SOUTH CENTRAL AMBULANCE SERVICE
NHS FOUNDATION TRUST

CORPORATE POLICY AND PROCEDURE No. 4

ADVERSE INCIDENT REPORTING & INVESTIGATION POLICY

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<td><strong>Author:</strong> Deirdre Thompson, Director of Patient Care</td>
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SOUTH CENTRAL AMBULANCE
NHS FOUNDATION TRUST

ADVERSE INCIDENT REPORTING & INVESTIGATION POLICY

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<th>Type of Change</th>
<th>Date</th>
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</tr>
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| V.6        | Annual review    | Jul 2012  | - Addition of Amendment Log  
- Changes to reflect Foundation Trust status  
- Changes to job titles following Clinical/Operational restructure  
- Healthcare Commission replaced with Care Quality Commission  
- CFSMS replaced with NHS Protect  
- SUI replaced with Serious Incident Requiring Investigation (SIRI)  
- Removal of SIRI procedure (stand alone SIRI Policy has been produced)  
- Amendment to IR1 Form (Appendix 1)  
- Amendment to IR1 Procedure (Appendix 2)  
- Amendment to Easy Guide (Appendix 3) |
| V.7        | Annual review    | Jul 2013  | - Replaced SHA with NHS England CCG  
- All references to IR1 to include DATIX reporting system (IR1 to remain as backup in extremis)  
- Addition to Appendix I of DATIX reporting and Dif 1 completion Guide  
- Replace reference to Sentinel with DATIX |
SOUTH CENTRAL AMBULANCE SERVICE
NHS FOUNDATION TRUST

ADVERSE INCIDENT REPORTING & INVESTIGATION POLICY

1.0 POLICY STATEMENT

1.1 South Central Ambulance Service NHS Foundation Trust recognises its statutory, civil, moral and financial responsibility to manage risk. The Trust Board is committed to providing robust risk management strategies and procedures in order to safeguard the organisation, its employees, patients and others who may be affected by its activities.

1.2 The Trust supports the principles of fair blame and promotes a culture where incidents (including complaints and claims) can be reported and investigated in a non-punitive and supportive environment to ensure that investigations identify whether the actions of individuals were due to systems failures or whether the individual knowingly committed a reckless intentional unsafe or criminal act. The Trust will encourage the use of the National Patient Safety Agency's 'Incident Decision Tree' (IDT) to promote fair and consistent staff treatment. This is a web based tool developed to help managers decide whether they need to suspend (exclude) staff involved in a serious incident or not pending the outcome of the investigation of the adverse event. Disciplinary action will only be taken against an individual(s) where there is a reasonable belief that intent to cause harm, negligence or reckless behaviour existed.

1.3 The Trust requires that all adverse incidents, near misses or hazards be reported and that this reporting is completed via electronic DATIX reporting tool via SCAS Intranet services or backup manual IR1 reporting process as part of a proactive approach to risk management. This policy details the action to be taken, which applies equally to both clinical and non-clinical incidents.

1.4 Where adverse incidents are reported they will be investigated and all reasonable steps taken to implement control measures which will either remove or reduce the level of risk to an acceptable level. The Trust will aim to respond quickly and positively to all risk issues in order to mitigate their consequences in the best interests of the organisation, patients and staff.

1.5 The Trust will ensure that all policies and procedures relating to risk management (including safe working practices) are made widely available to all staff and will ensure that all employees are suitably informed and trained in the Trust procedures for the reporting and management of risk.

1.6 This Policy will be reviewed by the Board annually and should be read in conjunction with the Trusts Risk Management Strategy which sets out:

- The Trust’s definition of Risk & Risk Management
- Organisational structures and accountability for the management of risk
- Committee Structure for the management of risk
- Strategic Aims and Objectives for the management of risk
1.7 This policy will provide guidance to managers and staff on adverse incident reporting, investigations, Being Open, analysis and improvements and supporting staff through incidents, claims and complaints.

2. DEFINITIONS

2.1 An ‘adverse incident’ is any occurrence or set of circumstances, which has the potential or does result in loss, damage, injury or unwanted effect, to the organisation or any individual including staff, patients, customers or members of the public. Such “incidents” may be clinical or non-clinical in nature and include such examples as, an adverse reaction in a patient following treatment, failure of medical equipment, breach in security, theft or property damage, fire, major failure in plant or machinery, all injuries sustained by a member of staff, patient or third party to whom the Trust owed a duty of care.

2.3 A ‘hazard’ is anything that has the potential to cause harm, injury, loss or damage.

2.4 A ‘risk’ is anything that poses a threat to the achievement of our objectives, programmes or service delivery. This may include damage to the reputation of the Trust which could undermine the public’s confidence in us. It is measured by the potential impact or consequence of the risk occurring and the likelihood or frequency of such occurrence.

2.5 A ‘near miss’ is defined as any accident or adverse event which did not occur but had the potential to prevent the Trust from delivering on its objectives, notwithstanding the fact that no adverse consequences occurred from the specific incident.

2.6 A ‘medical device’ is any instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for human beings for the purpose of: diagnosis, prevention, monitoring, treatment or alleviation of disease.

2.7 ‘Immediate Cause’ is defined as the factor(s) which triggered the actual incident.

2.8 ‘Contributory Cause’ is defined as the circumstance(s) which contributed to the occurrence or incident, which by itself would not have caused the incident to arise.

2.9 ‘Root Cause’ is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent or minimise the likelihood of recurrence.

2.10 Other definitions from the Risk Management Strategy

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>The process by which hazards are identified and the risk rated using tools implemented by the Trust for use by all employees. Assessments can either be general or specific, but will be undertaken by competent persons who have received the appropriate degree of information, instruction and training.</th>
</tr>
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<tr>
<td>Risk Management</td>
<td>The identification, quantification, control, mitigation, review and audit of any risk that threatens the services delivered or assets of the Trust. This shall include such diverse aspects as health &amp; safety, clinical care &amp; patient experience, property, vehicles &amp; equipment and relationships with stakeholders.</td>
</tr>
<tr>
<td>Risk Matrix</td>
<td>The tool that is used to “score” each risk and determine its place on the Risk Register, levels of authority are determined through the matrix and this will provide a priority list for managers to use within their respective area of control.</td>
</tr>
<tr>
<td>Corporate Risk Register</td>
<td>The register is the recording tool for identified risks and will be held centrally, maintained by the Director of Patient Care. The register will also record risk identified through the Assurance Framework.</td>
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</tr>
<tr>
<td>Health &amp; Safety Risk Register</td>
<td>The register is the recording tool for risks identified and will be held centrally, maintained by the Head of Risk &amp; Security. The register will be monitored by the Health, Safety and Risk Group and issues escalated for inclusion on the Corporate Risk Register as appropriate.</td>
</tr>
<tr>
<td>Acceptable Risk</td>
<td>The Trust Board accepts that no system can be totally risk free and that there are occasions when the Trust will have to accept a degree of risk in the course of its undertakings. Work practices, procedures and equipment will be assessed so as to identify the significant hazards and risks and ensure that controls are implemented to eliminate or reduce the risks to the lowest reasonably practicable level.</td>
</tr>
<tr>
<td>Organisational Risk</td>
<td>Any potential threat or occurrence that could prevent the Trust from delivering its aims, achieving its objectives or developing projects to improve its services within the economic, human, environmental and technological boundaries.</td>
</tr>
<tr>
<td>Clinical Risk</td>
<td>Any potential threat or occurrence related to the diagnosis, treatment and/or outcome of patient care where the likelihood is that the identified hazard causes harm or distress to the patient.</td>
</tr>
<tr>
<td>Financial Risk</td>
<td>Any potential threat or occurrence that could prevent the Trust from effectively managing its finances, meeting its statutory financial duties and operating within the appropriate control systems.</td>
</tr>
<tr>
<td>Information Risk</td>
<td>Any potential threat or occurrence that could prevent the Trust from effectively processing information relating to corporate services or directly relating to Patients or Staff.</td>
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| Board Assurance Framework | From 2001/2002 all NHS Chief Executives have been required to sign a Statement on Internal Control (SIC), which forms part of the statutory accounts and annual report. To provide this Statement, Boards need to be able to demonstrate that they have been properly informed through assurances about the totality of their risks, not just financial, and have arrived at their conclusions based on all the evidence presented to them. 

*The Board need to be confident that the systems, policies and people it has in place are operating in a way that is effective, is focused on key risks and is driving the delivery of objectives. Through the consideration of a formal organisational assurance framework the Board will have full awareness of the strategic risks facing the organisation.* |

### 3.0 DUTIES

3.1 The **Chief Executive** has overall responsibility for having effective and safe systems in place for risk management within the Trust and for meeting all statutory requirements and adhering to guidelines issued by the Department of Health and the Health and Safety Executive (HSE) etc.

3.2 The **Board** is will receive assurances that there are safe systems in place for risk management. They will receive:

- minutes of the Quality and Safety Committee
- all risk assessments categorised as ‘Red’ (high scoring risks)
- monthly reports from the Director of Patient Care and other Directors
• assurance reports provided by external bodies such as the Care Quality Commission, NHS Protect and the NHS Litigation Authority (NHSLA) etc.
• monthly Key Result Areas and Key Performance Indicators reports.

3.3 The Director of Patient Care has delegated responsibility for ensuring that there are safe systems in place for risk management and incident reporting.

The Director of Patient Care responsibilities include:

• Coordinating and ensuring the implementation and continued development of the risk management process throughout the Trust
• Communicating the Trust’s commitment to the Adverse Incident and Investigation Policy throughout the organisation
• Identifying & interpreting new legislation and Government guidance in relation to risk
• Advising the Chief Executive, Directors and Board on matters of risk management
• Coordinating and obtaining assurances from each of the Executive Directors in relation to risks within their directorate
• Receiving and monitoring risk, adverse incident, claims and complaints reports, identifying trends and producing statistical data for the Trust Board
• Acting as the Trust's designated Board and Executive Level Lead for Risk
• Acting as the designated Executive lead for Security Management.

3.4 The Executive Directors have delegated responsibility for the Adverse Incident Reporting & Investigation Policy and will be responsible for ensuring that the policy is adopted in their respective area.

Responsibilities of the Executive Directors will include:

• championing the risk management policy implementation process within their respective directorates
• in conjunction with the Risk Department and Director of Patient Care, ensure that the Trust’s key risks relating to adverse incident, claims and complaints are identified and addressed
• raise staff awareness of the Adverse Incident Reporting & Investigation Policy
• provide the Trust Board with assurance that risk is managed within their directorates.

3.5 Managers are responsible for implementing and monitoring the Adverse Incident Reporting & Investigation Policy within their designated areas and scope of responsibility. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, managers are responsible for bringing these risks to the attention of the appropriate Risk Manager. They should also report the issue via the on-line electronic DATIX reporting tool or in extremis the Trusts Adverse Incident Report Form (IR1).

All Managers and Supervisors have a responsibility to undertake risk assessments as required, to supervise activities within their area of responsibility to ensure that policies and procedures are properly applied and that areas of risks are adequately controlled. In the event that a member of staff identifies a risk or issue to them, they will investigate and implement appropriate control measures to minimise that risk. Where the required action is outside or beyond their area or level or authority they will document their actions and recommendations before passing the matter to the next level of management for attention.

Trust Managers and Supervisors will:

• fully support and implement the Adverse Incident Reporting & Investigation Policy within their directorates
• ensure that their department as a whole is effective and efficient in the management of Adverse Incident Reporting & Investigation
• ensure that the Adverse Incident Reporting & Investigation Policy is followed by carrying out investigations and risk assessments and monitor the outcome
• ensure they follow the principles of this policy in an open and transparent manner and support staff through any adverse incident, claim, complaints or court hearing process.

3.6 **Company Secretary** will work closely with the Chairman, Chief Executive and other Executive Directors to co-ordinate the Trust Board and other relevant committees’ agendas. This will ensure that the Trust meets all legal, corporate and mandatory obligations. The Corporate Secretary will also co-ordinate all claims received by the Trust and work with the Assistant Director of Quality to review and process the claims and provide regular reports on claims to the Quality and Safety Committee.

3.7 **Assistant Director of Quality** will be responsible to the Director of Patient Care for the development of effective Trust wide policies and procedures. Specific responsibilities will include monitoring all areas of risk management performance, maintaining and developing the Trust’s Risk Register and risk databases, providing reports to the Quality and Safety Committee and Strategic Health, Safety and Risk Group on incident reporting, SIRIs, claims and complaints and identifying trends and actions. The Assistant Director of Quality will be the point of reference within the Trust for all internal and external contacts in relation to all matters relating to Risk Management, incidents, claims, PALS and complaints.

3.8 **Risk Department** will support the Assistant Director of Quality in managing risks. They will provide specialist advice and support to managers. They will ensure that investigations, safety audits and inspections are carried out. The Risk Managers will act as the designated ‘competent person’ in relation to Health and Safety as required by the ‘Management of Health and Safety at Work Regulations 1999’ (Regulation 7) and provide reports to the Strategic Health, Safety and Risk Group on incident reporting, identifying trends and actions.

3.9 **Head of Patient Experience** is responsible for coordinating the investigation and responses to all complaints, concerns, comments and compliments received by the Trust. They will provide reports to the Patient Experience Review Group and Quality and Safety Committee and monitor trends of complaints/compliments to ensure that learning points can be identified and implemented.

3.10 **Investigation Managers** will be responsible for carrying out the investigation of SIRIs, serious incidents and complaints as agreed with the Assistant Director of Quality.

3.11 **Information Governance Manager** will coordinate the annual Information Governance self assessment and provide specialist advice in relation to FOI, Data Protection and Records Management. They will be responsible for the development and delivery of an annual improvement plan for information governance.

3.12 **All Employees**

All Trust employees will:

• understand and co-operate with the Adverse Incident Reporting & Investigation Policy
• report any identified areas of risk immediately in accordance with the Management of Health and Safety at Work Regulations 1999 (Reg. 14), the Trust’s Risk Management Strategy and Adverse Incident Reporting & Investigation Policy
• co-operate in any investigation relating to an adverse incident, claim or complaint to ensure an appropriate conclusion
• use the Adverse Incident Reporting Procedure (IR1) to report any identified risks and near misses, completing the form fully with a completed risk assessment score and fax it to the Risk Department
• Inform their line manager and seek support for any concerns around incidents, claims and complaints and any pending court appearance.

3.13 For the Trust’s Committee Structure see the Risk Management Strategy

4.0 ADVERSE INCIDENT REPORTING PROCEDURE

4.1 It is the responsibility of all staff to report any adverse incidents, potential incidents (i.e. near miss) and all identified hazards and risks. In all cases, reports must be made without delay and in writing using the Trust’s Adverse Incident Report Form (IR1) (Appendix 1) and faxed to the Risk Department by the member of staff within 24 hours of the incident taking place.

4.2 Where serious injury, risk, death, fire or loss occurs, the EOC and Risk Department should be informed immediately with a request for a Senior Manager to attend the incident. The relevant Operational Director and the Director of Patient Care must be notified immediately by telephone, including events that occur outside of normal working hours. In the event of it not being possible to contact the relevant Operational Director, the duty Executive Director must be immediately informed.

4.3 Below are examples of unexpected serious incidents to patients, staff or others, as a result/consequence of our undertaking and or activities:

a. Death of a patient, member of staff or member of the public.
b. Any major fractures as defined by Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
c. Dislocations of shoulders and hips of patients or staff.
d. Loss of sight, major burns.
e. Any treatment or incident that leads to a patient or member of staff which results in unconsciousness.
f. Drug administration error.
g. Road Traffic Accident.
h. Violence against staff resulting in injury.
i. Trust property stolen
j. Major national health scare
k. Loss of information technology functions
l. Major incident
(These are examples of serious incidents which are not exhaustive)

4.4 Once faxed to the Risk Department, IR1s must be forwarded to the member of staff’s line manager. Line managers must ensure they have a process in place within their team/department to receive notification of submitted IR1s from their staff such as a phone call, email or collection point. On receipt of an IR1 the line manager will:

• Check that the IR1 has been completed correctly and the risk rated by the member of staff. If not, the form should be updated and re-faxed to the Risk Department
• Ensure that a copy of the IR1 has already been faxed to the Risk Department. This should be indicated in the box on the top right hand corner of the form
• Undertake an initial investigation to ascertain the facts and identify any immediate actions required to eliminate, reduce or control the risk where possible. If appropriate, staff should be alerted verbally, on notice boards or by email.
• Conduct any necessary interviews and obtain statements to accompany the IR1 where appropriate.
• Complete the Line Manager’s Comments section of the IR1. This should include any immediate actions taken and, if appropriate, the department/person to whom the IR1 has been forwarded for investigation. This will be dependant upon the type and risk rating of the incident/risk. Investigation guidance is included at Section 7 of this Policy.
• Forward the IR1 to the department/person responsible for the investigation. A copy of the form should be retained by the line manager.
• Upon completion of the investigation and return of the IR1 ensure the Actions section of the form has been completed with actions or recommendations and an updated risk rating. If they are not satisfied with the outcome of the investigation they should redress the issue with the investigating officer or raise their concerns with the Risk Department or a Senior Manager within their Directorate.
• Ensure they or the investigating officer provides feedback to the member of staff who submitted the IR1. This should be recorded on the Staff Sign Off section of the form. Feedback to staff on the actions taken following a reported incident/risk is critical in improving and maintaining staff engagement.
• Fax or send via internal post the completed IR1 including any statements, reports, photographs etc to the Risk Department.

4.5 It is essential in the case of injury or other incident, which may subsequently result in insurance claims or litigation, that a full detailed report is produced and wherever possible, photographs taken for future reference. These should be attached to the IR1 at the time of completion or subsequently forwarded to the Risk Department for attachment.

4.6 Notifiable and industrial injury/incidents absences exceeding 7 days must be reported on an IR1 and this information provided to the Risk Department by the eighth day of absence to allow timely HSE reporting.

4.7 It is essential that potential incidents (near misses) are also reported in order to maintain the Trust’s proactive approach to both clinical and non-clinical risk management.

4.8 On receipt of an IR1 the Risk Department will review the risk rating and actions to ensure they are proportionate to the level of risk and record the incident on the Trust’s incident reporting database.

4.9 In the event of further action being required the Risk Department will initiate such action. They will also be responsible for reporting such incidents as are required to be reported to other departments and or external agencies such as the Health and Safety Executive.

4.10 The Trust actively encourages staff to report adverse incidents and has adopted a fair blame culture with regards to reporting risk. The primary purpose of any investigation is to learn why the incident occurred by identifying the root causes of the incident and to prevent reoccurrence and not to apportion blame. The Trust encourages openness and constructive criticism particularly in relation to clinical care.

4.11 Guidance on completion of the IR1 is contained on the inside of the front cover of the pad along with the Easy Guide issued by the Risk Department (see Appendix 3). All employees will receive formal instruction on adverse incident reporting and IR1 completion during corporate induction training and through the Trust’s training needs analysis process.
Individuals who have yet to receive training may need guidance in relation to the procedures or assistance in completion of the form. Assistance is available from the Risk Department or any manager, supervisor or mentor.

4.12 All incidents (any unintended or unexpected incident which could have or did lead to harm) involving patients will be reported by the Clinical Risk Manager to the National Reporting and Learning System (NRLS). The patient, if appropriate, will receive a visit from the Investigating Officer and regular welfare checks from the Trust’s Head of Patient Experience.

4.13 It is the line manager’s responsibility to ensure that a copy of this policy is kept within the department/station, is up to date and is readily available to staff.

4.14 Access to SCAS computer which has the Datix Link must be available to staff 24/7 and a copy of DATIX completion/use instructions to be available at all times and made available to staff.

5.0 INCIDENT GRADING

5.1 All reported incidents will be initially graded by the member of staff according to their perception of the impact and the likelihood of recurrence as soon as possible after the event. A matrix is included within the on-line Datix Reporting system for this purpose this matrix is also included within the backup manual IR1 reporting process.

The level of investigation and management action required for each report should be dependant upon the incident grading.

5.2 The ‘Impact’ and ‘Likelihood’ scores when plotted on the chart (See Appendix 4A) will provide a colour coded risk level.

- Red = High Risk
- Amber = Significant Risk
- Yellow = Moderate Risk
- Green = Low Risk

5.3 Examples are given in Appendix 4 as to the qualitative measures which might be considered under each of the headings consequence or impact.

5.4 The following grid provides example descriptions in relation to the Likelihood axis

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Example description (Likelihood)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Not expected to occur annually &lt;1%</td>
</tr>
<tr>
<td></td>
<td>Will only occur in exceptional circumstances</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Expected to occur at least annually 1-5%</td>
</tr>
<tr>
<td></td>
<td>Generally unlikely to occur</td>
</tr>
<tr>
<td>Possible</td>
<td>Expected to occur at least every 6 months 6-25%</td>
</tr>
<tr>
<td></td>
<td>Has a reasonable chance of occurring</td>
</tr>
<tr>
<td>Likely</td>
<td>Expected to occur at least monthly 26-60%</td>
</tr>
<tr>
<td></td>
<td>Is likely to occur</td>
</tr>
<tr>
<td>Almost Certain</td>
<td>Expected to occur at least weekly &gt;60%</td>
</tr>
<tr>
<td></td>
<td>More likely to occur than not</td>
</tr>
</tbody>
</table>

5.5 The initial incident grading will be reviewed and adjusted if necessary following the completion of any in depth investigation by the Manager or following review by the Risk Department.
6.0 REPORTING OF SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs) or NEVER EVENTS TO THE CCG’s/NHS England

6.1 SIRI/Never Events will be reported and investigated in accordance with the Trust Serious Incident Requiring Investigation Policy.

6.2 A SIRI may be defined as:

**Any event which:** Involves a patient, service user, member of the public, contractor, NHS staff, locum staff and out of hours providers, children, young people, prisoners and young offenders, or other providers of healthcare involved in the process of treatment, care or consultation on NHS premises, or in the course of treatment or care that is commissioned by the NHS but may be delivered by a private provider on non NHS premises which results in (or could have resulted in) one or more of the following:

- Serious Injury
- Unexpected death
- Permanent harm
- Significant public concern
- Significant media concern
- Significant disruption to health care services.

The process for reporting and investigation of a ‘Never Event’ as defined by the Department of Health (DH 2011 The ‘never events’ list 2011/12) is the same as for a SIRI.

6.3 For further guidance on reporting SIRIs see the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation which can be found at: [http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173](http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173) and the Clinical Commissioning Group Guidance for Serious Incident Process.

7.0 INVESTIGATION OF ADVERSE INCIDENTS, CLAIMS AND COMPLAINTS

For Duties see section 3.0 to 3.12.

7.1 The primary purpose of an investigation is to establish the facts and sequence of events leading up to the adverse incident (whether an incident, complaint or claim) to determine what happened, how it happened, why it happened, who was involved and to determine the impact on patients and/or staff.

7.2 Human error is frequently seen as the direct or a contributory cause of incidents. However, the root cause is often a more complex series of factors which have been lying dormant or have been tolerated and have come together to allow the incident to occur. Unless incidents are investigated to identify the underlying, tolerated or dormant factors and these are addressed, improvement strategies aimed solely at individual practice are unlikely to be successful in preventing a recurrence.

7.3 The structured and systematic approach to the review of all events leading up to an adverse incident facilitates the identification of the direct, contributory and root causes of adverse incidents.
Direct Cause is defined as the immediate cause which triggered the incident.

Contributory Cause is defined as a cause which contributes to an incident but which by itself would not have caused the incident.

Root Cause is defined as the underlying cause to which the incident could be ultimately attributed and which, if corrected, would prevent a recurrence.

7.4 The analysis of the information gained from the investigation allows the determination of recommendations that will help to prevent another incident of the same kind or one caused by similar issues. The lessons learned through the investigation process will be used to ensure learning takes place either by individuals, teams or the organisation.

7.5 Not all incidents need to be investigated to the same extent or depth. Having assessed each incident against the risk grading matrix the level of investigation and analysis effort should be expended in relation to the risk level and whether the incident has resulted in harm.

Risk Rating of Incidents Explained

a. Green incidents – low/no harm
These incidents generally do not have ongoing serious consequences and can be managed promptly on the spot. The department manager would undertake any review which may identify learning points or safety improvements. Any identified control measures should be implemented immediately.

b. Yellow incidents – Moderate harm or low risk
These incidents should be reviewed in the department where the event occurred. The department manager would undertake any review but the nature of the incident and possible implications may require a more senior manager to be informed. Any identified control measures should be implemented promptly.

c. Amber incidents – Significant harm or moderate risk
These should be subject to a root cause analysis investigation led by a suitably trained manager. It will be the responsibility of the investigating manager to ensure all learning points and safety improvements are appropriately identified and implemented.

Any controls identified which are not within the control of the local management team should be included on the appropriate risk register for consideration/action by a more senior manager or director.

Details of all reported incidents are recorded on the Trust’s risk management database to allow monitoring of trends. It may be appropriate to establish any causes or contributory factors where trends are identified and for this information to be shared with other departments, locations or other stakeholders to share safety lessons.

d. Red incidents – High Major/Catastrophic harm or high/very high risk
Where major (i.e. permanent injury) or catastrophic harm (avoidable death or significant shortening of life expectancy) has occurred an investigation team led by a suitably trained manager will be identified and a full root cause analysis carried out. The recommendations from the investigation report will be included on the corporate risk register and any identified
actions to reduce or eliminate the risk of the incident recurring will be monitored by the Quality and Safety Committee.

7.6 A full and detailed explanation of root cause analysis techniques and how they should be applied can be found at [www.england.nhs.uk](http://www.england.nhs.uk). There is also further guidance for managers on investigation and root cause analysis at Appendix 5 within this policy.

7.7 The investigation must be undertaken by more than one person. However, depending on the severity of the incident individuals may conduct all, or part, of the investigation. The lead investigator should be trained in incident investigation and root cause analysis techniques and should be chosen from a cadre of expert/specialist, trained members. For example:

- someone with specialist knowledge about an aspect of the incident e.g. a member of the clinical team, risk department, fleet engineer
- someone with no specialist knowledge to provide an objective view
- someone from the training department peer group support

7.8 For major incidents i.e. where death or serious injury has occurred, where a criminal investigation may result or where there has been a serious failure of a piece of equipment, external agencies such as the Health and Safety Executive, Medicines and Healthcare Regulatory Agency, CCG, NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY or Police should be communicated with to either form part of the investigation team or to share lessons learnt.

7.9 The investigating officer may be able to take remedial action immediately for any immediate and/or underlying causes but will more usually make recommendations for possible solutions to prevent a recurrence. If the recommendations fall within the remit and level of authority of the investigating officer they should be implemented without delay and recorded on the IR1 form. If they are of a wider scope, require additional resources or have implications across the Trust they will be referred to the appropriate Director and included on the Corporate Risk Register and forwarded for approval via the Health, Safety and Risk Group to the Quality and Safety Committee.

7.10 SIRIs or ‘Never Events’ reported to the CCG will be investigated by an Investigations Manager supported by relevant experts depending on the nature of the incident.

7.11 The Serious Incident Review Group will monitor and follow up all relevant action plans developed from SIRIs/Neuer Events reported to the CCG. The lead manager or departmental director will monitor and follow up action plans developed from a green or yellow risk investigation.

8.0 SUPPORTING STAFF INVOLVED IN ADVERSE INCIDENTS, CLAIMS AND COMPLAINTS

For Duties see section 3.0 to 3.12.

8.1 If any member of staff is experiencing difficulties following an adverse incident, complaint or claim the line manager should offer immediate support.

8.2 Managers are responsible for ensuring that staff are given the opportunity to debrief following an adverse incident (whether an incident, complaint or claim) and that staff are informed of how to access counselling services and additional support. This list of actions is available for managers or individuals to take if the staff member is experiencing difficulties associated with the event:
8.3 No member of staff should attend a court hearing or an internal investigation on their own. If a member of staff receives notification of court proceeding they should contact their line manager immediately.

8.4 The Trust will provide support to staff identified as a witness in any investigation or court proceedings, in the preparation of statements, the court appearance and a debriefing following the court appearance. This will be assessed by the line manager and the Risk Department and the appropriate level of internal and external support provided.

8.5 Managers are to maintain regular contact with all staff involved in any adverse incident, claim or complaint until such time as the members of staff are satisfied and the proceedings or concerns are completed.

9.0 BEING OPEN (PATIENT SAFETY INCIDENTS)

9.1 These guidelines describe how the Trust meets its obligations to healthcare organisations/teams and patients and/or their carers by being open and honest about any mistakes that are made in the way patients are cared for and treated.

9.2 Details are provided on how and when staff should communicate with healthcare organisations/teams, patients and/or carers following a patient safety incident. It is based on recommendations made by the National Patient Safety Agency (NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY) document ‘Being Open: Communicating patient safety incidents with patients and their carers’. The document is available at:
http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077

9.3 A patient safety incident is defined as ‘any unintended or unexpected incident that could have, or did, lead to harm for one or more patients receiving NHS funded healthcare’.

9.4 ‘Being Open’ simply means apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident. This process only applies to those incidents where a patient has been harmed; it is not a requirement that no harm or near miss incidents are discussed with the patient and/or their carers.

9.5 Apologising to a healthcare organisations/teams, patient and/or carers does not constitute an admission of liability. Ref NPSA/2009PSA003

9.6 Key Principles
Communicating effectively with healthcare organisations/teams, patients and/or their carers is a vital part of the process of dealing with errors or problems with their care or treatment. Not only does effective communication reduce the distress caused by the incident, it has been shown that the likelihood of legal action is reduced as the majority of patients involved in a patient safety incident want an apology and explanation of what happened rather than financial compensation or disciplinary action. Patients are less likely to forgive medical errors for which they have not received an apology, or which have not been fully explained and as a result are more likely to press for compensation.

Throughout the whole process healthcare organisations/teams, patients and/or carers should be treated with sympathy, respect and consideration. Confidentiality should be maintained at all times by anyone involved in the incident.

The NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY ‘Being Open’ document details ten key principles that should be adhered to when communicating with patients and/or carers about an incident. These are:

1. Acknowledgement of the incident
2. Truthfulness, timeliness and clarity of communication
3. Apology, verbal and written
4. Recognition of patient and carer expectation
5. Professional support
6. Risk management and systems improvement
7. Multidisciplinary responsibility
8. Clinical governance
9. Confidentiality
10. Continuity of care

These principles have been considered in developing these guidelines.

9.7 The incident may be identified by the healthcare organisations/teams, patient, carer or member of staff through a PALs inquiry, claim, complaint or IR1. All concerns must be taken seriously, patient concerns should never be dismissed without further investigation.

9.8 Following the occurrence of a patient safety incident staff involved in the patient’s care must explain to the patient and/or carer that an incident has occurred and that this will be investigated. A verbal apology should be offered as soon as the incident is identified and a record on the patient report form made.

9.9 The initial information given must be truthful, unambiguous and based solely on the facts known at the time. No speculation as to possible causes, no attribution of blame or comments or criticisms should be made. The patient should be informed that they will be updated through face to face meetings, verbal and or written communication as new information emerges. Further explanations and apologies may be necessary as the patient and/or carer begins to comprehend the situation. The patient and/or carer may require additional support and staff should facilitate this by providing repeated opportunities for further questioning and a single point of contact for any additional questions.

9.10 A Datix on-line report must be completed or backup IR1 and this must be brought to the attention of the line manager. Staff as well as patients can be affected by their involvement in an incident. The line manager must ensure that the staffs involved are fully supported after the patient safety incident and throughout any subsequent investigation. See Supporting Staff section 8.0.
9.11 A face to face meeting should be set up as soon as possible to discuss the incident and establish the level of detail required by the healthcare organisations/teams patient and/or carers as they may not wish to know the details, this may be especially relevant if there has been a severe injury or a death. Clarity around the identity and role of the staff must be explained to the patient and/or carer as they may have some preference regarding who is present.

9.12 All communication should be documented and a copy provided to the patient and/or carers. The documentation should include the time, place and date of the meeting along with the name and role of all meeting attendees and include the patient and/or carers account of the events, which will further inform the investigation of the incident, and any concerns raised. Medical jargon and acronyms should be avoided. The documentation should be securely filed along with any correspondence notes, incident report forms and any statements taken.

9.13 Only clear, unambiguous and accurate information should be given. If all the facts are not known at the time of the meeting this should be explained to the patients and/or carers. Information of any support that can be accessed and information on the PALS service and complaints procedure should be provided.

9.14 Details of how this information will be shared must be given to the patient and an opportunity for them to object given the proviso that information may not be shared for legal or public interest reasons.

9.15 During these meetings the patient and/or carers may express feelings of anger, confusion or anxiety and these should be dealt with appropriately.

9.16 An investigation into the cause of the incident must be conducted the level of which will depend on the seriousness of the incident. The Patients and/or carers should be kept updated on progress with the investigation by further meetings, or verbal and /or written correspondence. Information should only be provided to the patient and/or carers once the facts have been confirmed and the outcome report reviewed by the Risk Department. If this is not to be for some time regular contact with the patient and/or carers must be maintained to reassure them that the investigation is still underway.

9.17 At all points during the contact the patient and/or carers should be asked if they require any contact details such as PALS or external support agencies. These may have been declined at an earlier stage but may be required subsequently.

9.18 When the investigation is complete a written apology on behalf of the Chief Executive should be sent to the patient and/or carer. This should include an explanation of why the incident occurred i.e. the results of the investigation, any actions that have been put in place to prevent recurrence and a clear statement that the Trust is sorry for any harm or distress caused. Any concerns expressed by the patient and/or carer throughout the process should be summarised and addressed in this letter. The patient and/or carer should be offered an opportunity to provide feedback on both the outcome of the investigation and the Being Open process.

9.19 Throughout the process it is important that the patient is reassured that any dispute will not detract from future care.

9.20 Where patients and/or carers are not satisfied with the process a mutually acceptable mediator should be arranged to help identify the issues where there is disagreement. The patient and/or carer should always be made aware of how to make a formal complaint.
9.21 The Head of Patient Experience should be informed of all patient safety incidents and will make the initial contact with the healthcare organisations/teams, patient or carer and work with the managers throughout the investigation process.

9.22 The Trust has a duty to provide a safe environment for patients and to learn from mistakes when they occur. The Trust will report all Patient Safety Incidents to the National Patient Safety Agency (NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY) in line with National Guidance.

Significant incidents will be subjected to full Root Cause Analysis as recommended and taught by the NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY. The Trust has made available to all managers the NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY Incident Decision Tree which will be used for all significant incidents and can be found at http://www.msnpsa.nhs.uk/idt2/(5cl3wq55tdnrrde1mdvipz45)/index.aspx

9.23 The Trust is committed to increasing the reporting of patient safety incidents and provides an open reporting culture for staff to report incidents and provide feedback to staff. This in turn will encourage reporting from staff and will enable them to feel able to admit errors. The Trust reviews patient safety incidents to improve the patients experience and care provided by the Organisation. The Trust has appointed a Non Executive Director to the role of Patient Safety Champion who is a member of the Quality and Safety Committee and the Strategic Health, Safety and Risk Group.

10.0 ANALYSIS AND IMPROVEMENT

For Duties see section 3.0 to 3.12.

10.1 The DH publication ‘An organisation with a memory’ (2000) emphasises the need to learn from adverse events. Whilst the occurrence of adverse incidents, claims and complaints almost automatically leads to reactive risk management (damage limitation and immediate remedial action) they can also be seen as an opportunity for proactive risk management (learning from what has happened) and looking ahead to see how the same things or worse can be prevented from happening again.

10.2 The Trust has an integrated risk management software system (DATIXTHE IO) which records incidents, complaints, PALS inquiries, claims and Freedom of Information requests. This system will be used to manage and process all incidents reported and will provide regular aggregated reporting information to the appropriate Groups and Committees. This information is mapped the NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY NRLS system and can be used to identify trends.

10.3 The Clinical Directorate, using the database, will collate all adverse incidents, claims, compliments and complaints and produce aggregated reports to include qualitative and quantitative analysis, trends, actions and recommendations at every meeting held by the Quality and Safety Committee, Strategic Health, Safety and Risk Group, Patient Experience Review Group and the Clinical Review Group. See Committee Structure in the Risk Management Strategy.

10.4 Reports for claims, incident, compliments and complaints should include the following:

- The numbers by month through the year compared to last months/years data to identify variations in numbers in form of graphs
- The numbers by category by month and through the year and a comparison made between last months/years data to identify variations in numbers in the form of graphs
• Narrative should include, within each report, an overview of previous reports and current situation. Include all high risk areas within the report in detail. Identify any trends either high or low and make recommendations and action plan with named individuals for approval.

The system is able to identify trend and locator analysis which contributes to the above reports.

10.5 Each of the Groups/Committees will receive and review the reports as follows:

a. Serious incidents will be reviewed and actions/recommendations monitored by the Quality and Safety Committee and Trust Board

b. A claims report will be reviewed and actions/recommendations monitored by the Quality and Safety Committee

c. Adverse incidents, will be reviewed and actions/recommendations monitored by the Strategic Health, Safety and Risk Group, and the Quality and Safety Committee

d. All clinical incidents will be reviewed and actions/recommendations monitored by the Clinical Review Group

e. All compliments and complaints will be reviewed and actions/recommendations monitored by the Patient Experience Review Group and Quality and Safety Committee.

10.6 All of the Groups and Committees have agreed Terms of Reference and meet four or six times a year and report to the next Quality and Safety Committee through reports and minutes. Throughout the committee structure there is representation from all directorates and groups to ensure good communication. See Committee Structure in the Risk Management Strategy and TORs.

10.7 The relevant group/committee will be the primary reviewer of the relevant reports and will identify any underlying causes within the report. The group/committee or panel will use the report to produce an improvement strategy with prioritised actions designed to eliminate root causes, responsibilities, timescales and indicators to measure the effectiveness of the actions taken. Residual risk that cannot easily or immediately be resolved by the implementation of the improvement strategy will be incorporated into the corporate risk register and reported to the Quality and Safety Committee.

10.8 It is vital that changes from incidents locally and organisationally are communicated across the Trust in order to demonstrate continuous learning. Outcomes will be shared with appropriate groups or committees and where appropriate internal and external stakeholders will also be informed to share safety lessons. Where follow up action has involved a change of practice or there are lessons to be learnt this will be communicated through Trust newsletter, training programmes and training needs analysis, risk/safety bulletins, risk alerts, safety notices and staff briefings. We will also communicate with our stakeholders in writing sharing lessons learnt and providing regular updates where appropriate. A log demonstrating implemented change will be maintained by the Serious Incident Review Group.

10.9 Progress on implementing recommendations to reduce the risk and measure the effectiveness of actions taken will be monitored by Quality and Safety Committee through regular reports until such time as the risk has been managed to an agreed level.

11.0 ADVERSE INCIDENTS RELATING TO MEDICAL EQUIPMENT
11.1 All adverse incidents will be reported through the completion of an IR1.

(Note: Examples of medical devices include resuscitators, wheelchairs, defibrillators, syringes and needles, dressings, lifting equipment including stretchers, etc.)

11.2 Following the failure of a medical device the item of equipment must be immediately withdrawn from service and held securely for inspection.

11.3 The local manager will investigate and document the background to the incident. All associated documents, e.g. statements, service records, etc are to be forwarded to the Clinical Risk Manager via a DATIX report or backup IR1.

11.4 The Assistant Director of Support Services will via the Clinical Risk Manager advise the Medicines and Healthcare products Regulatory Agency (MHRA) of any reported incidents, the manufacturer/supplier, and will notify other Ambulance Trusts as necessary.

12.0 INCIDENTS RELATING TO MEDICINES MANAGEMENT

12.1 All incidents regarding medicines should be reported immediately to the Trust Medicines and Research Manager who will advise on MHRA notification.

12.2 In the event of a defect or suspected defect the medicine must be labeled and stored separate from other medicines to prevent inadvertent use. The line manager must be notified and will decide (in consultation with the Medicines and Research Manager or a Medical Director) if it is appropriate to withdraw from use all medicine of the same batch pending further investigation.

12.3 All other departments (including the Make Ready service, a commissioned service) holding stock of the faulty medicines should be informed immediately by telephone. If appropriate, Emergency Operations Centres should be informed and instructed to notify all vehicles to prevent further administration.

12.4 All incidents must be reported to the Risk Department via on-line DATIX report or backup IR1.

13.0 ACCIDENTS AND INJURIES

13.1 All accidents including those which involve injury to employees, patients, contractors and third parties affected by the Trust’s operation must be reported to the Risk Department on an IR1.

14.0 EXTERNAL AGENCIES

14.1 RIDDOR reportable injuries and incidents must be notified immediately to the Risk Department in order that the Health and Safety Executive (HSE) may be informed at the earliest possible opportunity.

(Note: Further information may be found in the Trust RIDDOR Policy).

14.2 All incidents involving Violence and Aggression towards SCAS staff will be reported to the Head of Risk & Security. Line managers are required to encourage and support all staff that have been subject to violence or abuse, in reporting all such incidents to the Police and recording them as a crime.

(Note: Further information may be found in the Trust Violence and Aggression Policy)
14.3 All relevant adverse incidents involving medical products will be reported by the Clinical Risk Manager to the MHRA.

14.4 The National Patient Safety Agency (NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY) will be advised by the Clinical Risk Manager of all incidents involving injury or 'near miss' to patients.

14.5 The NHS England (local CCG) Trust commissioners and the Care Quality Commission will be advised of all Serious Incidents Requiring investigation (SIRIs).

In the event of a SIRI/Never Event involving a death, the relevant Coroner should be informed of the circumstances and that an investigation is taking place.

14.6 The Trust will share cross border risks with other Health and Local Authority partners and will work collaboratively in any investigation and subsequent implementation of control measures and or lesson learned ensuring feedback to the teams concerned.

15.0 SECURITY

15.1 All incidents (either actual or potential) regarding security matters shall be reported using on-line DATIX reporting system or a backup IR1. Such incidents may include theft, criminal damage, unlawful entry to Trust premises, etc.

15.2 The Police are to be informed immediately in cases of all incidents including theft, criminal damage or suspicious behaviour. Copies of any statements and details of the Police action and Crime Report Number are to be forwarded to the Head of Risk & Security.

16.0 FIRE INCIDENTS

16.1 In all cases of Fire the Trust Fire Policy and local premises fire procedures must be strictly adhered to.

16.2 The Duty Executive Director must be notified immediately by the Emergency Operations Centres of any confirmed fire involving Trust property.

16.3 The senior manager present or attending the fire shall complete an on-line DATIX report or a backup IR1. All false alarms should be similarly recorded.

16.4 It shall be the responsibility of the Estates Manager to report any Fire incidents to the NHS Estates Department.

17.0 DEFECTS IN ENGINEERING PLANT, INSTALLED SERVICES, BUILDINGS AND BUILDING FABRIC.

17.1 Normal day-to-day failure of equipment and plant need not be reported under the guidelines of this policy. Only major, repeated or potentially serious failures and those involving actual or potential injury or harm should be reported on an IR1. In all other cases the Trust Defect Reporting Procedures will apply.

18.0 VEHICLE ACCIDENTS AND DEFECTS.
18.1 All traffic accidents involving Trust vehicles shall be reported and investigated in accordance with the Driving and Care of Trust Vehicles Policy.

18.2 Where personal injury occurs as a result of a road traffic accident involving a Trust vehicle then on-line DATIX report or a backup IR1 must be completed.

18.3 Normal day-to-day vehicle defects should be reported in accordance with the Trusts vehicle defect reporting procedure. An on-line DATIX report or backup IR1 should be submitted where there are concerns about safety, or welfare of staff, patients or others.

18.4 The Driving Standards Manager will review and investigate all vehicle accidents and recommend the appropriate actions.

19.0 WHISTLEBLOWING POLICY

19.1 The Trust believes that any member of staff wishing to express their concerns regarding any issue within the Trust will be able to do so freely, without fear of blame or retribution, and will have their voice heard.

19.2 In the unlikely event that issues are not resolved through other Trust Procedures, and the member of staff has genuine and serious concerns that the risk has not been adequately addressed the individual may recourse to the Trusts Whistle Blowing Policy.

20.0 MONITORING

20.1 Key performance indicators will be monitored by the Quality and Safety Committee every six months, these will include:

- Number and Percentage of staff completing mandatory and induction training in year
- Number of incidents reported through the Whistle Blowing Policy
- Number of Adverse Incidents, Serious Incidents, Complaints and Claims reported and the time taken to complete along with the outcome and learning of these incidents and the pathway in which a claims arose from
- Number of Root Cause Analysis performed on Adverse Incidents, Complaints, Claims, Serious Incidents and reported outcome
- Number of reported incidents to external agencies (NPSA/NRLS,NHS England(CCG)STEIS and Commissioners)
- Proportion of identified potential control measures that have been actioned against risks identified through incident investigation (monitored through risk register review)
- Compliance with NHSLA Risk Management Standards for Ambulance Trusts.

20.2 All of the KPI’s are monitored at the Quality and Safety Committee. Specific ones are also monitored at the following:

- Quality and Safety Committee monitor all of the above and in particular the Trust Monitoring of Action Plans which includes high level investigations
- Clinical Review Group will monitor progress and outcomes of Clinical investigations, patient involvement and subsequent action plans
- A review on achievements against objectives set in Committee Terms of Reference will be escalated through the committee structure.
- Annual review of Job Descriptions and Responsibilities

20.3 Effectiveness of managerial investigation will be monitored by the Quality and Safety Committee and risks identified will be entered onto the Corporate Risk Register.
20.4 The Assistant Director of Quality will audit this policy and KPIs annually and a full report on
the above will be presented to the Quality and Safety Committee in conjunction with the
reviewing of this policy. Any action plans required to ensure policy compliance will be entered
onto the Trust’s Health, Safety and Risk Action Plan which is monitored by the Quality and
Safety Committee.

21.0 TRAINING

21.1 The Education Review Group reviews the training needs analysis annually taking
into consideration risk assessments and the trends analysis of Key Performance Indicators
(KPIs) that it receives at each meeting.

21.2 The results of the training needs analysis are used to inform the SCAS Training Programme.

21.3 The Trust recognises the importance of Training and Education in increasing
awareness of risk and safety issues. All staff will receive information, instruction, training and
supervision in relation to Health and Safety, Risk Management, Complaints, Claims, PALS,
Being Open and Adverse Incident Reporting as provided through the Trust’s Training Needs
Analysis.

21.4 Managers will provide advice at a local level; in particular they will emphasis the need for
open communication and seek further professional advice when required.

22.0 OTHER REFERENCE & RELATED DOCUMENTS

Risk Management Strategy
Health and Safety Policy & Procedures
Control of Infection Policy & Procedures
Four Cs Policy and Procedures
Claims Policy
Risk Register and Associated Risk Assessments and Action Plans
Whistleblowing Policy
Capability Policy
Disciplinary Policy
Driving Standards Policy
Security Policy
Counter Fraud Policy
Serious Incidents Requiring Investigation Policy

National Patient Safety Agency National Framework for Reporting and Learning from Serious
Incidents Requiring Investigation (March 2010)
South Central Strategic Health Authority Guidance for Serious Incident Process
NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY Website:
www.npsa.nhs.uk
- Incident Decision Tree
- RCA Forms and Toolkit
Appendix 1

SCAS Reference Guide

Contents:

Page 2    A: The DIF 1 and initial reporting
Pages 3–5 B: The DIF 2 and investigation
Page 5    C: Reporting of errors and concerns
A: The DIF 1 and initial reporting

The DIF (Datix Incident Form) 1 is designed for the easy reporting of information by all SCAS employees and can be accessed through the SCAS Intranet. With knowledge of their ESR number a full report of any occurrence can be made by a member of staff with access to a PC in less than 10 minutes.

Fields marked with ★ are mandatory: to successfully submit a form these must be fully completed.

Following submission all information captured is transferred automatically to a DIF 2, which requires a username and password to access and is designed for investigation and review of the event.
B: The DIF 2 and investigation
On the left-hand side of the screen (red) is a selection of tabs: Initial Details, People Affected, Investigation, Actions, Documents, NRLS/RIDDOR/SIRS, Communication and Feedback, Progress Notes and Linked Records. The function of each tab is explained below.

**Initial Details**

This tab is divided into six sections: Initial Details, Incident Status, Location, Incident Categorisation, Severity and Result and Details. Most of these fields are populated from the DIF 1 with the exception of the Incident Status section, which is completed by the investigator. While investigation is ongoing the ‘Being Reviewed’ option should be selected by the investigating manager – this can be changed to ‘Awaiting Final Approval’ to notify the Risk Team that it requires their attention, at which point it will switch to ‘Being Approved’. Final Approval and Rejection options should only be used by members of the Risk team to signify that an investigation is completed or that an incident has been removed.

**People Affected**

This tab is populated from the DIF 1 information and will show the people involved in/affected by this incident. Clicking on a name will bring up personal details and also list any injuries. If a contact is listed as ‘Unapproved’ click the ‘Check for matching contacts’ button. If a matching person is found select this person and then click the ‘Create a link’ button when returned to the personal details page to link the incident to the person permanently. If a matching contact cannot be found click ‘Cancel’ and manually approve the person when returned to the main page.

**Investigation**

This tab is where the list of persons involved in the investigation is kept, as well as the outcome and a list of required actions. At the conclusion of the inquiry this section must be filled out as completely as possible, with further details of actions taken noted in the Actions tab if required. The Risk team will then assign a risk grading and check the outcomes/actions are appropriate and resolve the issue at hand.

**Actions**

This tab is used to provide a record of all actions taken as a result of the investigation. Press ‘Create new action’ to open a form and complete the details required. These should be completed with as much detail as possible to provide an accurate record of progress following the outcome of an inquiry.

**Documents**

The Documents tab is used to upload any supporting documentation linked to the incident and will also contain any documents attached by the reporting member of staff. Please ensure that all documents are directly relevant and are uploaded from certified Trust IT equipment.
NRLS/RIDDOR/SIRS

The NRLS (National Reporting and Learning System) has replaced the NPSA and receives incidents involving harm or potential harm to patients. RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) allows all instances of injury or ill health involving a member of staff lasting over 10 days to be submitted to the HSE; SIRS (Security Incident Reporting System) allows for any violent/security incident to potentially be submitted to NHS Protect. As a result of the above all incidents must have as much detail as possible available to allow for correct reporting; these external reporting systems will be completed by the Risk team as required.

Communication and Feedback

This tab can be used to communicate with the reporting member of staff, other investigators and any other person as required by either the investigating officer or the Risk team. All messages sent through the internal Datix system will be saved, allowing records of all communications to be kept. This mechanism should be used for all correspondence relating to an investigation.

Progress Notes

The Progress Notes tab allows an investigator to keep a record of developments during the course of their inquiry; this is saved chronologically. Notes can also be added by any person with access to the record, allowing messages to be left centrally and actions taken accordingly.

Linked Records

Linked records are other events, whether incidents or Patient Experience, that relate to the current record accessed. This tab will display any current links and allow those with sufficient access to link further records if required, allowing a complete picture of an event to be seen.

C: Reporting of errors and concerns

Any concerns, errors or issues should be mailed to risk@scas.nhs.uk. Alternatively please make a member of the Risk team aware of the problem
**South Central Ambulance Service Incident Report Form**

A * indicates a mandatory field.

Dates must be entered in the format *dd/mm/yyyy*. Alternatively, click the 📅 button to select the date from a calendar.

Click the 📜 icon for help with a particular field.

For assistance with completing this form, please email risk@scas.nhs.uk.

### Details of person reporting the incident

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>Forenames</td>
<td></td>
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<tr>
<td>Surname</td>
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<tr>
<td>ESR Number</td>
<td>Type your surname and ESR number followed by ‘Search’.</td>
</tr>
<tr>
<td>Type</td>
<td>Select correct option if displayed, otherwise complete all displayed options as fully as possible.</td>
</tr>
<tr>
<td>Injury Caused?</td>
<td></td>
</tr>
</tbody>
</table>

### Incident Details

- **Incident date (dd/mm/yyyy)**
- **Time of incident (hh:mm)**
- **Job Number**
- **Vehicle Callsign**

### Incident Location

- **Trust**
- **Directorate**
- **Department**
- **Working Area**
- **Location (type)**
- **Location (exact)**

### Initial Outcome & Impact

- **Initial Outcome**
- **Impact**

### Additional Information

- **Was any other person involved in the incident?**
- **Are there any documents to be attached to this record?**

### Incident Description

- **Description**
  - Enter facts, not opinions. Do not enter names of people.
- **Action taken**
  - Enter action taken at the time of the incident. Include patient/staff outcome if applicable.

- **Type**

### Clear Section

- Type own surname and ESR number followed by ‘Search’. Select correct option if displayed, otherwise complete all displayed options as fully as possible. Select appropriate manager to report to when prompted.

- Complete incident details, including official SCAS reference (‘Job Number’) and vehicle designation.

- Select own department and working area from dropdown lists, followed by the exact location of the incident.

- Grade as appropriate from own experience.

- Details of any other person involved in this incident/supporting documentation.
## Adverse Incident Report Form (IR1)

### Staff Area
- Berks
- Bucks
- MK
- N Hants
- Oxon
- SE Hants
- SW Hants

### Type of Incident
- (tick the main area of concern)
  - Clinical
  - Operational
  - Security
  - Equipment
    - Near Miss
    - Transport
    - Violent
    - Other
  - Estates
  - Personal Accident/Illness
  - Radio/IT/Comms
  - Other

### Did the Incident Result in Injury/Ill Health?
- Yes
- No

### Details of Incident
- **Date**
- **Time**
- **Call Sign**
- **Job No**

### Location
- **House No/Name**
- **Street**
- **Town**
- **County**
- **Postcode**

### Details of Person Injured/Affected/Involved
- **Staff**
- **Patient**
- **First/Co Responder**
- **Private Provider**
- **Member of the Public**
- **Contractor**
- **Other Medical Staff**
- **Other**

### Person Reporting Incident/Witness (if different than above)
- **Name**
- **Job Title**
- **Place of Work**

### Equipment/Consumable (retain and quarantine item and packaging if appropriate)
- **Type of Equipment**
- **SCAS Asset No**
- **Model No**
- **Serial No**
- **Batch No**
- **MR Pouch No**
- **Tag Colour**
- **OSD Ref No**

### Violent Incident
- **Name of Assailant**
- **Age**
- **House No**
- **Street**
- **Town**
- **County**
- **Postcode**
- **Police Informed?**
- **Yes**
- **No**

### Further Action Required?
- **Police**
- **Special Situation**
- **Warning Letter**
- **None**

---

**Note:** Insert cross when faxed.
### Incident Details:

- **Risk Score the incident and include the sequence of events, any immediate actions undertaken and the outcome of any person injured or affected.**

<table>
<thead>
<tr>
<th>Impact</th>
<th>Insignificant (1)</th>
<th>Minor (2)</th>
<th>Moderate (3)</th>
<th>Major (4)</th>
<th>Catastrophic (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>Rare (1)</td>
<td>Unlikely (2)</td>
<td>Possible (3)</td>
<td>Likely (4)</td>
<td>Almost Certain (5)</td>
</tr>
</tbody>
</table>

**Total Risk Score (Impact X Likelihood)**

(Refer to Trust Risk Scoring Matrix for guidance)

(continue on a separate sheet if required)

**Name**

**Signature**

**Date**

**Place of Work**

---

### Line Manager's Comments:

**Name**

**Signature**

**Date**

**Place of Work**

---

### Actions:

**Name**

**Signature**

**Date**

**Place of Work**

---

### Risk Score:

- **Risk Score**
  - (should be completed by Line Manager once investigation and any remedial actions have been undertaken)

<table>
<thead>
<tr>
<th>Impact</th>
<th>Insignificant (1)</th>
<th>Minor (2)</th>
<th>Moderate (3)</th>
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<td>Likely (4)</td>
<td>Almost Certain (5)</td>
</tr>
</tbody>
</table>

**Total Risk Score (Impact X Likelihood)**

(Refer to Trust Risk Scoring Matrix for guidance)

**Staff Sign Off:**

**Signature**

**Date**

via email

declined

---

### Additional Reporting:

- **Risk Dept to complete**

<table>
<thead>
<tr>
<th>CCG</th>
<th>NHS Protect</th>
<th>RIDDOR</th>
<th>Police</th>
<th>NHS Special Situation</th>
<th>MHRA</th>
<th>Other NHS Body</th>
</tr>
</thead>
</table>

---

### Risk Dept Review:

**Risk Manager**

**Date**

…………………..
South Central Ambulance Service
Process for the Reporting of Risk/Adverse Incidents

Adverse Incident occurs or risk identified
Member of Staff

Incident report form (IR1) completed and faxed to Risk Department within 24 hours
01869 365215
Member of Staff

IR1 received by Risk Department, reviewed and entered onto Risk Management Database
Risk Assistant

Line Manager collects IR1, begins investigation and implements any immediate actions
Line Manager

Incidents reviewed and reports produced for Health, Safety & Risk Group Meeting. Operational Risk Register updated where necessary
Risk Managers

Depending on type of incident and risk score, IR1 may be sent to Department Head, Area/Lead Operational Manager etc for investigation and feedback
Investigating/Line Manager

External Agencies such as: HSE, CCG, NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY, MHRA, NHS Protect informed as required

Investigation to be completed with 29 days, feedback provided to originator and IR1 returned to Risk Department for processing and closure on database
Investigating/Line Manager

Quality & Safety Committee review trends and serious incidents
Assistant Director of Quality (ADQ)

Significant risks identified and staff informed via Risk Information Notices
Risk Department

Trust Board review trends, serious incidents and processes including recommendations
Director of Patient Care (DOPC)

Incident trends and performance reported to staff via Hot News and Staff Matters
Risk Department

Risk formally assessed and assurance sought that appropriate actions are taken
Risk Managers

Assistant Director of Quality (ADQ)

Operational Risk Register updated where necessary
Risk Managers
This guide is an ‘aide memoire’ to assist staff and managers in the IR1 reporting procedure detailed in the Trust Adverse Incident and Reporting Policy. All staff and managers must read this policy before using this guidance.

Why Report?

The Trust actively encourages staff to report adverse incidents and has adopted a fair blame culture with regards to reporting risk. The primary purpose of reporting and investigating is to learn why the incident occurred by identifying the root causes of the incident and to prevent reoccurrence and not to apportion blame. The Trust encourages openness and constructive criticism particularly in relation to clinical care.

Successful risk management depends upon both pro-active and reactive risk identification and reporting. Datix on-line reporting tool is the initial mechanism for the reporting of incidents a backup system of the Trust’s Adverse Incident Report Form (IR1) can also be used in extremis these two systems should be used to report all risks irrespective of their type or origin and where the incident may result in a complaint or litigation being brought against the Trust. If in doubt report the incident or contact the Risk Department for advice. The following list provides examples but is not exhaustive.

- All incidents involving injury to patients, staff or third parties
- All violent incidents irrespective of whether physical assault occurred
- All security incidents, such as theft, vandalism, intruders on Trust premises or breaches in Information Technology
- All clinical incidents such as equipment failure, medication errors, drug reactions or inappropriate procedures
- Any hazard or risk which if left unattended might result in loss or harm to the Trust, patients, staff or others
- Any near miss
- Any breach of patient confidentiality

Guidance for Staff

IR1s should be faxed to the Risk Department on 01869 365215 by the reporting member of staff within 24 hours of the incident taking place.

- Forms should be completed neatly and legibly using a black or blue pen
- Complete the form as fully as possible, if necessary continuing on a separate sheet which must include the original IR1 serial number
- Tick all the appropriate boxes
- Ensure all comments are accurate, relevant and factual. Do not make subjective comments as the form may need to be produced in a court of law
- If concerned over the potential seriousness of the incident contact the Risk Department by telephone for advice
- All cases of crime must also be reported to the Police and the Crime Unique Reference Number (URN) recorded on the form
- In the case of injury to staff clearly indicate the anticipated period of absence from work as there may be a need for the Trust to inform the HSE under RIDDOR
- Once faxed, forward the IR1 to your line manager.

Where serious injury, risk, death, fire or loss occurs, the EOC and Risk Department should be informed immediately with a request for a Senior Manager to attend the incident. The relevant
Operational Director and the Director of Patient Care must be notified immediately by telephone, including events that occur outside of normal working hours. In the event of it not being possible to contact the relevant Operational Director, the duty Executive Director must be immediately informed.

**Guidance for Managers**

Once faxed to the Risk Department, IR1s must be forwarded to the member of staff’s line manager. Line managers must ensure they have a process in place within their team/department to receive notification of submitted IR1s from their staff such as a phone call, email or collection point. On receipt of an IR1 the line manager will:

- Check that the IR1 has been completed correctly and the risk rated by the member of staff. If not, the form should be updated and re-faxed to the Risk Department
- Ensure that a copy of the IR1 has already been faxed to the Risk Department. This should be indicated in the box on the top right hand corner of the form
- Undertake an initial investigation to ascertain the facts and identify any immediate actions required to eliminate, reduce or control the risk where possible. If appropriate, staff should be alerted verbally, on notice boards or by email
- Conduct any necessary interviews and obtain statements to accompany the IR1 where appropriate
- Complete the Line Manager’s Comments section of the IR1. This should include any immediate actions taken and, if appropriate, the department/person to whom the IR1 has been forwarded for investigation.
- Forward the IR1 to the department/person responsible for the investigation. A copy of the form should be retained by the line manager
- Upon completion of the investigation and return of the IR1 ensure the Actions section of the form has been completed with actions or recommendations and an updated risk rating. If they are not satisfied with the outcome of the investigation they should redress the issue with the investigating officer or raise their concerns with the Risk Department or a Senior Manager within their Directorate
- Ensure they or the investigating officer provides feedback to the member of staff who submitted the IR1. This should be recorded on the Staff Sign Off section of the form. Feedback to staff on the actions taken following a reported risk is critical in improving and maintaining staff engagement
- Fax or post the completed IR1 including any statements, reports, photographs etc to the Risk Department.

**Guidance for Investigations**

The level of investigation will be dependant upon the risk rating and the type of incident/risk. General guidelines are as follows:

**Risk Rating:**

- **Low Risk (Green, 1-3)** – Local line manager should investigate and identify learning points or safety improvements
- **Moderate Risk (Yellow, 4-6)** – Local line manager should investigate however the nature of the incident and possible implications may require input from another department and the involvement of a more senior manager
- **Significant Risk (Amber, 8-12)** – Requires root cause analysis investigation led by a suitably trained manager. It will be the responsibility of the investigating manager to ensure all learning points and safety improvements are identified and implemented
- **High Risk (Red, 16-25)** – Requires full root cause analysis investigation by a suitably trained manager, or one of the dedicated Trust Investigation Managers in the event of a SIRI. The
recommendations from the investigation report may be included on the corporate risk register and any identified actions monitored by the Quality and Safety Committee.
# South Central Ambulance Service NHS Foundation Trust – Risk Scoring System

## Consequence/Impact Score

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>1 Insignificant</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Major</th>
<th>5 Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injury (Physical &amp; Mental)</strong> to anyone</td>
<td>Minor injury (not requiring first aid)</td>
<td>Minor injury or illness (first aid treatment needed)</td>
<td>Reportable to external agencies/statutory bodies (e.g., RIDDOR, HSE, NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY, Police, MHRA, CCG)</td>
<td>Major injuries, long term incapacity / disability (loss of limb)</td>
<td>Death or major permanent incapacity</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Unsatisfactory patient experience no injury</td>
<td>Unsatisfactory patient experience and or involving first aid treatment – readily resolvable</td>
<td>Mismanagement of patient care requiring more than first aid treatment and is likely to take more than one month to recover (breach of working practices)</td>
<td>Serious mismanagement of patient care (major permanent harm) (breach of working practices)</td>
<td>Totally unsatisfactory patient care (breach of working practices)</td>
</tr>
<tr>
<td><strong>Complaint / Claim Potential</strong></td>
<td>Locally resolved complaint</td>
<td>Justifiable complaint peripheral to clinical care / management</td>
<td>Justifiable complaint involving lack of appropriate care / management Claim below excess</td>
<td>Multiple justifiable complaints. Claim above excess</td>
<td>Multiple claims or single major claim</td>
</tr>
<tr>
<td><strong>Objectives / Projects</strong></td>
<td>Insignificant cost increase / schedule slippage Barely noticeable reduction in scope or quality</td>
<td>&lt; 5% over budget / schedule slippage Minor reduction in quality or scope</td>
<td>5 – 10% over budget / schedule slippage Reduction in scope or quality requiring client approval</td>
<td>10 – 25% over budget / schedule slippage Does not meet secondary objective(s)</td>
<td>&gt; 25% over budget / schedule slippage Does not meet primary objective(s)</td>
</tr>
<tr>
<td><strong>Service / Business Interruption</strong></td>
<td>Loss / interruption &lt; 1 hour</td>
<td>Loss / interruption &gt; 1 hour and &lt; 8 hours</td>
<td>Loss / interruption &gt; 8 hours and &lt; 24 hours</td>
<td>Loss / interruption &gt; 24 hours and &lt; 1 week</td>
<td>Loss / interruption &gt; 1 week</td>
</tr>
<tr>
<td><strong>Human Resources / Organisational Development</strong></td>
<td>Short term low staffing level temporarily reduces service quality &lt; 1 day</td>
<td>Ongoing low staffing level reduces service quality</td>
<td>Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)</td>
<td>Uncertain delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training</td>
<td>Non delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training</td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td>Small loss &lt; £100</td>
<td>Loss &gt; 0.1% of budget or &gt; £100 and &lt; £1,000</td>
<td>Loss &gt; 0.25% of budget or &gt; £1,000 and &lt; £5,000</td>
<td>Loss &gt; 0.5% of budget or &gt; £5,000 and &lt; £10,000</td>
<td>Loss &gt; 1% of budget or &gt; £10,000</td>
</tr>
<tr>
<td><strong>Adverse Publicity / Reputation</strong></td>
<td>Rumours Local Media interest (short term)</td>
<td>Local Media interest (long term)</td>
<td>National Media interest &lt; 3 days.</td>
<td>National Media interest &gt; 3 days.</td>
<td></td>
</tr>
</tbody>
</table>
South Central Ambulance Service NHS Foundation Trust – Risk Scoring System

<table>
<thead>
<tr>
<th>Likelihood Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost Certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>Not expected to occur annually</td>
<td>Expected to occur at least annually</td>
<td>Expected to occur at least every 6 months</td>
<td>Expected to occur at least monthly</td>
<td>Expected to occur at least weekly</td>
</tr>
<tr>
<td>Probability</td>
<td>&lt; 1%</td>
<td>1 – 5%</td>
<td>6 – 25%</td>
<td>26 – 60%</td>
<td>&gt; 60%</td>
</tr>
</tbody>
</table>

GOVERNANCE & RISK MANAGEMENT

Successful risk management depends upon both pro-active and reactive risk identification and reporting, the Consequence/Impact & Likelihood Descriptors can be used by any part of the organisation to help determine any eventuality whether it be Financial, Human Resources or Training etc and for scoring items being placed on the Trust Risk Register.

INCIDENT REPORTING/INVESTIGATION (IR1)

PROCEDURE Person reporting

1. Identify a heading from the Descriptor column in Table 1;
2. Consider and match to as near as possible the Consequence – Impact of the incident / occurrence from the definitions under;
   a. Insignificant, Minor, Moderate, Major, Catastrophic;
3. Tick the box on the IR1 form that corresponds to this figure under Impact heading in ‘Incident Details’.
4. Identify a heading from the Descriptor column in Table 2;
5. Consider and match to as near as possible the Frequency and or Probability from the definitions under;
   a. Rare, Unlikely, Possible, Likely, Almost Certain;
6. Tick the box on the IR1 form that corresponds to this figure under Likelihood heading in ‘Incident Details’.
7. Multiply the figures together from the Impact & Likelihood boxes and place this number in the ‘Total Risk Score’ box.

PROCEDURE Person investigating

1. Following your investigation of the incident/occurrence follow the steps outlined above in 1 – 7
2. The scores identified from the Descriptors column in Table 1 & 2 are decided upon following any remedial action identified/taken.
### Appendix 4A

#### South Central Ambulance Service NHS Foundation Trust - Risk Assessment Matrix

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Rare (1)</th>
<th>Unlikely (2)</th>
<th>Possible (3)</th>
<th>Likely (4)</th>
<th>Almost Certain (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insignificant (1)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Minor (2)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Moderate (3)</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Major (4)</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Catastrophic (5)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

It is important that all reported incidents are immediately and appropriately investigated and feedback provided to the submitting member of staff by the investigating officer/line manager as early as possible, however not all incidents require investigation to the same extent and depth.

<table>
<thead>
<tr>
<th>Category</th>
<th>Investigation</th>
<th>Analysis</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red (High)</td>
<td>- Full investigation by local/duty manager</td>
<td>- Full Root Cause Analysis</td>
<td>- Immediate control measures implemented</td>
</tr>
<tr>
<td></td>
<td>- Executive Director notified by telephone</td>
<td>- Refer to Ex Team</td>
<td>- Long term improvement strategy developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Refer to QSC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Board informed</td>
<td></td>
</tr>
<tr>
<td>Amber (Significant)</td>
<td>- Full investigation by local/duty manager</td>
<td>- Consider Root Cause Analysis</td>
<td>- Planned implementation of control measures</td>
</tr>
<tr>
<td></td>
<td>- Executive Director notified within 24 hours or</td>
<td>- Refer to Ex Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>by telephone if appropriate</td>
<td>- Refer to QSC</td>
<td></td>
</tr>
<tr>
<td>Yellow (Moderate)</td>
<td>- Investigation by local manager</td>
<td>- Trends monitored</td>
<td>- Where possible risk reduction measures introduced</td>
</tr>
<tr>
<td>Green (Low)</td>
<td>- Minimal investigation</td>
<td>- Trends monitored</td>
<td>- Minimal action</td>
</tr>
</tbody>
</table>

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GUIDANCE FOR MANAGERS ON INVESTIGATION AND ROOT CAUSE ANALYSIS

Introduction
The following guidance notes have been produced as an ‘aide memoire’ to assist managers in investigating reported risks, adverse incidents and near misses.

When do I need to investigate?
All risk reports require some degree of investigation and action, however in many cases incidents are relatively minor in nature and can be resolved quickly at a local level without the need for a formal investigation. In order to ascertain where the boundary is it is first necessary to risk score the incident report using the grid provided on the inside cover of the Risk/Adverse Incident Report Pad.

All significant risks (i.e. high risks and those involving injuries to patients, staff or others) should be fully investigated and recorded using full root cause analysis where appropriate.

Medium risks generally require full investigation but do not usually require root cause analysis unless re-occuring on a high frequency.

Investigating officers are required to use the NHS COMMISSIONING BOARD SPECIAL HEALTH AUTHORITY Incident Decision Tree http://www.msnpesa.nhs.uk/idt2/(5cl3wq55tddnrde1mdvipz45)/index.aspx as part of their investigation process and should always be completed before any decision regarding staff suspension.

INCIDENT REPORTING INVESTIGATION PROCEDURES
All incidents are to be investigated thoroughly by the appropriate line managers and the findings recorded on the on-line DATIX reporting system or the backup IR1 form.

Purpose of Investigation

- To fulfil Legal Duty
- To protect and gather evidence immediately following the incident
- To ensure appropriate lessons are learnt

The investigation must include full details of the circumstances of the incident to include:

a. Any equipment involved, recording type and serial number
b. Any medication, recording batch number and date of drug
c. Persons involved including staff and others
d. Vehicles involved including make and registration
e. Staff absences recording the length of time with an estimated return to work. Treatments received or follow up treatment planned
f. Statements taken from third parties
g. Police involvement recording incident number and PC identity
h. Record facts which lead to the incidents, time, date, location, position of staff and where incident occurred
i. Root Cause Analysis outcome
j. Utilising tape recording within the call centre
k. Utilising information from support databases
Incident investigations should:

- Learn from the incident and make recommendations to help prevent or minimise recurrences, thus reducing future risk of harm
- Identify underlying failures in infrastructure
- Identify reasons for substandard performance
- Satisfy mandatory and other reporting requirements

Investigations will be led by a manager with the relevant knowledge and experience to make authoritative recommendations. In most instances within SCAS the Investigating Officer will either be a Team Leader, PTS Manager or a nominated Senior Manager, other managers with specific areas of expertise e.g. Risk Managers, Assistant Director of Quality, Human Resources Department, Operational Directors or Ergonomics Adviser, may need to be involved or advise on certain cases. Other external stakeholders may also need to be involved, e.g. manufacturers of equipment, Health & Safety Executive. SIRIs and Never Events will be investigated by Investigation Managers.

A good investigation is prompt and thorough, to the necessary level and where possible remedial action or solutions will be recommended. If the investigation is not done as soon as practicable after the event, conditions and memories fade. The Investigating Officer is required to compile their report, basic analysis, action plan and recommendations.

There are five components of any investigation:

1. Collect evidence about what happened
2. Assemble and consider the evidence
3. Compare the findings with relevant standards, protocols or guidelines, whether these are particular to SCAS or national, to establish the facts, draw conclusions about causation
4. Make recommendations for action to minimise risk of recurrence *
5. Implement the recommendations, seeking collaboration with staff where possible and track progress

(* when a full Root Cause Analysis is undertaken this may result in an Improvement Strategy being drawn up with prioritised actions, responsibilities, timescales and indicators to measure the effectiveness of actions taken)

1. Collecting Evidence
The sources of information and methods that can be used in investigation typically fall into the three following categories:

Direct observation which is crucial to avoid losing important evidence about the scene, equipment involved, relationships between parts etc

Documentation, which identifies what has been recorded as happening at the time, helps establish should have happened, as well as providing evidence of prior risk assessment, inspections, tests etc

Interviews, which, conducted sensitively, provide both direct testimony as well as an opportunity to check back on any issues arising from examination of the physical and documentary evidence.

Although these are distinct and important elements of a thorough investigation, they complement each other. They provide an opportunity to ‘read across’ from one part of the process to another to check reliability and accuracy as well as resolve differences and gaps in evidence.
Adverse incidents seldom arise from a single cause; there are usually underlying failures in management systems, which have contributed to the circumstances leading to the incident.

2. **Assembling and Considering the Evidence**
Good investigations identify both immediate and underlying causes, including human factors. Immediate causes include the patient, the task, the work environment and the people involved, either individually or as part of a multi-disciplinary team. Underlying causes are the management, organisational, cultural and contextual factors that explain why the event occurred. Getting to the root of the problem by identifying the key underlying, or root causes, will help ensure development of an effective improvement strategy later on in the process that, if properly implemented, should prevent or significantly reduce the risk of recurrence.

3. **Comparing findings with relevant standards & protocols**
The next stage of the investigation is to compare the conditions and sequence of events with relevant standards, guidelines, protocols etc. This helps to minimise the subjective nature of investigations and to generate recommendations which have the maximum impact and relevance. The objectives are to decide:

- If suitable standards/procedures etc have been set to control all the factors influencing the incident
- If standards/procedures etc exist, are they appropriate and sufficient?
- If the standards/procedures were good enough, were they applied or implemented appropriately?
- Why any failures occurred?

4. **Make Recommendations**
Where the investigation identifies immediate or underlying causes involved, the Investigating Officer may be able to either take remedial action immediately or make recommendations for possible solutions to prevent recurrence within the Action Plan.

5. **Implement Recommendations**
If recommendations fall within the remit and level of authority of the Investigating Officer, they should be implemented without delay. If however, they are of a wider scope, require additional resources or have implications across the Trust, the risk and recommendations should be placed on the appropriate risk register and discussed with their line manager or Director, in accordance with the Trust Procedure for the Maintenance of Risk Registers.

Red incidents (and some Amber) will be followed up by the SIRI Review Group who will instruct that a full root cause analysis of the incident be undertaken. This will usually result in an Improvement Strategy being drawn up with prioritised actions, responsibilities, timescales and indicators to measure the effectiveness of actions taken.

It is important that progress on implementing recommendations or improvement strategies are tracked and that the effectiveness of actions taken is monitored. Effective actions result in demonstrable improvements in safety and, where appropriate, quality of care.

For advice and guidance on completing the incident report forms contact the Risk Department.
Further Guidance on carrying out a Risk Assessment

Introduction

South Central Ambulance Service NHS Trust has produced this document to provide a generic guide for the establishment and implementation of the risk management process involving establishing the context and the identification, analysis, evaluation, treatment communication and ongoing monitoring of risk. Risk Management is recognised as an integral part of good management practice. The Organisation is committed to expanding its knowledge of risk management and the intention is for a fully comprehensive risk management programme to be conducted throughout the services provided. To ensure adequate Healthcare Standards and clinical governance processes are followed. This document has been prepared using the joint Australia/New Zealand Standard on Risk Management, revision AS/NZ 4360:1999, which has been adapted to meet the needs of the Organisation to assess risks associated to Health and Safety incidents, Clinical Incidents and Complaints. This document is accepted as an International best practice document.

Aim

The principal aims of the risk assessment procedure are:

a. Reduce the exposure of risk to the lowest possible level
b. Provide the Organisation with an acceptable level of risk, which can be managed throughout the Organisation
c. Provide an early warning system for managing risk events
d. Provide data and information to monitor and manage risk within the Organisation.

Objective

To control the risk for the Organisation across all directorates by identifying and managing risk and at the same time heightening the awareness and importance of risk management.

Operational Use

Risk management can be applied at strategic and operational levels within the organisation. It may be applied to specific projects to enhance the decisions process and manage specific recognised risk areas. Risk Management is an interactive process that can contribute to organisational improvement. With each cycle, risk criteria can be strengthened to achieve progressively better levels of risk management. For each stage of the process adequate records should be kept, sufficient to satisfy independent audit.

Management of risk is a multifaceted process, appropriate aspects of which are often best carried out by a multi-disciplinary team. A risk assessment should be carried out using members of staff, from all levels, with relevant experience in the area being assessed. The line manager, along with the Risk Department, will be responsible for co-ordinating the risk assessment and provide the appropriate members of staff. The assessment team should be kept to a minimum and be able to communicate the findings and influence the outcome.

The Risk Assessment Tool should be applied for the following reasons or function:

a. For grading all incidents and complaints reported through the Organisation’s incident reporting system by senior managers, line managers and supervisors
b. Introduction of equipment, vehicles or premises
c. For any new initiative introduce by the Organisation i.e. SRV and First Responders, new IT software
d. Any major risk which has been identified by the Organisation

e. To manage and risk assess corporate management issues, policies and procedures

f. Identify risk within each operational directorate.

g. When changing clinical and non-clinical practice (change management).

h. Re-evaluate existing risk treatment plans on a continuous basis.

Methodology

The main elements of the risk management process are as follows:

a. Establish the context: establish the strategic, organisational and management context in which the rest of the process will take place. Criteria against which risk will be evaluated should be established and the structure of the analysis defined.

b. Identify risks: identify what, why and how things can arise as the basis for further analysis.

c. Analysis risk: determine the existing controls and analysis risks in terms of consequence and likelihood in the contexts of those controls. The analysis should consider the range of potential consequences and how likely those consequences are to occur. Consequence and likelihood may be combined to produce an estimated level of risk.

d. Evaluate risks: compare estimated levels of risk against the pre-established criteria. These enable risks to be ranked so as to identify management priorities. If the levels of risk established are low, then risks may fall into an acceptable category and treatment may not be required.

e. Treat risks: accept and monitor low-priority risks. For other risks, develop and implement a specific management plan, which includes consideration of funding.

f. Monitor and review: monitor and review the performance of the risk management system and changes which might affect it.

h. Communicate and consult: communicate and consult with internal and external stakeholders as appropriate at each stage of the risk management process and concerning the process as a whole.

Risk Documentation

Each stage of the risk management process should be documented. Documentation should include assumption, methods, data sources and results. The reasons for documentation are as follows:

a. To demonstrate the process is conducted properly

b. To provide evidence of a systematic approach to risk identification and analysis

c. To provide a record of risks and to develop the organisation’s knowledge database

d. To provide the relevant decision makers with a risk management plan for approval and subsequent implementations

e. To provide an accountability mechanism tool

f. To facilitate continuing monitoring and review

g. To provide an audit trail and

h. To share and communicate information.

The Organisation will maintain a risk register using an IT software Risk Management System, providing regular reports to the Trust’s Quality and Safety Committee and Board. The following documents are provided for the record and assessment of identifying risk within the organisation:
Risk Assessment Evaluation and Risk Rating

Risk assessments should be reevaluated using SCAS Risk Consequence (Impact) Score. With an agreed end date to ensure that the risk has been effectively managed. When analysing the risk the following guidelines should be adhered to:

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>DESCRIPTION OF RISK</th>
<th>REVIEW TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Low risk; managed by routine procedures*</td>
<td>One to two years</td>
</tr>
<tr>
<td>Yellow</td>
<td>Moderate risk; management responsibility must be specified</td>
<td>Six to a year</td>
</tr>
<tr>
<td>Amber</td>
<td>Significant risk; senior management attention needed</td>
<td>Three to six months</td>
</tr>
<tr>
<td>Red</td>
<td>High risk; immediate action required</td>
<td>One to three months</td>
</tr>
</tbody>
</table>

* Defined as replacement/repair of equipment or local training at Departmental level. This would include Health and Safety issues relating to the premises and working practice in the work place.

Using the Risk Consequence/Impact Score to identify the severity and likelihood of reoccurrence provides the Trust with information to quantify the level of acceptable risk. The colour coding within the risk assessment tool provides the Trust with four levels of risk. This is achieved by assessing the likelihood of reoccurrence on the column down the left hand side, and the consequences or impact on the Trust using the top horizontal row. Identifying the colour in the square at the horizontal and the vertical juncture will give you the risk evaluation. The colour corresponds to the four levels of risk, Green and Yellow to be dealt with at local level by operational and line manager responsibility and the Amber and Red to be reported to the SIRI Review Group via the Quality and Safety Committee and Trust Board. The Trust Board has the authority, and may choose to accept risks that are indentified high scoring risks.

Review timescales should be applied to all levels of risk as in the above chart. This would involve re-evaluation of the Risk.

Root Cause Analysis

Unless the fundamental, or root causes of adverse events or complaints are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in risks. Adverse incidents rarely arise from a single cause; there are usually underlying failures in management systems, which have helped to create the circumstances leading to the incident.

Full Root Cause Analysis (RCA) will, in the majority of circumstances, be undertaken by the Investigation Panel (IP) often with the assistance of the relevant Investigating Officer or other managers with expertise in specific areas. Where necessary, this group will also seek advice from external experts.

The purpose of the analysis exercise is to identify the Immediate, Contributory and Root causes of the incident or complaint and recommend remedial actions through an Improvement Strategy. It is not
proposed, in this guidance, to include a detailed explanation of RCA, however RCA would normally include the following steps:

1. Identify the incident
2. Preserve direct evidence from the scene & make detailed records/complete IR1
3. Chart the event with current knowledge
4. Gather documentary and other evidence
5. Revise the chart
6. Arrange and carry out interviews
7. Revise the chart
8. Identify causal factors
9. Analyse causal factors
10. Decide on and cost the options for improvement
11. Provide a report
12. Ensure implementation of improvement strategy, phased if necessary

The Investigation Panel would initially review the investigation report for the incident and confirm the identified causal factors from the Investigating Officer's IR1 and complete a RCA Checklist and then analyse all the factors to identify possible risk treatments. The ultimate focus for the Investigation Panel will be on the underlying causes, as described earlier, the management, organisational, cultural and contextual factors. The Investigation Panel will use the Root Cause Analysis Report to summarise their findings and produce an Improvement Strategy.

Improvement strategies should be designed to eliminate the root cause(s). This may involve changes in training, policies, procedures, equipment etc.

Where it is not practicable to implement risk treatments identified within the Improvement Strategy, the risk(s) should be logged on the appropriate Risk Register (in accordance with the Trust Procedure for the Maintenance of Risk Registers) to enable monitoring and review.

Membership of the Investigation Panel will be subject to the type of incident and which specialist manager is qualified to inform and take action on the identified Root Cause. The Investigation Panel will have a core membership of:

- Director of Patient Quality
- Assistant Director of Quality
- Risk Managers
- Investigating Officer
- Other managers as appropriate

Other members will be called at an add hoc basis as they are required. This will always include the investigating officer who investigated the incident(s) to be reviewed.
# RCA Tools – SCAS Tabular Timeline

<table>
<thead>
<tr>
<th>Event date and time</th>
<th>Event</th>
<th>Supplementary information</th>
<th>Notable Practice</th>
<th>Care/Service delivery problems</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
RCA Tools – SCAS
5 Whys

Issue to be explored:

Why?

   Why?

   Why?

   Why?

   Why?

   Why?
RCA Tools – SCAS
Fishbone

Patient factors:
- Clinical condition
- Social factors
- Physical factors
- Psychological/mental factors
- Interpersonal relationships

Individual (staff) factors:
- Physical issues
- Psychological
- Personality
- Social/domestic

Task factors:
- Guidelines/procedures/protocols
- Decision aids
- Task design

Communication factors:
- Verbal
- Non-verbal
- Written
- Electronic

Team + social factors:
- Role congruence
- Leadership
- Support + cultural factors

Education + Training Factors:
- Competence
- Appropriateness
- Availability
- Accessibility
- Supervision

Equipment + resources:
- Equipment supplies
- Visual display
- Integrity
- Positioning
- Usability

Working condition factors:
- Environment
- Design of physical environment
- Administrative
- Staffing
- Time/workload

Organisational + strategic factors:
- Organisational structure
- Policy, standards, goals
- Externally imported risks
- Safety culture
- Priorities

Problem or issue (CPD/SDP)
## RISK ASSESSMENT RECORD (CE01)

| ID No: | |
| Status: | |
| Register: | |

### Management Level
- **Low (Green) 1-3**
- **Moderate (Yellow) 4-6**
- **Significant (Amber) 8-12**
- **High (Red) 15-25**

<table>
<thead>
<tr>
<th>LIKELIHOOD</th>
<th>INsignificant</th>
<th>unlikely</th>
<th>likely</th>
<th>Almost certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>MINOR</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>MODERATE</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>MAJOR</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>CATASTrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

**X** Initial risk score

**X** Mitigated risk score

1. **What is the Risk?**

2. **What are the potential consequences?**

3. **Risk Management measures and references**

4. **Estimated Financial Costs associated with Actions**

5. **Additional Notes (including associated references)**

6. **Date of next review:**

Signed:

Position:

Date:
### DIRECTORATE ACTIONS

Risk Register updated (Date):

Quality and Safety Committee Review
(If appropriate)

Trust Board informed
(If appropriate)