fully with this policy.

3.2 The **Chief Operating Officers/ Clinical Directors/ Operational Directors** have responsibility to:

Ensure compliance with this policy
Provide evidence that lessons have been learnt.
Ensuring that there are sufficient members of staff who are suitable and who have received training to undertake review of incidents within the Risk Management System - SAFEGUARD (RMS)
Provide support to all staff and patients involved in an investigation whether it is as a result of an incident, claim or complaint
Ensure action plans are developed and progressed which take into account both local and corporate improvement.

3.3 The **Clinical Governance Leads** have a responsibility to:

Be aware of, and comply with this policy
Ensuring that there are sufficient members of staff who are suitable and who have received training to undertake review of incidents within the RMS
Provide support to all staff and patients involved in reporting of incidents (actual and near miss)
Ensure that all investigations are dealt with effectively and appropriately
Ensure that action plans are appropriate and are implemented within their services
Provide evidence that lessons have been learnt
Monitor the quality and effectiveness of reporting and subsequent investigations by

receiving and analysing reports regarding incidents relevant to their service.

3.4 The **Patient Safety Team** has responsibility to:

Be aware of, and comply with this policy

Play a key role in ensuring that as an organisation we meet the performance requirements of the commissioning organisation

Produce reports showing trends in incident reporting

Support the review of root causes and learning from these incidents at the Service Line

Highlight any particular concerns / changes to practice, and the lessons learned, to relevant staff, committees, Sub-committees and Groups

3.5 The **Information Governance Team** has responsibility for:

Ensuring all IG incidents are reported to the appropriate bodies including the Information Commissioner

Contributing to the review and management of IG incidents, within the RMS, as the subject experts

Producing an IG incident report showing trends

Discussing root causes and learning from these incidents at the Information Governance Steering Committee

To support and provide IG Training

3.6 The **Caldicott Guardian and Senior Information Risk Officer (SIRO)** has responsibility for:

Reflecting patients' interests regarding the use of patient identifiable information

Ensuring patient identifiable information is shared in an appropriate and secure manner

Fostering a culture for protecting and using data

Providing a focal point for managing information risks and incidents

Receiving updates from the Information Governance Team regards trends relating to Information Governance SIRI

3.7 The **Service Line Managers/Clinical Leads** have a responsibility to:

Be aware of, and comply with, this policy

Investigate all reported incidents / informal verbal complaints / concerns and ensure that the investigation is documented within the RMS as appropriate

Be aware of all reported incidents in their team / department

Develop action plans and risk reduction measures to reduce the likelihood and recurrence of incidents / complaints / claims and that this is documented within the RMS as appropriate

Raise any concerns regarding incidents / complaints / claims with the relevant Head of Service

Ensure that all Trust incident reports are initially reviewed (and within 48 hrs of incident occurring) within the RMS

Ensure all staff undertake principles of incident investigation training as detailed in this policy

Report on the monitoring of incidents to their Head of Service/Line Manager

Review the relevant risk assessments following an incident

Inform the Risk Management Team if the incident results in staff absence from work (even if this does not happen immediately after the incident) or changes to their duties

Inform the Risk Management / Pals and Complaints Team of any changes to action plans

To consider and where appropriate implement the *Being Open Policy* when reporting incidents

Provide support to all staff and patients involved in an investigation whether it is as a result of an incident, claim or complaint. Liaise with HR if any employment/performance related issues.

3.8 The **Patient Experience Team** have a responsibility to:

Initiate the investigation process into the complaints/concerns

Produce reports showing trends, together with written analyses explaining the trends
Highlight any particular concerns / changes to practice, as well as lessons learned, to relevant staff and Committees and Groups

3.9 **Employees** have a responsibility to:

Be aware of, and comply with, this policy
To consider and, when appropriate, implement the *Being Open Policy* as regards informing patients and carers, as appropriate, when reporting incidents. These actions should be included on the incident reporting form
To ensure that serious incidents, which are required to be reported to external agencies, are raised with the relevant member of staff, as detailed in this policy, as soon as practicable but at least by the end of the clinical session or shift. Details of these actions should be included on the incident report
To report any risks as they are identified
To be fully open and co-operative with the investigation process as detailed within this policy but also the Solent NHS Trust HR Investigation Policy

4. INVESTIGATIONS

4.1 Investigations are necessary to provide a retrospective review of events to identify what, how and why an event happened. An action plan will be developed from the investigation which is used to identify areas for improvement, and sustainable solutions, to help minimise risk of re-occurrence in the future

4.2 The Trust promotes a no blame culture, as outlined in the Risk Management Strategy Policy, advocating learning. As such, all incidents and near misses must be reported. It is recognised that 'human factors' often play a significant part in incidents and near misses, and that such factors cannot be entirely eliminated. It is vital that the systems and processes which operate must be designed to minimise the risk of human error and, therefore, each incident or near miss must be looked upon as a learning opportunity. Staff understanding of the investigation process is crucial to ensure that the safety culture of the Trust is maintained and that the likelihood or impact of future similar incidents is reduced.

4.3 When an incident occurs, it is easy to attribute it to human error, claiming negligence, or to simply believe the incident has occurred as a rare, unpredictable happening (National Patient Safety Agency, 2004). In reality, there are often many contributing components that can be shown to lead to an incident (Appendix 1). It is these components that are explored when conducting an investigation.

4.4 Supportive investigations based on factual understanding rather than blame gives opportunities to learn and reduce the likelihood and/or impact of future incidents. The purpose of the risk management investigation processes detailed in this policy is to promote safe practice, promote understanding and learning and not to apportion blame. (NHS Confederation, 2003).

5. DEPTH OF INVESTIGATIONS

5.1 All incidents, complaints and claims need to be investigated. However, the degree of investigation (the depth and length of time to be taken) varies depending on different factors, such as the level of actual or potential harm to the patient / carer / relative or staff member or impact on the organisation and the complexity, which could include incidents, complaints or claims which are of a high frequency, but are low severity.

5.2 All informal verbal complaints must be investigated by the relevant manager / supervisor with reference to the Complaints Policy.

5.3 All formal complaints which cannot be addressed by the departmental investigation must be investigated using a full investigation which involves root cause analysis with reference to the Complaints Policy.

5.4 All potential and actual claims will be investigated with regard to the complexity and actual harm involved and in line with requirements of the NHS Litigation Authority. The Solicitor and Claims and Litigation Manager will arrange for investigations to take place in line with the Claims Policy.

5.5 With regard to incidents, the risk rating matrix (*Reporting of Adverse Events Policy)* is used to grade the incident if it were to recur, based on the potential for the incident to recur and the severity should it recur. All incidents entered onto the Risk Management database are graded. The following determines how different incidents must be investigated. The Patient Safety Team will use their discretion to determine any variation from this standard based on the best outcome for the Trust.

	Risk Grading Matrix	**B - Likelihood**				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost Certain
A - Severity	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5
	NB: Negligible = Near miss / insignificant					
	Severity X Likelihood = Risk Grading					

5.5.1 **The department/Service Line Investigation:** These incidents must be investigated and reviewed locally in the ward or department in which the incident occurred, with senior nurse/manager involvement if necessary. The departmental/ service team must take the responsibility to identify learning points or safety improvement measures which are within the department's control and ensure that those safety measures identified, which are not within the control of the department, are appropriately communicated to the relevant Management Team for consideration. The Patient Safety Team must be informed of all findings from the investigation and actions taken. This should take place within three days following the investigation.

5.5.2 The Patient Safety Team may review these incidents and undertake a follow-up investigation or instigate a specialist or further Investigation.

5.5.3 The Patient Safety Team may decide that learning from the incident or near miss should be shared within the Trust, with other organisations or wider and will make appropriate arrangements for this to happen.

5.5.2 **High Risk Incidents (HRI)**

5.5.2.1 **High Risk Incidents Investigation:** A strategy meeting may be held to determine the investigating team and key issues and a proportionate response agreed in consultation with the Clinical Lead and Governance Lead for the service line. Incidents graded as moderate must be subject to a management investigation by one or two key staff. This must be led by a suitably trained person within the service line in which the incident occurred and involve the immediate line manager of persons involved.

5.5.2.2 The Patient Safety Team may review these incidents and undertake a follow-up investigation or instigate a specialist or further Investigation.

5.5.2.3 The Patient Safety Team will decide whether any learning from the incident or near miss should be shared within the Trust, with other organisations or wider and will make appropriate arrangements for this to happen. Liaise with the Learning and Development team if training is necessary.

5.5.3 **Serious Incidents (SI)**

5.5.3.1 Where major or catastrophic harm has occurred, this is known as a Serious Incident (SI) Incident. A strategy meeting will be held to determine the investigating team and key issues and a proportionate response agreed in consultation with the Clinical Lead and Governance Lead for the service line. The subsequent report will be reviewed at the Service Line Governance Groups and considered for closure. The RMT will maintain a central log of these types of incident and the Service Line Governance Groups will provide status updates on request or as appropriate. Where the incident meets the Serious Incident (SI) criteria, reference must be made to the SI Policy for reporting, investigation and learning requirements. The subsequent investigation report must identify learning points and be presented to the SI Panel for approval.

6. DEPARTMENTAL INVESTIGATION – COMPLAINTS, POTENTIAL CLAIMS AND INCIDENTS

6.1 The relevant manager/supervisor is responsible for investigating all incidents, concerns and potential claims which have taken place in their area. They must ensure that the investigation appropriately identifies all learning points and safety improvements. The Patient Experience Team and Patient Safety Team are available to provide advice and support for departmental investigations into complaints, claims and incidents, respectively, as required.

6.2 When dealing with incidents, the relevant and identified reviewer must complete a full and through review any relevant incident report inclusive of likely causes, lessons learnt and actions to be undertaken to prevent recurrence within the RMS. It is the responsibility of the relevant manager/supervisor to review the documented actions and agree or amend accordingly at the earliest opportunity.

6.3 Following a departmental investigation after an informal complaint or potential claim the relevant manager/supervisor should develop an action plan to reduce the likelihood of a similar complaint or claim occurring.

6.4 The relevant team (i.e. complaint, litigation or risk management) should be informed when action plans have been completed, or when changes to action plans have been made.

6.5 The relevant manager/supervisor may believe that a full investigation using root cause analysis should be undertaken. In this case, the Patient Safety Team must be informed and the process for undertaking a full investigation commenced.

6.6 The relevant manager/supervisor must place all risks that cannot be immediately rectified on the risk register within the RMS scoring them appropriately.

6.7 In the case of incident reporting, the relevant manager/supervisor is responsible for providing feedback to the person reporting the incident in addition to any other relevant people for example the Service Manager/patient/team via the RMS in addition to individual or team feedback mechanisms

6.8 It is expected that the relevant manager/supervisor will up-date his/her team about complaints and claims relating to the team/service including details about any action plans developed.

7. CORPORATE INVESTIGATION

7.1 Incident Investigation

7.1.1 All completed incident reports are held within the RMS. A member of the Patient Safety Team may further assess the incident from the information available and decide whether or not the action plan and risk assessment, as documented, requires further investigation.

7.1.2 If the Patient Safety Team believes that the action plan or risk assessment requires further investigation, the following may be instigated:

- Follow-up Investigation (see section 8)
- Specialist Investigation (see section 9)
- Root Cause Analysis – Full comprehensive investigation (see section 10)

7.1.3 The Patient Safety Team may investigate any incident in the Trust and may at any time audit incident reports to ensure that all necessary corrective action has been taken.

7.2 Complaints Investigation

7.2.1 Complaints will be managed in accordance with the Managing Concerns and Complaints Policy and Procedure by the Patient Experience Team.

7.2.2 The Trust has Investigating Officers who are authorised to investigate complaints on behalf of their Service Line. The role of the Investigating Officer is also to investigate complaints where the complainant does not wish to raise their concern with the people directly involved in their care, or where front-line staff are unable to deal with a complaint.

7.2.3 The Patient Experience Team capture data in relation to outcomes arising from complaints and record when these have been actioned. Complaint outcomes are reported to board.

7.2.4 Dependent on the nature of the complaint, if more than the Departmental Investigation is required, it will be investigated and analysed using Root Cause Analysis i.e. Full Investigation (See Section 3.2.10)

7.3 Claims Investigation

7.3.1 In accordance with the Claims Management Policy and Procedures, all staff have a responsibility to notify the Solicitor and Claims and Litigation Manager of likely or actual claims received and to co-operate fully with the Patient Safety Team /or Patient Experience Teams, Trust solicitors and NHSLA claims handlers.

7.3.2 Any member of staff receiving written notification of a claim or intended claim should not enter into correspondence or communication with the claimant or the claimants legal representative. All such correspondence should be forwarded immediately to the Solicitor and Claims and Litigation Manager.

7.3.3 Claims will be investigated as detailed in the Claims Management Policy. The Patient Safety Manager or the relevant manager/supervisor will ensure that risks that cannot be immediately mitigated are documented on the Risk Register.

8. FOLLOW-UP INVESTIGATION (INCIDENTS)

8.1 If the Patient Safety Team requires further information concerning the incident, and details of any remedial action taken, a follow-up investigation will be instigated.

8.2 This additional information may be obtained from the incident reporter, incident reviewer, manager or service manger, by telephone or by any form of correspondence, including e-mail or letter. Any requests for information and the information received will be retained within the Risk Management system by:

- Retention of emails within RMS associated with the incident
- Scanning and addition of information within RMS to the associated incident file if paper documentation provided

8.3 In some cases, the Patient Safety Team might visit the reporting area where the incident occurred to obtain further information/supportive evidence.

8.4 Staff are required to support the investigation process by supplying the required information in a timely manner and/or advising if the information is unavailable.

8.5 Incidents which require an immediate response, for example, to meet the statutory timescales dictated by external bodies, will be given an appropriate response deadline and, wherever possible, the relevant person will be contacted by telephone for an immediate response.

8.6 On receipt of the additional requested information, the Patient Safety Team, in consultation with the service, may decide if the investigation is sufficient and, if so, no further investigation will be necessary. The service will update the RMS with the new information and the incident follow-up will be closed.

8.7 It is the responsibility of the relevant manager to inform the incident reporter of the additional actions taken.

8.8 The Patient Safety Team may, at any time, monitor any remedial action taken by the service area to ensure that it has been implemented and that appropriate risk reduction measures have been taken.

9. SPECIALIST INVESTIGATION & SHARING SAFETY LESSONS

9.1 A specialist investigation may be commissioned by the Associate Director of Quality & Safety. In some circumstances, the Patient Safety Team may believe that the reported incident should be referred to other relevant internal or external services or specialists, for information or for further investigation and for sharing lessons learned. Some referrals may be mandatory; others may be based on professional and specialist judgement. These services/specialists include:

- **Internal:**
  - Facilities Management
  - Infection Prevention and Control
  - Safeguarding Children (Child Protection)
  - Safeguarding Adults (Vulnerable Adults)
  - Pharmacy
  - Health & Safety
  - Fire Officers
  - Occupational Health
  - Human Resources

- Caldicott Guardian & Information Governance
- Clinical Director
- Chief Nurse

- **External:**
  - Health and Safety Executive (particularly in regards to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations -RIDDOR)
  - Medicines and Healthcare Regulatory Agency (MHRA)
  - Counter Fraud and Security Management Service (CFSMS)
  - Strategic Health Authority
  - Care Quality Commissioning (CQC)
  - National Patient Safety Agency (NPSA)
  - NHS Commissioners
  - Other NHS organisations

9.2 Certain incidents referred to other specialists will be monitored for 'closing the loop' purposes and to monitor any actions plans/risk reduction measures that have been implemented. These services/specialists are expected to provide relevant feedback to the Patient Safety Team

9.3 All patient safety incidents are reported to the National Patient Safety Agency.

9.4 All incidents involving staff, moving and handling and health and safety issues are routinely sent to the Occupational Health/Health and Safety Team by the Patient Safety Team for information and/or follow-up.

9.5 The Patient Safety Team review all individual moderate harm incidents and other reported incidents identified as requiring their review. The incidents are checked to see if there is relevance to the Occupational Health Team, Health and Safety Team etc. Each incident form is then sent to the relevant team for information or action via the RMS.

9.6 The Patient Safety Team may request a specialist to undertake a Follow-up Investigation and be kept informed of the progress of such investigations and is available to assist the Health and Safety Team and the Occupational Health Team. All action plans/changes to practice as a result of these investigations are sent to the Patient Safety Team and reflected in the review of the reported incident within the RMS

9.7 On submission of a reported incident, an internal team, service or individual may believe that a Full Investigation, using root cause analysis, should be undertaken. In these cases, the RMT must be informed and the process for undertaking a Full Investigation must be followed.

10. FULL INVESTIGATION (COMPLAINTS, CLAIMS AND INCIDENTS)

10.1 It will be necessary for some reported incidents, high risk incidents, to be subject to a more in-depth analysis. This could be as a result of their complexity or sensitivity and not necessarily because of their severity scoring. These incidents may have been highlighted as a result of incident reporting, complaints, claims or other means. For incidents identified as Serious Incidents, the SI Policy must be followed.

10.2 If a full investigation requiring root cause analysis is required the lead team i.e. The Patient Safety Team or Patient Experience Team will inform the relevant manager/supervisor and provide reasons for the need to conduct a full investigation.

10.3 An initial meeting, known as the Strategy Meeting, will be arranged by a member of the Patient Safety Team or Patient Experience Team to include the relevant manager/supervisor and any

other relevant parties which may be required to assist in the investigation, for example a relevant Director, member of the health and safety team, or clinical/non-clinical specialist.

10.4 At this meeting it will be agreed who will lead the investigation. The lead investigator must be trained in root cause analysis but may on occasion be a member of the Patient Safety Team, Patient Experience Team, Health and Safety Team or, depending on the nature of the incident, could be a Director.

10.5 A commissioning brief for conducting the investigation will be agreed and this will include information regarding the collecting and collating of further information/evidence. Information may be obtained from various sources, such as health records, diaries, training information, prescription charts, off-duty, equipment and from staff interviews.

10.6 Minutes of this meeting will be recorded on the relevant form and kept with the investigation findings.

10.7 Those involved in the incident will be informed that a full investigation is taking place and will be given the details of the incident, investigation team and lead investigator.

10.8 Staff are required to be supportive of the investigative process by providing relevant and/or requested information.

10.9 As part of the investigation, staff interviews may take place. The interview should follow a set process (See Appendix 2) and, in all cases, staff being interviewed must be aware of the reasons for the interview before it takes place. Two investigators will attend the interview, one will be responsible for leading the meeting and the other will record the key points.

10.10 In certain situations, the interview may be conducted by phone or teleconference, or the questions sent to the relevant person by letter or e-mail.

10.11 Serious Incident Requiring Investigation investigators are to engage with all key stakeholders (which may include family members)/ services that were/are involved in a person's care and offer them input into the investigation process.

10.12 Staff involved in internal investigation interviews should be informed that there is no requirement for them to be accompanied when they meet members of the investigation team. However, although the interviews are conducted as informally as possible it is acknowledged that they may be a cause for anxiety and staff are, therefore, welcome to have someone present, such as a colleague or member of their trade union/professional union at their interview. If someone accompanies a member of staff they must understand and agree that all information regarding the interview and investigation must remain confidential. The member of staff must not be accompanied by someone who was involved in the incident or investigation. (Based on guidance from the Health Service Ombudsman for England – accessed October 2007)

10.13 At the end of the interview (whether it is face-to-face or in another form) the investigator will prepare a summary of key information from the interview. The interviewee will be sent a copy and asked to confirm whether it is accurate.

10.14 As this information is obtained the lead investigator will compile a chronological list of events, called a timeline. If there is an investigation team, they may meet at this stage to review the information gathered and clarify what is known, as well as identifying any gaps in the information.

10.15 As demonstrated in Appendix 1, an incident occurs when controls are breached, or if there are insufficient controls in place. The investigation team will identify what controls were in place (i.e.

procedures, equipment or staffing levels) and where they were breached. This information will support the timeline. Additional staff / specialists may be required to join or contribute to an investigation team to describe the controls normally in place; this will be agreed and arranged by the lead investigator.

10.16 Once all the information has been gathered and the timeline is complete, the Investigator will identify the root cause(s) of the incident by:

- Identifying the contributory factors involved in the incident (see Appendix 3) and/or

- Using the 5 Whys (for simple/non-complex problems) (see Appendix 3)

10.17 The root cause(s) as agreed by the Investigator must be documented and kept with the investigation findings.

10.18 Areas of good practice, such as those areas where practice either minimised the impact of the incident or prevented further problems, or where action was taken in a timely manner will be highlighted and documented.

10.19 The Lead Investigator will write a report based on the set report structure (Appendix 4), to be approved by the investigating team.

10.20 When investigating incidents, areas of practice which require improvement but which were not directly applicable to the incident may be identified. These areas should be highlighted as they provide valuable opportunity for quality improvement. These areas should be included in Part 2 of the investigation report (Appendix 4).

10.21 The relevant manager(s) / supervisor will meet the Lead Investigator who will discuss the incident findings with them and make recommendations to prevent recurrence of the incident. If a Part 2 report has been written, this will be discussed and further recommendations made. A full copy of the report will be given to the manager before the meeting for consideration. Risks identified during the course of the investigation that cannot be immediately mitigated must be added to the Risk Register.

10.22 If the relevant manager(s) / supervisor disagree with the conclusions reached by the investigation team they will be asked to provide, in writing, rationale for this disagreement. This feedback will be considered by the Lead Investigator. If significant changes are made to the report as a result of the disagreements then the relevant manager / supervisor will be given further opportunity to comment on the final report. (Based on guidance from the Health Service Ombudsman for England – accessed October 2007).

10.23 The Manager, with the support of the Lead Investigator if required, will de-brief all relevant staff.

10.24 The relevant manager(s) with the support of the Investigation Team, will produce an action plan to eliminate or reduce the likelihood / consequences of the root cause(s) to prevent a similar incident occurring. Where appropriate the relevant manager(s) will also produce an action plan to address issues raised in the report. Action Plan(s) must be discussed with and agreed by the relevant Clinical Director.

10.2 The action plan(s) will be included as part of the final report and should be realistic, sustainable and cost effective. When writing action plans it is good practice to involve, where appropriate, all staff and patients.

10.26 At any point during the full investigation, information gleaned may require that the incident is raised with other specialists (internal or external) as outlined in Section 3.2.9.

10.27 The completed investigation report is presented by a member of the Lead Investigator to the SI Panel and/or Service Line Governance Group as appropriate. It will then be agreed at these meetings how organisational and local learning from the report will be achieved.

10.28 The Patient Safety Team may contact the service area to monitor progress of the action plan and progress reports may be presented to the SIRI Panel who may require assurance that all remedial actions are being / have been taken. Assurance will be provided to Assurance Committee by the Clinical Director and Governance Lead for the Service Line.

11. SUPPORT FOR STAFF DURING AN INVESTIGATION

11.1 Being involved in an incident, complaint or claim which is under investigation can be a stressful experience. The Trust supports an open and honest approach, as outlined in Supporting Staff Involved in an Incident, Reporting of Adverse Events Policy. Help and support is available through Occupational Health. Staff can also seek advice from Union/Staff Side Representatives if appropriate. Please refer to the Supporting Staff Involved in an Incident, Complaints or Claim Policy.

11.2 It is not the intention of the investigation process to assess whether employment action against an individual member of staff should be considered. However, if as a result of the investigation there is prima facia evidence of a breach of the law, professional misconduct, or repetitive incidents, further action may need to be considered. In these circumstances, the appropriate senior manager will consider whether employment policies should be invoked. Staff should also be aware that in exceptional circumstances their actions may give rise to personal criminal liability.

12. ANALYSIS OF INCIDENTS, CLAIMS AND COMPLAINTS

12.1 The Trust recognises the upmost importance for coordinated and aggregated analysis of incidents, complaints and claims.

12.2 The Patient Safety Team ensures that a coordinated approach is achieved in respect to the aggregation of analysis of high level data from Complaints, claims and reported incidents.

12.3 Each of the Service Line, via their Governance Groups is responsible for local aggregated analysis of their incidents, complaints and claims. The Patient Safety Team may assist with producing monthly reports to the Governance Groups, and also attending meetings to help with the analysis and learning across incidents, complaints and claims.

12.4 The minimum content requirement for standardised reports reflects both qualitative and quantitative analysis and include

12.5 **Incidents:**

- Type of incidents
- Numbers of incidents for reporting period
- Incident cause groups
- Grade/ severity of incidents

- Trend data from previous reporting periods
- Summary of high risk and serious incidents

12.6 **Complaints:**

- Number of complaints
- Types (by subject) of complaints
- Trend data from previous reporting periods
- Breakdown of complaints received by type
- Breakdown of complaints received by speciality
- A summary of how complaints have been handled and outcome of investigations

12.7 **Claims:**

- Number of claims and potential claims
- Trend data from previous reporting periods
- Breakdown of claims received by type
- Breakdown of claims received by speciality
- Trend Analysis from previous reporting periods

12.8 The Patient Safety Team will continually review the arrangements for ongoing analysis and ensure that communication requirements in regards analysis are established at all level of the organisation.

13. ORGANISATIONAL LEARNING AND IMPROVEMENT FROM INVESTIGATIONS/ ANALYSIS

13.1 Learning from experience is critical to the delivery of safe and effective services in the NHS. It is recognised that 'human factors' play a significant part in incidents and near misses, and that such factors cannot ever be entirely eliminated.

13.2 The systems and processes which operate in the Trust must be designed to minimise the risk of human error at every stage and therefore each incident or near miss must be looked upon as a learning opportunity. The Trust is committed to a systems approach to learning, achieving improvements into the organisation's culture and practice.

13.3 **Process for learning and improvement**

13.3.1 Learning and making improvements from adverse events, particularly incidents, complaints and claims can happen at a local level, corporate and across the wider health community.

13.3.2 **Locally:**

- All staff and local managers who are involved in an incident, complaint or claim are trained and are required to report it, investigate (where appropriate) identifying individual and local

learning from these events. A large number of these events could be prevented from re-occurrence if this local learning is achieved. Managers are required to ensure that events which are linked to either competency or discipline are managed in the appropriate manner in line with the applicable Trust policy

- Managers are responsible for implementing local improvements and risk reduction measures inline with their responsibilities. If they are unable they must escalate the issues

- Managers are responsible for highlighting lessons learned at a local level with staff in team/service meetings

- Managers must ensure that risks exposed as a result of local investigation and learning is captured on the applicable risk register. Risk can then be appropriately understood and improvements achieved.

13.3.3 **Corporately:**

- The identification of learning and improvement through aggregated analysis process is central and informs many of the subsequent objectives and initiatives of the Trust and the Patient Safety Team

- The Assurance Committee will seek assurance and monitor learning and improvement from the relevant Divisions, via regular reports from Service Line Governance Groups. The Patient Safety Team will also seek to identity learning across all Divisions and make recommendations to aid the improvements process

- The Patient Safety Team will attend the Service Line Governance Groups to support the learning and improvement processes

- The Patient Safety Team will also provide trend and detailed reports to various groups and committees with particular roles on request

- Serious incidents as a result of an incident, complaint or claim are managed in a specific and formal manner to ensure that a high level of learning at all level is achieved

- Significant adverse outcomes from incidents, claims and complaints will be captured on the Corporate and Divisional Risk Registers, where improvements required mitigating risks will be identified and monitored to ensure implementation

- Where appropriate policies, procedures and guidance will be changed to reflect changes in practice as a result of lessons learned from incident, complaints, claims and investigations. Staff are informed of changes in the policy in a number of ways.

- Improvements as a result of national patient safety alerts are implemented and managed

- Bespoke training will be delivered where appropriate in liaison with the Learning and Development team.

13.3.4 **Local Health Community**

- The Trust is committed to meeting all external reporting requirements for incidents, complaints and claims. This information informs other relevant stakeholders and regulators and helps them identify learning in national and local health economy content

- The Trust attends regular learning events run by the Healthcare Commissioners and improvements are able to be brought back to the Trust

- The Trust is a member of the regional Risk Managers Forum, where information and learning from Incidents, Complaints and Claims is discussed. Learning is to be shared and brought back into the Trust and shared as required

- The Trust participate in national benchmarking and seek to make improvements where identified, for example the National Patient Safety Agency reporting of adverse incidents

13.3.5 **Other areas which provide learning and improvements opportunities**

- Publication and distribution of an internal newsletter, which includes learning from incidents, complaints and claims from both local and national incidents

- Distribution of national safety alerts.

14. ADVICE AND GUIDANCE

14.1 Advice, guidance and support for staff and managers can be provided from:

- Executive Team

- The Associate Directors

- The Patient Safety Team

- The Patient Experience Team

- The Heads of Service

- Services Leads

- Clinical Leads

- Governance Leads

- Health and Safety Advisor

- HR

- Union / Staff Side Representatives

15. INVESTIGATION AND RISK MANAGEMENT TRAINING

15.1 All staff will receive basic training in the investigation of incidents, complaints and claims as part of their induction, within the organisational rolling skills training and as ad hoc in-service training inline with the Trust Training Needs Analysis.

15.2 Risk Management Training is incorporated in the following training sessions:

- Corporate Induction Process for all new staff

- Risk Assessment Principles and Practice Course

- Other staff group Induction training

15.3 The Patient Safety Team also provides on-going ad hoc training on request (or if a need is identified by the RMT) and in-service training through the joint management of accidents/incidents/risk registers/risk assessments between RMT and services.

15.4 Those members of staff who are required to undertake investigations of serious incidents or incidents that fall under the safeguarding umbrella will receive training for this role. This will include level 3 safeguarding training as detailed in the safe guarding vulnerable Adults policy. Detailed Root Cause Analysis Training provided by the Patient Safety Team or external agency as required, and training provided by the Human Resources team in investigating potential poor practice and the disciplinary procedure.

15.5 All training, education or learning and development activity detailed in this policy will be reported to the central Learning and Development team for recording on the central training management system and entered on the staff member's learning record.

15.6 Non-attendance at training, education or learning and development activity as detailed in this policy will be managed as per the Did Not Attend (DNA) process detailed in the Trust learning and Development Policy.

16. EQUALITY & DIVERSITY AND MENTAL CAPACITY ACT

16.1 The Trust embraces and accepts its legal, social and moral responsibility in relation to Equality, Diversity & Human Rights policy. The Trust is committed to delivering equality of opportunities for all service users, carers and staff and wider communities and to the elimination of ALL forms of discrimination.

16.2 As part of Trust policy an equality impact assessment (Steps 1 & 2 of the cycle) was undertaken (Appendix 6). The Trust is not aware of any evidence that different groups have different priorities in relation to this framework, or that any group will be affected disproportionally or any evidence or concern that this Policy may discriminate against a particular population group. Thus the equality impact assessment result is: no negative impact (Appendix 6).

17. RELATED POLICIES

- Adverse Incident Reporting (AIR) Policy
- Managing Concerns and Complaints Policy and Procedure
- Claims Management Policy and Procedures
- Learning and Development Policy
- Induction and Mandatory Training Policy
- HR Investigation Policy
- Policy on the Management of Allegations of Abuse Under Safeguarding Procedures
- Freedom to Speak Up Policy

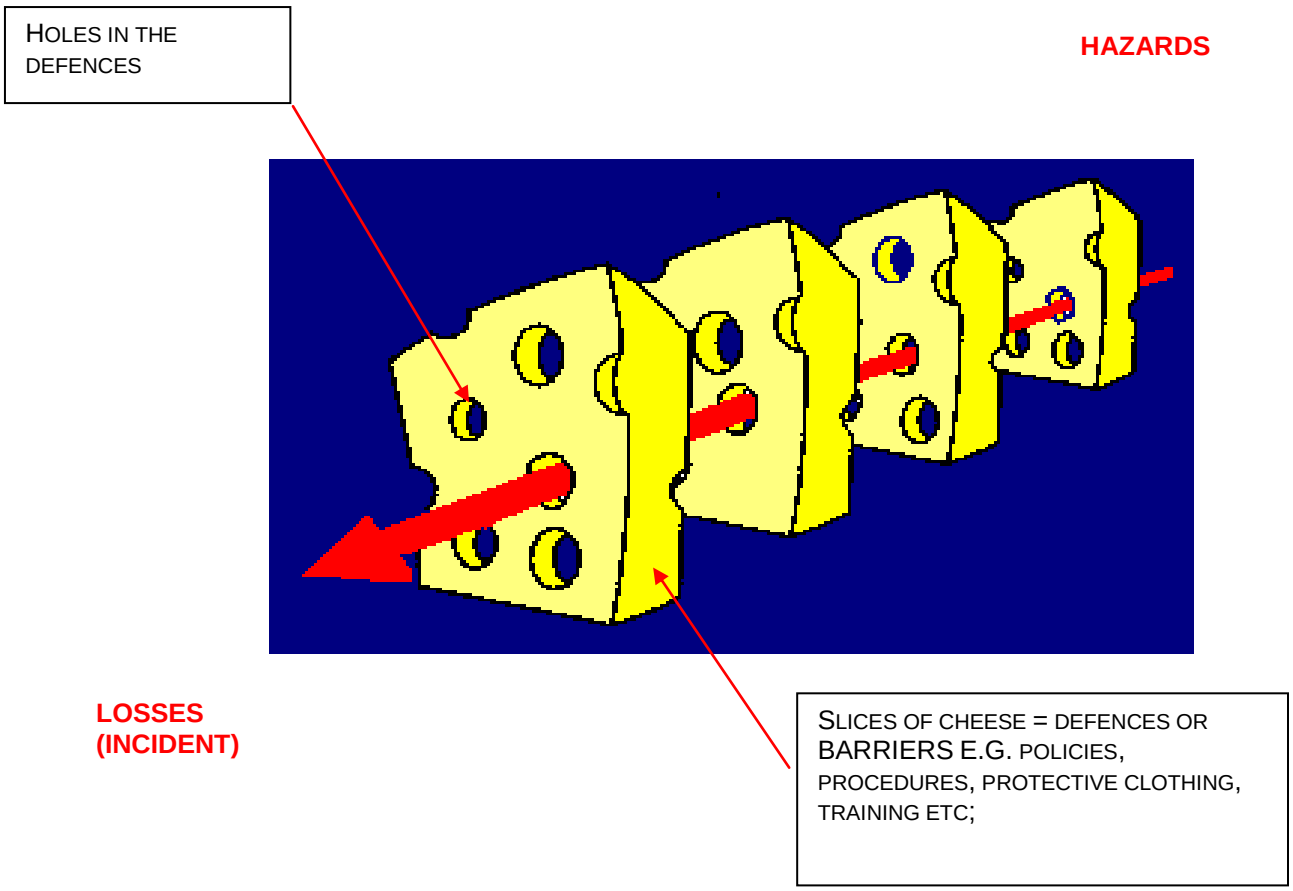
18. REFERENCES

- National Health Service Litigation Authority Risk Management Standards For
- Adverse Incident Reporting (AIR) Policy
- Risk Management Strategy Policy
- Complaints Policy and Procedure for Staff and Patients
- Trust Claims Management policy and Procedures
- Reducing error and influencing behaviour – HSG 48

APPENDIX 1

INCIDENT CAUSATION

The "Swiss Cheese" Model of Accident Causation



(based on Reason, 1997 in *An Organisation with A Memory*, 2000)

The slices of cheese represent barriers or controls that are in place when carrying out a task. For example, when carrying out maintenance work, the staff will have some controls in place: training, procedure to follow, someone to help, protective equipment etc.

The slices of cheese have holes in them, which represent holes in the defences/barriers i.e. breaches in the controls. These holes may occur as a result of inadequate training, an out-of-date procedure, lack of staff, protective equipment not worn, for example.

When, carrying out a task, if one barrier is breached, for example, the persons training was out of date, then, the fact that they followed the procedure correctly (another barrier) will prevent an incident (loss) from occurring.

However, **when all the controls are breached (shown in the diagram as all the holes lining up together) an incident occurs.** This diagram demonstrates that many components/breaches in controls occur for an incident to happen. It is these breaches that the Risk Management/Complaints/Claims will be exploring

A**PPENDIX 2**

INVESTIGATION INTERVIEW PROCESS

1. Welcome to meeting
2. Introduction
    - To the investigation team
    - The purpose of investigation
    - The purpose of the interview
3. Synopsis of incident
4. Questions by investigators
5. Questions from interviewee
6. Conclusion
    - Clarify key points raised at interview
    - Explanation regarding the process for verifying interview notes
7. Close meeting

APPENDIX 3

When identifying the root cause(s) of the incident, use the following methods

IDENTIFICATION OF THE CONTRIBUTORY FACTORS INVOLVED IN AN INCIDENT

The key part of the analysis is to identify the contributing factors lying behind each problem that you have identified. When doing this, it is useful to use the following factors as prompts:
Patient – clinical condition, social, physical, mental and psychological, interpersonal relationships
Individual – Physical, psychological, personality
Task – Guidelines and policies, decision-making aids, task design
Communications – Verbal, written, non-verbal
Team & Social – Role congruence, leadership, support and cultural factors
Education & Training – Education and training, appropriateness, supervision, availability
Equipment and Resources – Equipment and supplies, visual display, integrity, positioning, usability
Working Conditions – Administrative, design of physical equipment, staffing, time
Organisational & Strategic – Organisation structure, policy, standards and goals, externally imported risks, safety culture, priorities.

The use of these prompts ensures that you take a lateral view and that you don't forget any relevant areas that may have affected the problem.

THE 5 WHYS
This is another tool that you can use to identify the causes of each problem (although best used for simple/non-complex problems). Basically, the investigator has to ask 3, 5 or 7 "whys", until the questions cannot be answered further and this leaves you with a root cause, e.g.

Staff nurse gave Amoxicillin to a patient who was allergic to penicillin WHY?
She thought of penicillin as a specific drug, not a group of drugs WHY?
Not covered in IV training WHY?
Trainer thought it was unnecessary WHY?
She assumed staff already knew WHY?
Training was not competency based = ROOT CAUSE

These methods enable you to identify the root causes of the incident.

CONFIDENTIAL REPORT

FINAL REPORT

OF A SERIOUS INCIDENT REQUIRING INVESTIGATION (SIRI)

Prepared by:

…

Panel held on:

…

Incident Number: **STEIS Number:**	**CLINICALSERVICE LINE:**

Root Cause Analysis Investigation Report

Solent NHS Trust SIRI Summary Sheet	
SIRI Number	
Solent Incident Number	
Solent Service	
Category	
Level of investigation	
Criteria	
When was this SIRI discussed at the service line governance group?	
Has this been formally signed off by the Commissioning Manager?	
Has this report been agreed for closure by the Solent SIRI Panel?	
Has Duty of Candour been met with regard to this incident?	
Action Plan completion date	
Has this report been checked for Patient Identifiable Data?	
Staff present at the SIRI Panel:	

Contents	Page Number
Incident Description and Consequence	
Background and Context	
Terms of Reference	
Strategy panel membership	
Investigation Team	
SIRI panel membership	
Scope and Level of Investigation	
Investigations, type and methods used.	
Involvement and support of patient and relatives	
Chronology (timeline) of events	
Detection of the incident	
Conclusion	
Care and Service Delivery problems	
Contributory Factors	
Root Cause	
Lessons Learnt	
Recommendations	
Arrangements for Shared Learning	
Appendices	

Main Report

Incident Description and Consequence (concise incident description and outcome for patient, staff, service or organisation)	
Incident Date:	
Incident Type:	
Directorate (Service):	
Actual effect on patient:	
Actual severity of the incident:	

Risk Assessment		
A **Potential Severity** **(1-5)**	**B** **Likelihood of recurrence** **at that severity (1-5)**	**C** **Risk Rating** **(C = A x B)**

Background and Context (brief description and any contextual issues that may have an impact on the outcome)

Terms of Reference
Aim The aim of the investigation is to establish the facts of the case. This will include *what* happened (which will be documented using a tabular time line), to *whom, when* and *where.* Once the facts have been established the aim of the investigating team will be to establish the reasons *why* this incident occurred, including contributory factors and root causes. **Objectives** To establish whether failings occurred in care and/or treatment. To identify learning points and improvements rather than apportion blame. To establish how a recurrence may be effectively reduced or eliminated. To formulate realistic recommendation which address the root causes and learning points; to improve systems and services. **Outcome** To present the key findings in a report, as a record of the investigative process. To prepare an action plan for implementation of recommendations made. To provide a consistent means of sharing learning locally and nationally as appropriate. To ensure that provision is made for monitoring the action plans developed.

Strategy panel membership (Names will be removed when report is submitted to the CCG/SHA)	
Name	**Title**

Investigation Team (Names will be removed when report is submitted to the CCG/SHA)	
Name	**Title**

SIRI panel membership (Names will be removed when report is submitted to the CCG/SHA)	
Name	**Title**

Scope and Level of Investigation (Describe briefly what the investigation covered)

Investigation type, methods used (eg Root Cause analysis, medical records, staff interviews incident decision tree)

Involvement and support of patient and relatives (Duty of Candour, correspondence or meetings to discuss incident) (*Apology given* *Given information and offered opportunity to complain* *Informed of the investigation* *Arranged a meeting to discuss the report and its findings*)

Chronology (timeline) of events (A list of key events)	

Detection of the incident (How and/or when the incident came to light)

Conclusion (A discussion as to the outcome of the investigation and why the incident occurred. It must be evidentially linked to information in the report)

Care and Service Delivery problems (Care Delivery: relates to direct provision of care arising during the process of care – usually actions or omissions by members of staff. E.g. (1) care which deviated beyond safe practice (2) the deviation had at least potential direct or indirect effect on the adverse outcome for the patient, member of staff or 'general public'. Service Delivery: failures identified, which are associated with the way a service is delivered and the decisions, procedures and systems that are part of the whole process of service delivery.)	
Care Delivery problems	
Service Delivery problems	

Contributory Factors (Factors which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of Care or Service Delivery problems occurring. Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. Generally speaking, the removal of the influence may not always prevent or significantly reduce the chances of recurrence.)

Root Cause(s) (The prime reason(s) why the incident occurred; fundamental factors, removal of which will either prevent or reduce, the chances of a similar type of incident occurring in similar circumstances in the future. Root causes should be meaningful – not sound bites such as communication failure – and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient)

Lessons Learnt (Key safety and practice issues identified, which may not have contributed to this incident but from which others can learn)

Recommendations (Courses of action that are recommended to address the problems identified and analysed during the investigation. They must be directly linked to the root causes and lessons learnt and should be clear but not detailed – detail belongs in the action plan.)

Arrangements for Shared Learning (How lessons learned/changes in practice have been/will be shared locally/Trust-wide/with other organisations: by who and when by)

Author		
Name	**Title**	**Date**

Action Plan

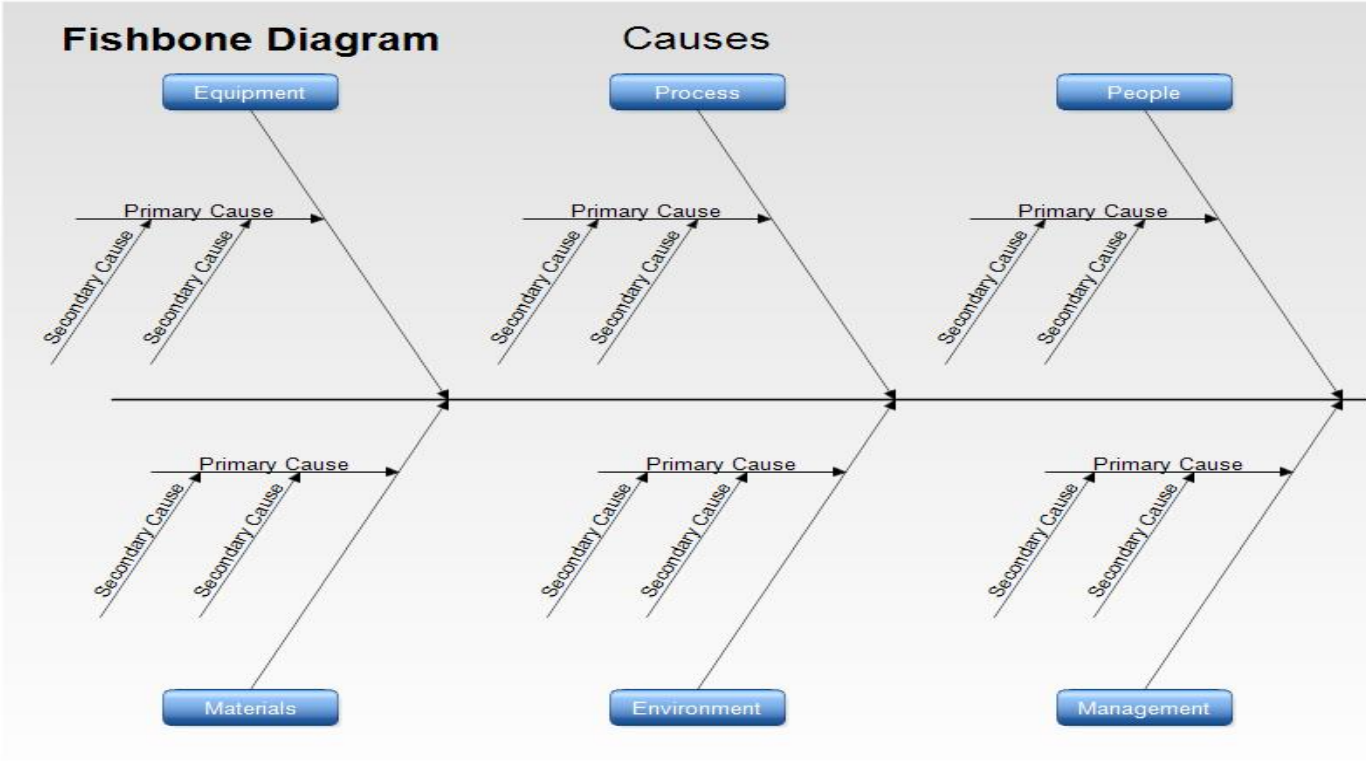
Organisation Name:		**Individual Completing Action Plan:**	
Service Line:		**Phone:** **Email Address:**	
Action Plan Title:	*(inc SIRI/HRI/Complaint ref)*		
Start Date:		**Finish Date**:	
The aim of this Action Plan is to:			
Evidence Base / Rationale for undertaking this Action:			
Audit requirements/links identified as: ***(ref to 'evidence of completion' column)***			

(G = in progress/completed; A = not yet started; R= Delay against timescale)

Issue 1	Action Required	Start Date	Finish Date	RAG	Action Owner	Outcome / Target	Evidence of Completion

Group signed off:	
Sustainability for this Action Plan:	
Action Plan completed:	

Example Fishbone Diagram



A cause and effect diagram, also known as an Ishikawa or "fishbone" diagram is a graphic tool used to explore and display the possible causes of a certain effect. In a typical Fishbone diagram, the effect is usually a problem needs to be resolved, and is placed at the "fish head". The causes of the effect are then laid out along the "bones", and classified into different types along the branches. Further causes can be laid out alongside further side branches.

A cause and effect diagram has a variety of benefits:

- It helps teams understand that there are many causes that contribute to an effect.
- It graphically displays the relationship of the causes to the effect and to each other.
- It helps to identify areas for improvement.

The main goal of the Fishbone diagram is to illustrate in a graphical way the relationship between a given outcome and all the factors that influence this outcome.

NPSA Root Cause Analysis Guidance:
http://www.msnpsa.nhs.uk/rcatoolkit/course/iindex.htm

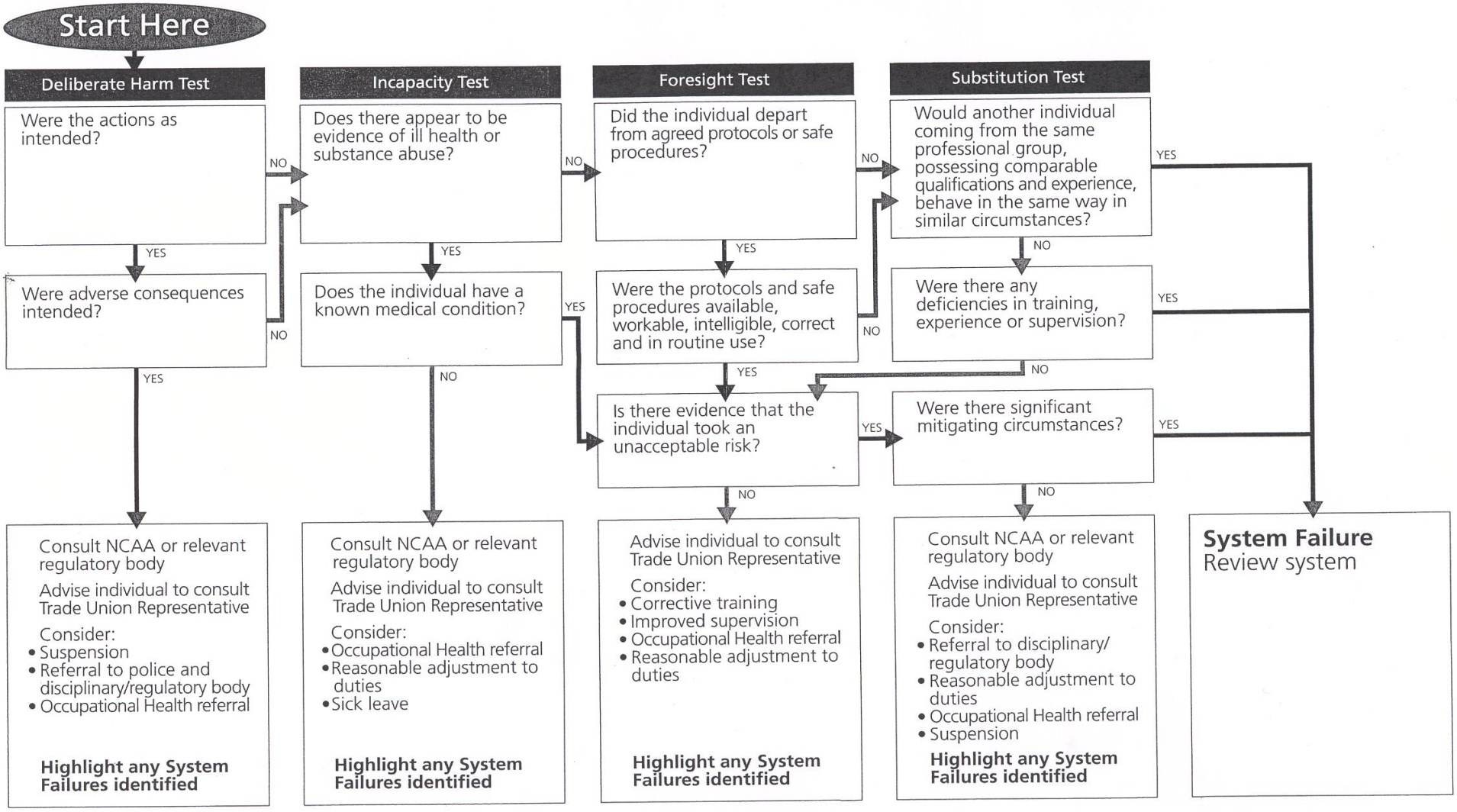
NPSA Root Cause Analysis (RCA) report-writing tools and templates:
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847
Including 'RCA investigation tools: guide to investigation report writing'

INCIDENT DECISION TREE*

Work through the tree separately for each individual involved

THE NHS CONFEDERATION

NHS National Patient Safety Agency



* Based on James Reason's Culpability Model

Appendix 6 - Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**
1. What are the main aims and objectives of the policy?	To enable all staff members to report an incident, accident or near miss, which affect the service, premises and property owned and occupied by the Trust and which may involve patients, staff and visitors, or other people who come into contact with the Trust's activities.
2. Who will be affected by it?	All Solent staff. Independent Contractors.
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Local targets Legal requirements Outcomes
4. What information do you already have on the equality impact of this policy?	
5. Are there demographic changes or trends locally to be considered?	No
6. What other information do you need?	None identified

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the policy unlawfully discriminate against any group?		✓	Information is in English only. This could mean exclusion of staff with communication difficulties. However this can be provided on request via Access to Communications.
2. Can any group benefit or be excluded?		✓	
3. Can any group be denied fair & equal access to or treatment as a result of this policy?		✓	
4. Can this actively promote good relations with and between different groups?		✓	
5. Have you carried out any consultation internally/externally with relevant individual groups?	✓		Please see routes of consultation and ratification process.
6. Have you used a variety of different methods of consultation/involvement		✓	Consultation within organisation. Please see above.
Mental Capacity Act implications			
7. Will this policy require a decision to be made by or about a service user? (Refer to the Mental Capacity Act policy for further information)	√		Possibly as part of the investigation process in order to interview a patient

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any modifications? Explain these?	

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the policy?	

Step 5 - Publishing the Results	**Answer**
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	