iD Medical

Incident Reporting Policy

Contents

Introduction

ID Medical Group Ltd aspires to deliver the highest standards of healthcare, to support NHS Trusts in achieving government's expectations on patient waiting lists, staff shortages and cost effective solutions.

As a private company, ID Medical's main objective is work in partnership with UK's biggest healthcare provider, the NHS.

When things go wrong, ID Medicals response will not constitute blame and retribution. It is our opinion that learnings are made from incidents such as these that allow us as a business to improve and build our service, whilst continuing their commitment to patient safety.

ID Medical encourages all colleagues and service users to raise their concerns, report mistakes and without fear and in line with our Whistleblowing Policy.

This policy is developed in line with Department of Health, National Patient Safety Agency Guidance, and Current NHS Policies. It is not intended to overwrite these policies or supersede current guidelines.

The policy is reviewed annually or wherever there is a need to adapt to the changing regulatory environment.

This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on our website, replacing the previous version.

Purpose and Scope

For the purposes of this document, two categories of incidents have been described:

1. Patient safety incident (PSI)
2. Non-patient incident

Additionally, the scope includes Good Care events.

The rationale for this is to distinguish and simplify the relevance of incident reporting for all staff.

This policy will outline the procedure for reporting PSIs and non-patient incidents at ID Medical and applies to reporting incidents from a patient safety aspect, coupled with those that may compromise staff safety concerns.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such

as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out ID Medicals approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

Definitions

Patient safety

The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum which refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment.

Patient Safety Incident (PSI)

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

Non-patient Incident

An incidents that occurs but does not involve a patient this include building issues, health and safety, data breaches, other information governance incidents and financial issues.

Near miss

An incident that did not reach the patient. It is an event not causing harm but has the potential to cause injury or ill health. Reviewing near misses can provide useful learning and areas for improvement.

Good Care Event

A Good Care event is a positive learning opportunity from care events that have gone well whilst delivering care to, and for patients.

After Action Reviews

An after action review is a structured approach for reflecting on the work of a group and identifying strengths, weaknesses and areas for improvement. The aim is to use this as a process to allow reflection and learning from the incident and so improve care. It is to be carried out after any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected.

Never events

Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The NHS Never Events Policy and Framework sets out the NHS policy on never events and this framework explains what they are and how staff providing NHS-funded services should identify, investigate and manage the response to them. It is relevant to all NHS-funded care.

Patient Safety Incident Investigations (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

Who is Responsible?

It is the responsibility of the individual who discovers an incident to ensure that those affected by the event are safe.

Once patient/person safety has been identified, then they will be immediately responsible for reporting the situation to their line manager/senior member of staff, completing the ID Medical incident form. A copy of the ID Medical Incident Report template is available on the internal shared drive.

The Line manager will be responsible for ensuring that the incident is fully reported in a timely manner. Once received, the line manager will have a duty to investigate the surrounding circumstances, escalating more serious reports to the Head of Quality as well as the Directors at ID Medical. Significant near misses, where moderate or greater harm has occurred or where it is suspected moderate or greater harm has occurred should be escalated by the line manager.

The Line manager has authority to take reasonable immediate actions to prevent recurrence of an adverse event, these will include but not limited to:

- Administering First-Aid (if necessary)
- Shutting down and quarantining any faulty equipment
- Report to line Manager
- Change the working practice to avoid re-occurrence

Unit 2, Mill Square, Featherstone Road, Wolverton Mill, Milton Keynes, England, MK12 5ZD.

- Complete incident report form

ID Medical Directors will have the responsibility to ensure that proportionate investigations to identify system factors and learning are undertaken and carried out in full and take action if and when requested/required. Where a significant incident is escalated, a meeting, as part of the performance and quality assurance with the Line Manager and Quality Manager, will be held to discuss the incident and agree a proportionate investigation response to minimise further risk. Significant incidents will be shared with the ICB for discussion and support on the most proportionate investigation pathway. ID Medical will work with the ICB and appropriate system partners for significant incidents involving multiple providers.

ID Medical has identified Our Responsible Officer, Prof. Fahed Youssef as being responsible for the risk management of services provided.

Investigations will be undertaken by ID Medical's case investigator – Rebecca Cumming and reviewed by the Head of Quality Sabina Grzeda-McArthur.

Once reported, all patient safety incidents and none patient incidents will be recorded on the internal Excel Worksheet. Any incidents will be recorded on Manage Engine portal for monitoring and reporting purposes. This will be done by the line manager/ case investigator. All incidents will be discussed routinely as part of the Clinical Governance Committee.

Duty of Candour

Following on from the Robert Francis report, the organisational and Professional Duty of Candour was introduced and imposed on all healthcare providers. This legislation is intended to ensure that all healthcare providers either NHS or Non-NHS are open, honest and transparent when things go wrong during a patients care. This statutory duty applies to the healthcare setting rather than individual based, however, individuals also have a duty to ensure that organisational obligations are met including reporting, assisting and managing.

Patients must be notified immediately or as soon as practically possible when a notifiable patient safety incident has been reported. A notifiable incident is something unexpected or unintended and result in moderate or greater harm including death. As an organisation, ID Medicals duty of candour means that our duty is to explain to a patient what went wrong, how it went wrong and the next steps being taken to prevent a similar incident from happening again. As a conscientious provider, ID Medical takes incidents extremely seriously and will ensure a formal apology is written and a written record of all patient correspondence is maintained including the patient initial notification.

ID Medical is responsible for ensuring that patients and/or families are kept fully up to date with the progress of an investigation and outcome in a timely manner.

ID Medical recognises that apologising when something goes wrong is not an admission of negligence or guilt; it is "the right thing to do".

ID Medical as an Institution has the responsibility to ensure high standards of patient safety and care is maintained by our workers who are also governed by their professional regulatory bodies.

ID Medical is accountable for ensuring it has the necessary systems in place for reporting, managing and maintaining & implementing effective solutions.

All incidents reported will be reviewed by ID Medicals Quality and Governance Team to review and ensure that health & Safety risk management issues are addressed and recommended improvements are implemented.

Reporting a Patient Safety Incident externally

When reporting a patient safety incident to an external body, i.e. Police, ICB, Social Services etc. ID Medical must at all times be kept informed to ensure full compliance with any further investigations.

Please see ***Appendix 1*** for external bodies whom may be contacted.

All reported incidents will be initially graded by the person responsible for reporting the incident in the first instance. The grading will be based on an initial judgement about the actual impact and are expected to grade the event accordingly. All levels of harm, should be reported even if no actual harm to the patient has occurred.

All incidents in relation to safeguarding must be reported immediately and appropriate actions undertaken and logged in line with the safeguarding policy.

As ID Medical works in partnership with NHS Trusts and NHS Integrated Care Boards, the NHS Risk Assessment levels will be used to make an initial judgement about actual impact.

Please see below and Appendix 2;

Term	Definition
No harm	Any patient safety incident that did not result in harm or injury or that had the potential to cause harm but was prevented, resulting in no harm (near miss)
Low harm	Any patient safety incident that required extra observation or minor treatment
Moderate harm	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm
Severe harm	Any patient safety incident that appears to have resulted in permanent harm.
Fatal	Any patient safety incident that directly resulted in death

There are national priorities for which a patient safety incident investigation must be undertaken, including Never Events and incidents meeting the learning from deaths criteria. Where an incident meeting the criteria for a PSII is reported, it must be declared as soon as the organisation becomes aware of the incident. A Patient Safety Incident Investigation report will need to be completed.

Initially these will be discussed between partners and managers although consideration must be made soonest as to the likely requirement that there will be a need to escalate to the local Integrated Care Board (ICB). All confirmed Patient Safety Incident Investigations need to be reported to the ICB within 5 working days. The service will also need to notify the CQC of any incident regarding patient harm or service delivery as soon as possible. See **Appendix 4** for the ICB escalation contact details.

All incidents which result in moderate, severe harm and death must be reviewed by a panel and investigated proportionately in line with a systems-based approach. The Head of Quality or Responsible Officer will inform ID Medical's Directors, Public Relations Manager and Solicitors as appropriate. They will also be responsible for advising on any external reporting requirements.

It is the responsibility of the patient's consultant to inform the GP of any major catastrophic event leading to patient harm.

A PSI involving one or more patients and likely to escalate to a significant legal, media or other interest must be reported to ID Medicals Director's immediately to ensure a hotline/helpdesk can be set up to assist in enquiries.

Timeframes

1. Patient safety learning responses start as soon as possible after the incident is identified.
2. Patient safety learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.
3. Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months.

Safeguarding Incidents

Any staff, patients or members of the public witness or suspect abuse have a duty of care to report it immediately in line with ID Medical's Safeguarding policy. Reporting of such incidents must be dealt with sensitively, accurately and timely.

Screening Incidents

Incidents involving screening of patients either locally or nationally must be discussed with ID Medical's Directors & Responsible Officer who are responsible for liaising with the Regional Quality Assurance Director in line with local and national guidelines.

Informing the Police

Any incidents that need reporting to the Police must be done by the person responsible and in charge of the department at the time of the event. Police must be informed if a death or injury to an employee, patient, visitor, contractor or member of public occurs and is deemed unusual or suspicious. Equipment involved in an incident of this nature will be isolated and left untouched until the police have visited.

Patient Safety Incident reporting internally

All staff are permitted to raise and complete a Patient Safety Incident report form. However, to enable learning and prevent similar repeat occurrences, it is requested that staff advise their line manager of their intention to complete a PSI report.

Patient and staff personal identifiable information is required when completing a report. However when sending the report to an external body this should be omitted and individuals should referred to as Patient A, Doctor A, Nurse A, etc.

There are a number of events and incidents that need to be recorded and/or reported and this includes the following:

- Patient safety incidents (PSI)
- Non-patient incidents including

The reporter must:

1. Ensure the immediate safety of those directly affected by the incident
2. Complete an on-line electronic incident form as soon as possible

3. Inform the appropriate senior member of staff / line manager

The senior colleague must:

1. Review the incident within 5 working days and confirm the grading
2. Complete details of investigation and any long-term actions necessary, on the electronic form and submit the incident for closure with the Head of Quality
3. Ensure feedback is provided to the reporter
4. Ensure an After Action Review is completed with the team

Root Cause Analysis & System Engineering Imitative for Patient Safety (SEIPS)

ID Medical views all complaints, concerns and incidents extremely seriously and is committed to learn from any shortcomings.

Learning from complaints and incidents is a priority whilst continual analysis is carried out by reviewing patterns and trends.

ID Medical has previously adopted the NHS Improvement RCA using the 'five whys' which will define, measure, analyse, improve and control the data that is given as feedback and the outcomes of which it delivers. Whilst we still use this approach we are moving towards System Engineering Imitative for Patient Safety (SEIPS).

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident. Healthcare is a socio-technical system because it is characterised by multiple interactions between various components, both human and technological.

ID Medical does not adopt nor endorse a blame culture and will support our workers with fair and effective management of concerns about behavioural patterns and will offer further training, guidance and develop professional development plans along with our Clinical Governance Team.

Internal Assurances

A Quality Assurance Report is submitted to the board monthly. The report is prepared by the governance and quality team to provide assurance to the board of directors regarding the effectiveness of the incident reporting system and processes within the organisation. This report aims to demonstrate that the organisation has a robust system in place to capture, analyse, and respond to incidents, promoting a culture of safety and continuous improvement. See **Appendix 3** for the 'Quality Assurance Report' template.

Engaging and involving patients, families and staff following a patient safety incident

At ID Medical we recognise the importance of engaging and involving patients, their families, and our staff following a patient safety incident. We believe that open and transparent communication, active collaboration, and shared decision-making are vital in fostering trust, learning from the incident, and promoting a culture of continuous improvement.

Following a patient safety incident, we are committed to the following principles of engagement and involvement:

Open and Timely Communication: We are dedicated to communicating openly and promptly with the patient and their family affected by the incident. We provide clear and empathetic explanations of what happened, the potential impact on the patient's care, and our commitment to addressing the situation. We encourage an environment where questions and concerns can be openly discussed and addressed.

Actively listening and Valuing Feedback: We value the perspectives and experiences of patients, families, and staff. We actively listen to their concerns, suggestions, and feedback regarding the incident and the overall patient safety practices within our organisation. We create avenues for individuals to share their experiences, both positive and negative, in order to learn and make meaningful improvements.

Providing Emotional Support: We recognise that patient safety incidents can be emotionally challenging for patients, families, and staff. We offer appropriate emotional support services and resources to help individuals cope with the emotional impact of the incident. This may include access to counselling services, support groups, or other means of assistance.

Shared Decision-Making: We believe in engaging patients, families, and staff in shared decision-making processes related to their ongoing care and any necessary actions following the incident. We encourage individuals to actively participate in discussions, ask questions, and collaborate with our healthcare team to develop an appropriate care plan moving forward.

Learning and Improvement Opportunities: We view patient safety incidents as opportunities for learning and improvement. We involve patients, families, and staff in the analysis of the incident, seeking their input on factors that contributed to the incident and potential preventive measures. We value their unique perspectives and insights in shaping our improvement initiatives.

Continuous Engagement: We maintain ongoing engagement with patients, families, and staff beyond the immediate aftermath of the incident. We provide updates on any actions taken as a result of the incident, share progress on improvement initiatives, and ensure that individuals remain informed and involved throughout the process.

By engaging and involving patients, families, and staff following a patient safety incident, we strive to create an environment of trust, compassion, and shared responsibility. Together, we can learn from the incident, implement necessary changes, and work collaboratively to enhance the safety and quality of care we provide to our patients.

Training and Education

We provide education and training to staff to enhance their understanding of patient safety principles and practices. We aim to empower individuals with knowledge and skills to actively participate in patient safety efforts and contribute to the prevention of future incidents.

Staff training is available on https://www.e-lfh.org.uk/ in Patient Safety. There are two modules available – these are general and not related to incident investigation but are related to safety culture.

Those completing PSII investigations should be trained to national standards.

Appendix 1 – Reporting to an External Body

Agency	Circumstance	Contact Details
MHRA/SHOT	Blood Transfusion reaction/error	https://www.gov.uk/report-problem-medicine-medical-device
Care Inspectorate	Recording Safeguarding Incidents	https://www.careinspectorate.com/index.php/news/5048-new-raising-concerns-in-the-workplace-guidance-for-employers-social-service-workers-and-social-work-students-published
Care Quality Commission	SIRIs related to breach of radiology regulations	http://www.cqc.org.uk/contact-us/report-concern/report-concern-if-you-are-member-public
Counter Fraud Agency	Actual or suspected Fraud	https://cfa.nhs.uk/

Health & Safety Executive	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995(RIDDOR)	http://www.hse.gov.uk/riddor/index.htm
Disclosure & Barring Service	Safeguarding. If you think an individual has engaged in relevant conduct, satisfied the Harm Test or received a caution or conviction for a relevant offence	https://www.gov.uk/government/collections/dbs-referrals-guidance--2
Information Commissioner	All level 3 information governance SIRIs	https://ico.org.uk/
Medicines and Healthcare Products Regulatory Agency (MHRA)	Suspected safety problems with medicines, medical devices, blood and blood components	https://www.gov.uk/report-problem-medicine-medical-device
Police	Death or injury where it is considered unusual or suspicious, Theft, malicious damage	Call 999 in an emergency or 101 for your local police force
Disclosure Scotland (PVG)	If you need to make a referral to Disclosure Scotland	https://www.mygov.scot/pvg-referrals/
General Medical Council	To Report a Doctor	https://www.gmc-uk.org/concerns
Nursing & Midwifery Council	To Report a Nurse	https://www.nmc.org.uk/concerns-nurses-midwives/
Health and Care Professionals Council	To Report a healthcare professional	http://www.hcpc-uk.org/complaints/raiseaconcern/

Appendix 2 – Assessing the Level of Risk

Score	1	2	3	4	5
Level	**None**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety: Physical/psychological harm	Minimal Injury needing no or minimal treatment No time off work Pressure damage	Minor Injury or illness needs minor intervention Less than 3 days off work Grade 1-2 grade	Moderate Injury needs professional intervention i.e. first aid 4-14 days off work Increase length of	Major injury – long term incapacity or disability More than 14 days off work Increase length of stay in hospital by 15 days	Incident leading to Death An event that impacts a large number of people Multiple permanent injuries or irreversible health effects

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	present at arrival	pressure damage on hospital	stay in hospital RIDDOR Reportable incident An event impacting a small no. patients Grade 3 Hospital Pressure Damage DUTY OF CANDOUR APPLIES	Mismanagement of patient care with long term effects Grade 4 Hospital Pressure Damage DUTY OF CANDOUR APPLIES	DUTY OF CANDOUR APPLIES
Security	Verbal Abuse Aggressive Gestures Disruption requiring security attendance but no intervention	Staff physical assault no injury Disruptive patient low level sedation Requiring Security attendance and intervention	Staff physical assault causing injury Disruptive Patient requiring restraint, full sedation Security/police Intervention for physical protection of others	Physical Assault causing significant injury Security Incident involving evacuation to another location i.e. bomb threat	Significant harm caused to multiple people including fatality Security incident resulting in multiple casualties/death
Quality/Complaints & Audit	Peripheral element of treatment or suboptimal of service Informal Complaint	Overall Treatment or suboptimal service Formal Complaint Stage 1 Local Resolution Single failure to meet	Significantly reduced effectiveness of treatment/service Formal Complaint Stage 2 Local resolution with potential to	Non-Compliance with national standards with significant risk to patient safety if unresolved Multiple complaints/independent review	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

		internal standards Minor implication for patient safety if unresolved Reduced performanc e rating if unresolved	be escalated Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Low performance rating Critical Report	
Adverse Publicity/ Reputatio n	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met	Local Media coverage – long term reduction in public confidence	National Media coverage less than 3 days service well below reasonable public expectation	National Media coverage of more than 3 days service well below reasonable public expectation, MP Concerned Total loss of public confidence
Service/B usiness interruptio n Environm ent impact	Loss/interr uption of more than an hour Minimal or no impact on the environme nt or service delivery	Loss/interru ption of more than 8 hours Minor impact on environmen t or service delivery	Loss/Interru ption of more than 1 day Moderate impact on environmen t or service delivery	Loss/Interrupti on of more than 1 week Major impact on environment or service delivery	Permanent Loss of core services or facility Catastrophic impact on environment or service delivery
Finance including claims	Small loss Risk of claim remote	Loss of 0.1 – 0.25 %t of budget Claim less than £10,000	Loss of 0.25-0.5 % of budget Claims between £10,000 and £100,000	Uncertain delivery of key objective/loss of 0.5 – 1 % of budget Claims between 100,000 and £1m Purchasers failing to pay on time	Non-delivery of key objective/loss of more than 1% of budget Failure to meet specification/slippag e Loss of contract/payment by results

					Claims of more than £1m
Statutory Duty/ Inspections/ Audit	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Human Resources/ Organisational/ Development/ Staffing/ Competence	Short term low staffing level that temporary reduces service quality (less than 1 day)	Low Staffing level that reduces the service quality	Late delivery of key objective/service due to lack of staff Unsafe Staff level or competence (more than 1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (more than 5 days) Loss of Key staff No Staff attending mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing level or competence Loss of severl key staff Reputation risk at national level (CQC)

Likelihood – choose one of the ratings below:

Score	Rating	Description
1	Rare	Do not believe this event will happen again except only in exceptional circumstances e.g. once a decade or a probability of less than 1%
2	Unlikely	Do not expect the event to happen again but it is a possibility e.g. once a year or a probability of 1-5%
3	Possible	The may re occur occasionally e.g. at least once a month, or a probability of 6-20%
4	Likely	The event will probably re occur at least once a week or a probability of 21-50%
5	Certain	The event is likely to re occur on many occasions e.g. at least once a day or probability of more than 50%. More likely to occur than not

Risk Assessment Matrix – this will produce the overall score

Likelihood	Consequence

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	Catastrophic 5	Major 4	Moderate 3	Minor 2	None 1
Certain 5	25	20	15	10	5
Likely 4	20	16	12	8	4
Possible 3	15	12	9	6	3
Unlikely 2	10	8	6	4	2
Rare 1	5	4	3	2	1

Key	Low Risk 1 - 3	Moderate Risk 4 - 6	High Risk 8 -12	Extreme Risk 15-25

Risk level and action required

Score	Risk Preventative Measures to be Taken or Planned
1-3	Low Risk – Manage by routine procedure, Implement any action that will eliminate the risk of the incident/risk occurring
4-6	Moderate Risk – Management action must be specified. The department manager must devise, agree and implement an action plan to reduce or eliminate the risk
8-12	High Risk – Senior Manager action needed. ID Medical Directors must be aware and the department manager must devise and implement an action plan to reduce, control or eliminate the risk. Risk must be inputted onto ID Medicals and Trust Risk Registers
15-25	Extreme Risk – Immediate action required. ID Medicals Directors and management team must be made aware and are responsible for ensuring an investigation and action plan is commenced immediately to reduce, control or eliminate the risk. The risk manager and Directorate must be made aware. The risk must be recorded onto the directorate and trust risk registers

Source of matrix: http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/

Once reported all, incidents will be recorded on our sophisticated reporting portal as well as the National Reporting and Learning System (NRLS) which can be accessed through the NHS England Portal https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/#healthcare

Appendix 3 - Quality Assurance Report Template

Quality Assurance and Escalations Report to the Board

Audit Report Number	Date Raised

Attendance/ Apologies
Matters arising from Clinical Governance Committee Meeting
Complaints
Incidents, Risks and Safeguarding

Compliments and Feedback
Patient Satisfaction
AOB

Audit Report Prepared By			
Report Prepared By	**Signature**	**Position**	**Date**
Report Reviewed By	**Signature**	**Position**	**Date**

Appendix 4 – ICB

Escalation Contact Details

NAME	EMAIL	MOBILE
Lauraine Jones (Commissioning Manager) Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board	lauraine.jones@nhs.net	07806798465
Kim Sloane – Contracts Manager Suffolk and North East Essex Integrated Care Board	kim.sloane@snee.nhs.ukmailto:Duncan.scott@snee.nhs.uk	01473770184