LINDSEY LODGE HOSPICE & HEALTHCARE

Risk Management Strategy Including Incident Reporting Policy and Procedure

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Risk Management Strategy including Reporting of Incidents and Near Misses

1.0 Introduction

As with any organisation, LLH carries a number of hazards/risks which, if not appropriately managed/controlled, have the potential to cause harm, loss or damage.

2.0 What is a Risk?

2.1 Risks are defined as 'hazards or exposure to potential danger to loss or harm'.

2.2 A good risk management system requires risk identification although, inevitably, many risks will be identified and appropriate action taken before risks inflict potential harm.

2.3 However, it is accepted that an element of risk management is reactive and that some risks will not be identified until something has gone wrong. An essential part of any **Risk Management Strategy** therefore is a system for identifying and reporting adverse incidents and other related occurrences.

2.4 This policy therefore sets out the approach LLH has in place for reporting adverse incidents. It is the responsibility of all staff to ensure that the principles set out below are consistently followed.

3.0 How does the Hospice manage or identify risks?

3.1 Incident Reporting Systems are a major tool in the way organisations manage risks; their purpose is to:

- ✓ Ensure that all incidents and near misses are reported, recorded and managed,
- ✓ Prevent the recurrence of preventable adverse clinical and non-clinical incidents,
- ✓ Provide 'early warning' of complaints/claims/adverse publicity,
- ✓ Ensure that sufficient information is obtained to meet internal and external reporting requirements (e.g. Care Quality Commission (CQC), Clinical Commissioning Group (CCG) and Health and Safety Executive), Charities Commission and Information Commissioners Office (ICO).
- ✓ Allow LLH to respond to complaints and potential litigation,
- ✓ Support trend analysis. This helps in the identification of risks and learning of lessons from these incidents.

4.0 What are the benefits of Incident Reporting?

4.1 If used effectively, the Incident Reporting System will:

- ✓ Enhance LLH ability to maintain good practice and improve quality of care,
- ✓ Enable LLH to learn lessons from mistakes made and take prompt action to prevent or minimise recurrence
- ✓ Protect patients, staff, contractors, volunteers and visitors through the provision of a safe environment

Assist in utilising LLH resources more effectively (i.e. reduces the amount of time/money being spent on complaints and litigation)

- ✓ Assist in identifying training, education and resource needs

- ✓ Provide 'early warning' of potential claims, complaints and/or adverse publicity to ensure that the Hospice is prepared for such occurrences

- ✓ Strengthen LLH position in the event of litigation

- ✓ Enable LLH to give early notification to the injured party and put in place the necessary corrective actions when incidents of harm have occurred.

5.0 Should I be worried if I report risks or incidents?

5.1 In any organisation, things will sometimes go wrong. When they do the response **should not** be one of blame but of learning in order to reduce risk for future patients and staff. Blame should not be attributed to any individuals.

5.2 The fear of disciplinary action and subsequent sanctions could deter staff from reporting incidents and therefore the Hospice's Incident Reporting System adopts a culture of 'fair blame' and will focus on '**what went wrong, not who went wrong'**.

Where errors have occurred, and are openly reported, an investigation into the facts may take place but disciplinary processes will not be instigated in respect of any member of staff except in the following well-defined circumstances:

- an incident in which the Hospice considers that a fundamental breach of professional practice has occurred, and/or an incident which might lead any professional registration body to review the individual's professional status

- further occurrences of actions involving an individual who has previously received counselling or been subject to disciplinary action related to the type of error that might have led to the incident

- where it appears that staff may have been guilty of a criminal offence or some act or omission which may result in formal action by a regulatory or professional body

- failure or significant delay in reporting an incident in which a member of staff was directly involved or about which they were aware

5.3 It should be noted that when any error occurs, if the member of staff is open in admitting to the error and reporting it to the appropriate individual a positive and supportive approach will be taken in order to address the root causes. However, it is also the case that when a member of staff decides to either delay reporting, or to attempt to conceal the error, the response to it is likely to be less favourable as this potentially prevents the Hospice from addressing the factors which caused the incident.

5.4 Guidance on raising concerns is also available by contacting the Senior Manager, Workforce Team at the Hospice.

6.0 What types of incidents may occur in Lindsey Lodge Hospice?

There are various definitions of incidents and it is important that staff are aware of how these incidents are categorised. This is to ensure that they follow the appropriate procedures and reporting processes.

6.1 'Near Miss' Incidents

6.1.1 If the incident did not result in harm, loss or damage, **but could have**, this is referred to as a 'Near Miss'. This may be clinical or non-clinical.

6.1.2 Near miss reporting is just as important in highlighting weaknesses in procedures and practices. If all near misses are reported this can help to prevent actual incidents of harm, loss or damage from occurring.

6.2 Adverse Incident (Clinical)

6.2.1 These are events which arise during clinical care of a patient that could, or did, lead to unintended harm.

6.3 Adverse Incident (Non-Clinical)

6.3.1 These are events that could, or did, cause harm, loss or damage to any individual or property for which LLH is responsible and which did not stem from the clinical care of patients.

6.4 Serious Untoward Incidents

6.4.1 These are defined as incidents which are likely to produce **significant** legal, media or other interest or give rise to large scale public concern which could result in significant loss of LLH reputation and/or assets.

6.4.2 In the event of a serious untoward incident occurring, staff must **immediately** report the incident to the Chief Executive or member of the Senior Management Team (SMT On-Call) in the absence of the Chief Executive. This applies even if the incident occurs out of hours.

6.5 'Never Events'

6.5.1 Adverse incidents involving patients are also known as 'Patient Safety Incidents' (PSIs). These are defined as 'any unintended or unexpected incident which could have, or did, lead to harm for patient(s)'.

6.5.2 'Never Events' are serious, largely preventable patient safety incidents that **should not** occur if the available preventative measures had been implemented.

6.5.3 All such incidents must be escalated as Serious Untoward Incidents. All 'Never Events' will be notified to the LLH Board of Trustees. The Board will also receive reports of any 'Never Events' incidents which occur and will monitor progress with the implementation of agree actions / changes in practice.

7.0 How do we keep track of common risks?

7.1 It is often the case that certain clinically related events can occur more than once and thus become a 'known litigation risk'. Where this is the case it is good practice to maintain 'trigger lists' of incidents which could be reported. These should be available to staff and displayed in team offices to raise the awareness of this particular type of risk.

7.2 It should be emphasised, however, that such lists will not be exhaustive. An element of judgement is, therefore, required as to whether an incident should be reported but where doubt exists the safest option will be to report the incident.

7.3 A list of potential clinical trigger points is listed in Appendix two.

8.0 How are incidents reported and investigated?

8.1 Unless the causes of adverse incidents are properly understood, lessons will not be learned and suitable improvements may not be made. However, not all incidents need to be investigated to the same extent or depth.

8.2 In the majority of instances, incidents will be minor or near miss and the cause of the incident will be clear. It is the responsibility of **the relevant senior manager or deputy** to ensure that the appropriate remedial action is taken to ensure, as far as possible, there is no recurrence. Trend analysis reports will be provided to the Quality Assurance subgroup of the Board in order to facilitate aggregate reporting and to enable LLH to learn lessons from incidents.

8.3 For other incidents and more serious incidents (actual and near miss) an appropriate level of investigation and root cause analysis will be required.

8.4 '**Root Cause Analysis**' is an investigation that aims to assist in the identification of the root or underlying causes of a particular event by determining **WHY** the failure occurred and the actions necessary to prevent or minimise the risk of recurrence.

8.5 Training for the relevant staff on investigation and root cause analysis will be provided as part of the Hospice's training programme.

9.0 What happens once the root causes of the risk are investigated?

9.1 A follow-up ('closing the loop') after each investigation is a key requirement of the incident reporting process. Corrective actions following on from incidents may be put into place.

9.2 As indicated above, in the majority of instances incidents will be minor or near miss and the appropriate remedial action can be taken at the time the incident occurs. However, following on from more serious incidents, an action plan will need to be prepared by the relevant manager in order to reduce the risk of recurrence.

9.3 Actions put in place will need to be monitored and reviewed to ensure they remain effective. At team level, monitoring of agreed action measures will be undertaken via the appropriate manager.

9.4 In order to finally 'close the loop' managers will share lessons learned arising from incidents with the staff involved and, where relevant, the wider organisation and external stakeholders. Within LLH lessons learned arising from incidents will be shared via the following routes:

- Staff/Team level meetings
- Staff Communication Books and Notice Boards
- Team talk/Chief Executive bulletin
- Team Leaders Meetings
- Senior Manager Team meetings
- Clinical Lead meetings

10.0 Where are risks reported and reviewed?

10.1 Lindsey Lodge Hospice has a Quality Assurance (QA) subgroup which comprises of the Chief Executive, Medical Director and Director of Clinical Services who take responsibility for clinical risk.

10.2 The Chief Executive takes responsibility for non-clinical corporate and financial risks. They also act as Senior Information Risk Officer (SIRO).

10.3 The Board has 4 four subgroups (QA, Workforce, ,Finance and Business Development) meeting regularly throughout the year and they are responsible for the oversight of the relevant Governance agenda including the Risk Register escalating issues to the Board as appropriate. The Board of Trustees are to be advised of any serious incidents and will take an overall responsibility for all HIGH RISKS.

10.4 LLH has a Health and Safety Committee which forms part of the SMT where risk management issues are escalated to QA through quarterly highlight report.

10.5 LLH Risk Register is categorised into various areas– which focus solely on risks to the safety and viability of clinical services provided within the Hospice - and non-clinical risks which focus on other, business critical, issues which could affect the Hospice.

10.6 Risks are assessed against the following risk matrix:

Likelihood	What is the probability of the risk arising?
Impact	What would be the impact of the risk should it occur?
Severity	What is the overall threat to the Hospice? *(a function of likelihood x impact)*

10.7 The Chief Executive is responsible for maintaining the risk register, the relevant subgroup is responsible for reviewing their appropriate risks and assuring the Board of Trustees that actions are in place to minimise the scale of the risk LLH faces.

11.0 **How do I report an incident?**

11.1 Incidents are input onto the Vantage system held on the Rainmeter/Systems/Vantage via google.

11.2 The Vantage system is used to record all incidents throughout Lindsey Lodge Hospice & Healthcare.

11.3 The Vantage system can be used to record complaints received verbal and written, also compliments received.

11.4 Each incident is firstly reviewed by appropriate SMT/Team Leader, Data Protection Officer and comments made on the database. The Chief Executive on final sign off will give further consideration to:

- Patient safety
- The reputation of the Hospice
- Operational impacts and practices
- Clinical significance
- Trends e.g. repeated incident, timings, people involved
- Regulatory and legislative requirements (CQC, HSE, DEFRA etc.)
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)
- Reporting to the Charity Commission
- Reporting to the ICO

Under the above legislation we are required to report the following:-

- A death or major injury due to an accident.
- An over three day injury that is when an employee has an accident at work and is unable to work for over three days, but does not have a major injury
- A work related disease
- A dangerous occurrence (this is when something happens that does not result in a reportable injury, but clearly could have done)

11.5 It is a regulatory requirement that **serious injuries** are reported to the Care Quality Commission and or Health and Safety Executive under RIDDOR depending on the nature of the incident. The Chief Executive or deputising Senior Manager is responsible for making the contact with RIDDOR.

The contact number for fatal/specified incidents is 0345 300 9923 (8.30 – 5pm)

11.6 Incidents should be reported to the Senior Manager/Team Leader straight away. If the relevant manager is not available the report is escalated to the Chief Executive or Senior Manager On-Call.

11.7 In the case of shops the incident will be reported to the Senior Manager- Retail by telephone within one working day and inputted straight onto the database.

11.8 The Senior Manager/Team Leader when receiving notification of the incident will complete a fact find. To ensure appropriate action has been taken. This may require additional notes or statements from staff/visitors to be requested if required.

11.9 The Chief Executive has an overall responsibility for reporting all non-clinical and clinical incidents to the Board, Health and Safety Executive the Charity Commission or the Care Quality Commission. The Chief Executive may choose to immediately escalate a risk to LLH Board Chairman where this is deemed necessary.

11.10 The Data Protection Officer has responsibility for reporting any Information Governance Breaches to the ICO within 72 hours.

12.0 What procedure should I follow?

12.1 The staff member (SM) involved/informed of the incident should complete the details onto the Vantage system on Rainmeter/Systems/Vantage, immediately following the incident. The Chief Executive should also be immediately alerted if a serious injury has occurred to any party or if the incident has an impact on the operational running of the Hospice.

12.2 SM obtains medical signature if required. (?)

12.3 If the incident occurs out of office hours, SM informs the Nurse in Charge of the Hospice and if felt support is required informs the Chief Executive (out of hours contact numbers are available in each clinical area)

12.4 Senior Manager/Team Leader investigates incident with staff involving others as appropriate.

12.5 Senior Manager/Team Leader informs DPO of any information governance incident.

12.6 Senior Manager/Team Leader then makes comments on the Vantage System within five working days. The Chief Executive will instigate a further investigation if required.

12.7 The Chief Executive reports incidents to the relevant subgroup of the Board, the Board, Health and Safety Executive, the Charity Commission Care Quality Commission as required.

12.8 All clinical incidences are reviewed at Clinical Leads and reported quarterly to the QA sub-committee.

13.0 How are risks managed within the Hospice?

13.1 Whilst the reporting of incidents is a vital part of good governance it is essential that this process is embedded within an overarching Risk Management Strategy.

13.2 It should be acknowledged that new risks can emerge as service provision develops and it would be inappropriate for these to be identified only after they have resulted in an incident. Risk identification needs to be on-going and proactive rather than reactive once an incident has occurred.

13.3 Other than incident reporting the following activities form of total risk control:

- direct and indirect patient care
- infection control
- quality management
- health and safety
- fire safety
- water systems
- moving and handling
- waste management
- security
- contingency and emergency planning
- corporate governance including sound financial, and human resource, management
- preventative maintenance
- management of contractors
- information governance
- managing concerns/complaints

Successful risk management at Lindsey Lodge Hospice & Healthcare is based on:

- identifying risk in all areas of work
- managing the risk
- involving and training all staff
- incident reporting procedure forms part of the Induction procedure and training
- encouraging an open, objective culture for incident reporting and identifying risks
- directing controls at the causes of accidents, incidents and hazardous situations

13.4 Risk Assessment should be carried out whenever there has been a change in the physical environment or working practice.

13.5 LLH will maintain a risk register which will record all risks which have been identified as part of the total risk control process. The individual risks held on the register subject to a risk assessment in order to categorise the potential scale and impact of the risk in order to determine the measures needed to control and, if possible, eliminate this. The register will be subject to regular review by the relevant subgroup of the Board.

13.6 The mechanisms which will be deployed in order to control the risk once it has been identified and registered are as follows:

RISK CONTROL MECHANISMS	
Avoid	to understand whether a activities can be undertaken in a different way so that the risk does not occur
Reduce	to assess whether actions can be taken to reduce the impact and/or the probability of the risk occurring
Eliminate	to review whether actions can be taken to eliminate the Hospice's exposure to the risk
Transfer	to assess whether a particular risk which cannot be avoided or eliminated can be transferred – the most common form of this is via insurance
Accept	if, after the above mechanisms, the residual risk is unable to eliminated then it needs to be registered for ongoing review

13.7 Lessons learned from incidents and accidents will be shared in an open forum to try to ensure that the same event does not happen again. LLH policies are accessible to all staff and are reviewed appropriately and at least three yearly.

14.0 How do we review the effectiveness of services?

14.1 Audits offers staff a systematic way of looking at their practice and making improvements.

14.2 Audit can:

- Identify and promote good practice
- Provide information about the effectiveness of a service
- Highlights problems and helps with solutions
- Improves team working and communication

14.3 Clinical audit is a systematic process of looking at your practice and asking:

- What should we be doing?
- Are we doing it?
- If not, how can we improve?

14.4 As a result of an audit, stakeholders may effectively evaluate and improve the effectiveness of risk management, control, and the governance process over the subject matter

14.5 Audits must be carried out with appropriate consent from any patients and carers involved.

14.6 LLH has an annual audit calendar, in order that there is clarity on the type of audit (i.e. clinical/non clinical), who is leading and when it is required to be undertaken.

14.7 The Audit calendar and Audit results must be taken to the Quality Assurance group for agreement and oversight. Action plans will be endorsed by the QA group and should be monitored until completion, so that it is clear that the audit cycle is complete.

Appendix One - Vantage - Guidance Notes for Staff

The following incidents constitute a '**serious incident'** (NPSA 2010)

- ✓ Unexpected or avoidable death of patients, staff, visitor or members of the public
- ✓ Serious harm, e.g. fracture, burns, loss of sight, loss of limb, laceration
- ✓ A scenario that prevents LLH's ability to deliver health care e.g. actual or potential loss of personal/organisation information, damage to property, reputation or IT failure
- ✓ Allegations of abuse
- ✓ Adverse media coverage
- ✓ Never events (as relevant to LLH)

Notes for the completion of Incidents on the database

If an incident involves more than one person, please indicate this on the database and ensure all parties complete comments.

Patient Incidents
If an incident involves a patient then the following information is required:

- When was the patient last seen? And by whom?
- Any contributing factors (medication, confused patient)?
- Did anyone witness the incident? And who were they?
- Did the patient sustain any injuries?
- What is the medical opinion?
- How was the incident dealt with?
- How was the patient put back to bed in the case of a fall?
- What moving and handling equipment was required?
- Additional information should include a plan of how future incidents may be avoided or factors such as the use of bed rails, height of bed, pressure mats.

Additions to the original text require a signature and date. Alterations should be clearly initialled. Words or sentences that need to be removed from the text for any reason should be crossed out by using only one diagonal stroke of the pen and then clearly initialled.

Staff Member/Volunteer Incidents

- If a staff member or volunteer is injured
- Did they continue to the end of the shift?
- If staff member is off sick following the incident, did they visit their GP?

Other Incidents

In the case of burglary, theft, injury to customers or visitors, the Insurers may need to be informed. Staff should report these incidents to the Nurse in Charge of LLH, or a Senior Manager/Team Leader or a member of the Senior Manager Team as soon as possible.

Appendix Two – Generic list of clinical trigger points that can be considered if staff are unsure of reporting as an incident

- Failure/delay in referring/admitting to hospital
- Failure/delay in diagnosis
- Incorrect diagnosis
- Consent Issues (e.g. failure to warn, performance of unplanned, unconsented treatment)
- Treatment delays
- Incorrect treatment
- Failure to recognise complication of treatment
- Falls Pressures sores
- Allergic reaction
- Service disruptions
- Staffing shortages
- Failure of follow-up arrangements
- Failure to act on abnormal test results
- Medication Errors
- Infusion problems
- Medical records problems
- Discharge Issues
- Infection Control Issues (e.g. MRSA)
- Lack of adequate facilities/equipment/resources
- Equipment malfunction
- Transfusion problems
- Unexpected re-admission to hospital
- Unexpected death
-Safeguarding issues

Appendix Three - External Agencies and their remit

National Patient Safety Agency (NPSA)

On 1 June 2012, the key functions of the NPSA were transferred to **the NHS Commissioning Board Special Health Authority**, later known as NHS England. The Hospice is required to report all 'patient safety' incidents to the NPSA. The information submitted to the NPSA contains no staff or patients identifiers. The NPSA in turn will process reports and pass on relevant information to the CQC.

It should be noted that staff can also report incidents directly to the NPSA, (although they will be encouraged by the NPSA to ensure that their local health provider are also made aware of the incident in order to ensure that lessons can be learnt and action can be taken local to prevent recurrence).

Reports received from the NPSA are routinely offered to the Hospice Chief Executive and Senior Clinical Managers for review and consideration of actions required.

Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA is the Executive Agency of the Department of Health responsible for protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely.

The Hospice is required to report to the MHRA, any adverse incident involving a medical device, especially if the incident has led to or, were it to occur again, could lead to death or serious injury, medical or surgical intervention, hospitalisation or unreliable test results.

It is the responsibility of all staff that uses medical devices to report such incidents to the MHRA. Where incidents are reported to the MHRA, a copy of the MHRA report form should also be sent to Chief Executive. Where doubt exists as to whether incidents should be reported to the MHRA, advice can be sought from Senior Clinical Managers or the Chief Executive.

Other minor safety or quality problems should also be reported as these can help demonstrate trends or highlight inadequate manufacturing or supply systems. All adverse incidents should be reported to the MHRA as soon as possible. Serious cases should be reported by the fastest means possible. Initial incident reports should contain as much relevant details as is immediately available, but should not be delayed for the sake of gathering additional information.

Any medical device involved in an incident needs to be taken out of use, quarantined and retained for inspection. It should not be repaired, returned to the manufacturer, or discarded until the MHRA has been given the opportunity to carry out its own investigation. The MHRA will advise when and if it is necessary to submit a device for examination. If responding to such a request, you must ensure that the device has been appropriately decontaminated, securely packaged and clearly labelled (including the MHRA reference number).

Medicines

Doctors, pharmacists or nurses can report suspected adverse drug reactions by completing the **suspected adverse drug reactions** form. This is a yellow coloured form which can be found in the back of the current edition of the British National Formulary. The form also includes the address to forward the report to the Medicines & Healthcare Products Regulatory Agency (MHRA). More detailed information on reporting and a list of drugs/products currently under intensive monitoring can be found on the CSM homepage: (www.open.gov.uk/mea/mcahome.htm).

Defective Medicinal Products

This is defined as:

- proves to be harmful under normal conditions of use;
- lacking in therapeutic efficacy;
- the qualitative and quantitative compositions of the product is not as declared;
- the controls on the medicinal products and/or on the ingredients and the
- controls at the intermediate stage of the manufacturing process have not been carried out, or if some other requirement or obligation relating to the grant of the manufacture authorisations has not been filled.

If a healthcare professional observes:

- a clinical symptom(s)
- or a patient event, which indicates that a defective medicinal product has been used or that a defective product might be the explanation of this observation; or who may recognise that a medicinal product may be defective prior to use should contact a member of the Lloyds pharmacy team (who holds the Hospices current provider contract) immediately for further advice. The pharmacist should refer to a **Guide to Defective Medicinal Products** for guidance on how to proceed.

Care Quality Commission (CQC)

The Hospice has a statutory duty to notify the CQC in writing, usually without delay, about certain important events that affect people who user their services or the service itself. This will include notification of the following incidents:

- Certain deaths of people using the service
- Any abuse of allegation of abuse
- Events that stop or may stop the service from running safely and properly
- Serious injuries to people who use the service
- Deaths and unauthorised absences of people who use the service who are
- detained or liable to be detained under the Mental Health Act 1983
- Applications to deprive a person of their liberty under the Mental Capacity Act 2005, and their outcomes

Depending on the circumstances and severity of the incident, other external stakeholders may need to be notified, and in some instances involved in the investigation, of incidents which occur.
(This is a decision which would normally be taken by the Chief Executive or Registered Manager as part of the response to the incident.)

The Charity Commission

The Charity Commission requires charities to report serious incidents. If a serious incident takes place within our charity, it is important that there is prompt, full and frank disclosure to the Commission. We are required to report what has happened and, importantly, let the Commission know we are dealing with it, even if we have also reported it to the police, donors or another regulator.https://www.gov.uk/guidance/how-to-report-a-serious-incident-in-your-charity-
This guidance helps charity trustees identify serious incidents. It also explains how to report them and what to report.

What the charity commission classes as a serious incident?

A serious incident is an adverse event, whether actual or alleged, which results in or risks significant:

- harm to your charity's beneficiaries, staff, volunteers or others who come into contact with your charity through its work (who are collectively referred to throughout this guidance as people who come into contact with your charity through its work)
- loss of your charity's money or assets
- damage to your charity's property
- harm to your charity's work or reputation

For the purposes of this guidance, "significant" means significant in the context of your charity, taking account of its staff, operations, finances and/or reputation.

Information Commissioners Office

Following amendments to the Data Protection Act, wwhen a personal data breach has occurred, the likelihood and severity of the resulting risk to people's rights and freedoms needs to be accessed. This will be completed by the Data Protection Officer or Caldicott Guardian who will assess the risk of recurrence and the consequence grading, if applicable.

If it's likely that there will be a risk then the data protection officer must notify the ICO within 72 hours of being identified; if it's unlikely then you need to record on Vantage system with decision. However, if you decide you don't need to report the breach, you need to be able to justify this decision. This will be completed by the Data Protection Officer.

There is further guidance on the ICO website on how to report a breach
https://ico.org.uk/for-organisations/report-a-breach/personal-data-breach/
Also, further information can be found in the Data Security Breach Management Policy

REFERENCES:				
Author of Policy Karen Griffiths RATIFICATION DATE BY TRUSTEES (QA) 13th April 2017 Review interval 2 years				
To Be reviewed	Review completed	By	Approved By	Circulation
April 2019	March 2019	Karen Griffiths Chief Executive	QA Committee	L: Policies, Procedures & Guidelines
April 2021	February 2022	Kay Fowler		
February 2024				