South Central Ambulance Service
NHS Foundation Trust

SERIOUS INCIDENT (SI) POLICY

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
Bicester, Oxfordshire, OX26 6HR

TABLE OF CONTENTS

DOCUMENT INFORMATION

Author: Patient Safety Manager

Ratifying committee/group: Patient Safety Group

Date of ratification: September 2022

Date of issue: September 2022

Review date: August 2023

Version: 4

Previous version: **CPP23 No1**
21 August 2019 (revised September 2022)

NOTE: This document complements the Adverse Incident Reporting and Investigation Policy regarding the reporting of any incident or Serious Incident and as such does not negate the initial incident report completed on **DATIX** in the first instance.

DATIX is the core repository for all documentation and reports linked to any investigation which includes SI investigation. It is therefore a requirement for a reporting staff member, to raise a **DATIX** in respect of the incident. This will allow immediate access to information regarding the incident and allow communications via the email system within **DATIX** to be recorded and saved to that **DATIX** report itself.

This document will also, as changes are made through the NHS Patient Safety Strategy, July 2019 document, be updated to reflect the national changes that will be introduced through the Patient Safety Incident Response Framework (PSIRF).

1. Introduction

1.1 The South Central Ambulance Service NHS Foundation Trust (SCAS) 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. 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 If a university student is involved in a Serious Incident (SI) investigation the SCAS Education Department will be informed to liaise with the Higher Education Institute if required.

1.4 Suspension and if required disciplinary action will be undertaken by the local management team and the Human Resources Department, and not by the appointed Investigating Manager/Officer who is undertaking the SI investigation.

1.5 The Trust requires that all adverse incidents, near misses or hazards be reported and documented as part of a proactive approach to risk management utilising the DATIX reporting system. Through this reporting mechanism Serious Incidents, Never Events and Near Misses can be identified and have a rapid review by designated Patient Safety Managers, Clinical Governance Lead or other nominated Clinical Directorate manager, who will submit the review to the Incident Review Panel. The Panel will comprise of Assistant Directors, senior managers from within the Clinical Directorate, and a Medical Director if relevant to the incident. The review will identify if the incident is a serious incident (SI) as set out by NHS England 2018 SI Guidance document. Where it is custom and practice, the Incident Review Panel will also include the relevant CCG / ICB Commissioners. If it is declared a SI, the Incident Review Panel will appoint an appropriate investigating manager / officer who will log the incident onto the StEIS system. This policy details the action to be taken, which applies equally to both clinical and non-clinical incidents.

1.6 Where adverse incidents are reported and declared as a SI, they will be fully investigated with completion of that investigation being in line with the graded timeline as per StEIS requirements. All reasonable steps will be taken to implement control measures which will either remove or reduce the level of risk to an acceptable level should this have been identified through the reporting process. Additional steps in this regard can be implemented if identified during the investigation process in consultation with the Risk Management Team and

senior management. 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 patients, staff and organization.

1.7 The Trust will ensure that all policies and procedures relating to SIs are made available to all staff via the Intra and Internet electronic systems.

1.8 This Policy will be reviewed by the Patient Safety Group and upward report to Quality and Safety Committee every two years and should be read in conjunction with the Trust's Adverse Incident Reporting and Investigation Policy and the Duty of Candour policy (related policy is the Claims Management policy).

1.9 This policy will provide guidance to managers and staff on adverse incident reporting, investigations, Being Open, Duty of Candour, analysis and improvements and supporting staff through incidents, claims and complaints.

2. Scope

2.1 This policy applies to all staff in SCAS.

3. Equality statement

3.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees.

3.2 The Trust values differences between members of the communities we serve and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences to ensure equality of opportunity and diversity and remove any barriers that could potentially discriminate. Employees exercising their rights and entitlements under these regulations will suffer no detriment as a result. The Trust is entrusted to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

3.3 The Trust is committed to ensuring equality of opportunity and the absence of unfair discrimination is provided for all employees and stakeholders in line with the Equality Act 2010. We aim to demonstrate this equality of opportunity by removing barriers for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure.

3.4 SCAS seek to demonstrate our commitment to providing equality of opportunity by:

- Ensuring that everyone is treated fairly and with respect.
- Making sure that our workspaces are safe, secure and stimulating place for everyone.
- Recognising that people have different needs and understanding that treating people equally does not always involve treating them all exactly the same.
- Recognising that some employees need extra support to help them make progress and be successful.
- Aiming to make sure that no-one experiences harassment, less favourable treatment or discrimination because of:

  - Age
  - Disability
  - Race
  - Gender
  - Gender re-assignment
  - Religion and belief
  - Sexual orientation
  - Marriage and civil partnership
  - Being pregnant or having recently had a baby.

4. Aim

4.1 The aim of this policy is to ensure SIs are understood by all staff, reported in a timely way, set out statutory requirements and raise awareness of the opportunities for learning and its dissemination.

5. Definition of a serious incident (SI)

SIs are events in health care where the potential for **learning** is so great, or the **consequences** to patients, families and carers, staff or organisations are so **significant**, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond an incident which affect patients directly and can include incidents which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare or maintain 'business as usual'.

The occurrence of a SI demonstrates weaknesses in a system or process that needs to be addressed to prevent future incidents leading to:

- **Avoidable death** or **serious harm** to patients or staff
- **Future incidents** of **abuse** to **patients** or **staff**
- **Future significant reputational damage to the organisations involved**
- **Significant public concern**
- **Significant media concern**

SIs therefore require investigation to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

5.1 Examples of Serious Incidents
(Not exhaustive, intended as a guide only)

5.1.1 **Serious incidents involving patients** e.g. injuries to patients (RIDDOR reportable) and serious drug errors (including medical gases e.g. oxygen).

5.1.2 **Unexpected patient death on NHS premises in unusual or suspicious circumstances** as well as any situation whereby a death causes significant media interest.

5.1.3 **Serious injury, injury resulting in permanent harm, or unexpected death involving a member of staff, visitor, contractor or another person to whom the organisation owes a duty of care.**

5.1.4 **Serious damage to NHS property** e.g. through flood, fire or criminal activity.

5.1.5 **Major health risk** e.g. outbreak of infection such as salmonella or legionella.

5.1.6 **Chemical, biological, radiological or nuclear incidents** (CBRN incidents).

5.1.7 **Incidents likely to cause significant public concern and/or media interest.**

5.1.8 **Large scale theft, fraud, large confidentiality breaches or major litigation.**

5.1.9 **Suspension of health professional because of concerns about professional conduct, practice or criminal activity.**

5.1.10 **Incidents affecting large numbers of people.**

5.1.11 **Death, potentially life-threatening injury, or permanent impairment of health or development through abuse, neglect or serious sexual assault.**

5.1.12 **Marked trend or pattern of events causing concern for the Trust which is leading to further internal investigation.**

5.1.13 **Any event which is classified as the highest level of the Trust incident grading process and requires a significant level of internal Trust investigation or inquiry.**

6. Roles and responsibilities

6.1 Trust Board

6.1.1 The Trust Board will receive assurances that there are safe systems in place for risk management. They will receive:

- Upward report of the Quality and Safety Committee.
- All risk assessments categorised as 'Red' (high scoring risks) relating to SI events.
- Bi-monthly reports from the Executive Director of Patient Care and Clinical Transformation/Chief Nurse and other Directors.
- Assurance reports provided by external bodies such as the Care Quality Commission, NHS Protect and the NHS Resolutions (NHSR) etc.
- Monthly Integrated Key Performance Indicators reports.

6.2 Chief Executive

6.2.1 The Chief Executive has overall responsibility for having effective and safe systems in place for SI management and investigation within the Trust and for meeting all statutory requirements and adhering to guidelines issued by the NHS England and the National Reporting and Learning Systems etc.

6.3 Executive Directors

6.3.1 Executive Directors **have delegated responsibility for SI flagging / identification in conjunction with the Adverse Incident Reporting and Investigation Policy and will be responsible for ensuring that this policy is adopted in their respective area.**

Responsibilities of the Executive Directors will include:

- Championing the SI policy implementation process within their respective directorates.
- In conjunction with the Executive Director of Patient Care and Clinical Transformation/Chief Nurse and the Risk Department, ensure that the Trust's key risks relating to adverse incident, clams and complaints are identified and addressed.
- Raise staff awareness of the SI Policy and Adverse Incident Reporting and Investigation Policy.
- Provide the Trust Board with assurance that any SI investigating manager / Officers are provided with an appointed point of contact from the respective department, afforded full cooperation during the investigation, and that no undue delay is experienced in the completion of the investigation.

6.4 Executive Director of Patient Care and Clinical Transformation/Chief Nurse

6.4.1 The Director of Patient Care and Clinical Transformation/Chief Nurse has delegated responsibility for ensuring that there are safe systems in place for SI management and incident reporting.

The Executive Director of Patient Care and Clinical Transformation/Chief Nurse 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 Reporting and Investigation Policy throughout the organisation
- Identifying and 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 Trusts designated board and executive level lead for risk
- Acting as the designated Executive lead for Security Management.

6.5 Trust managers and supervisors

6.5.1 All Trust managers and supervisors are responsible for implementing and monitoring the SI Policy in conjunction with the Adverse Incident Reporting and Investigation Policy within their designated areas and scope of responsibility. In situations where a significant/serious incident (clinical or non-clinical) have been identified, immediate actions are to be taken to stop or prevent any further harm or injury to patient or staff.

They must ensure that the adverse incidents are reported via the Trust's incident reporting system DATIX.

They must also ensure that all related documentation is uploaded onto the relevant DATIX as soon after the incident as possible – and within a 12 hour period post incident.

Trust Managers and Supervisors will:

- Fully support and implement the SI Policy within their areas;
- Ensure that their department as a whole is effective and efficient in the management of potential and declared SI and their reporting and investigation;
- Ensure that the SI Policy is followed when assisting the nominated SI Investigations Manager (IM) / Investigations Officer (IO) in carrying out their investigations. They will also monitor the outcome either through

presentation of the investigation at the Incident Review Panel (IRP), or by reviewing the recommendations and implementing any changes needed through such recommendations within their directorate;

- Ensure that the 'responsible' and 'accountable' persons are named to undertake the actions identified within the report recommendations. Actions must be completed within the allotted timescale, and before the report is submitted to the reviewing ICB / CCG. Delays in completion of the actions must be justified and agreed with the ICB / CCG;
- Ensure they follow the principles of this policy in an open and transparent manner and support staff appropriately through any SI investigation process, claim, complaint or court hearing process;
- Requests for information, documentation and statements are provided by their Directorate's staff as quickly as possible.

6.6 Company Secretary

6.6.1 The 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 company secretary will inform the board when a SI has been declared.

6.7 Assistant Director of Quality

6.7.1 The Assistant Director of Quality will be responsible to the Executive Director of Patient Care and Clinical Transformation/Chief Nurse for the development of effective Trust wide policies and procedures. Specific responsibilities will include monitoring all areas of SI management, performance, maintaining and developing the Trust's SI databases. Providing information and reports on incident reporting, SIs, and complaints when required to the Quality and Safety Committee and commissioner contract meetings, with the purpose of 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 matters relating to SI management, incidents, concerns and complaints.

6.8 Patient Safety Specialist (PSS)

6.8.1 The Patient Safety Specialist will be responsible to the Assistant Director of Quality for the effective provision and installation of NHS England's National Patient Safety Strategy 2019 and the Patient Safety Incident Response Framework through provision of expert advice, support and high-level direction to SCAS as an organisation; and will require direct access to the executive team, which facilitates the escalation of patient safety issues or concerns. The PSS will also play a key role in the development of a patient safety culture, safety systems and improvement activity.

6.9 Risk Department

6.9.1 The Risk Department will support the Assistant Director of Quality in identifying any possible SIs that have been reported through the Trust's Incident reporting system. They will provide specialist advice and support to managers. They will ensure that investigations, safety audits and inspections are carried out. The Head of Risk and Security and Risk Managers will individually 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 Operational Health, Safety and Risk Group on incident reporting, identifying trends and actions.

6.10 Head of Patient Experience

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

6.11 Patient Safety Managers / Clinical Governance Leads

6.11.1 Patient Safety Managers / Clinical Governance Leads will be responsible for carrying out the investigation of SIs, Detailed Clinical Investigations, Systems / Joint SIs with other health care providers and any complaints as agreed with the Assistant Director of Quality and Patient Safety Specialist. They will also provide support to other investigating officers / managers within the Trust who may have been appointed to investigate incidents.

They will:

- Undertake reviews of incidents identified as a 'Potential SI' can be undertaken by any IM or Clinical Governance Lead (999, NHS 111 or PTS). The reviewer will ensure that as much information as possible has been collated and added to the 'Clinical Team' folder, then into the Investigations sub folder and onto the Excel spreadsheet named as 'Reviews of Datix Incidents'. Once this has been completed the person conducting the review will alert members on the **Incident Review Panel** of the incident and once all the required incident details have been obtained to allow for a decision to be made. Only then should the incident be reviewed by the Incident Review Panel. The Incident Review Panel will make the decision of either declaring the incident as a SI, Detailed Clinical Investigation or delegate the investigation to the named local management team to investigate.
- The nominated IM / IO will provide a 72 hour report for the respective ICB / CCG. This will be emailed via the respective ICB/CCGs **nhs.net** email

address for SI reporting. The SCAS Assistant Director of Patient Care and the Patient Safety Specialist must also receive a copy of the 72 hour report.

- The IM / IO will be responsible for recording the SI on the StEIS reporting system or getting someone who has access to StEIS to add it on for them.
- The IM / IO will also provide a brief synopsis of the incident – this to be sent to the Assistant Director of Quality who will review and send that to the Company Secretary and the Executive Board members.
- Ensure that weekly updates / progress are undertaken for each open SI – utilising the SI section that is found within the NRLS/RIDDOR/SI section in the Datix reporting system.
- The IM / IOs will populate an aggregated SI report – outstanding actions which will highlight unclosed actions on each open SI and naming the responsible persons for those actions. This will be submitted before each SI Incident Review Panel meeting for review.
- The Investigation Manager is responsible for initially completing the SI part of the section found on DATIX under the heading 'NRLS/RIDDOR/SI' option on the incident DIF2 screen. Thereafter completing as much as possible and updating the 'Investigation Progress' weekly in this section. Upon closure of the SI, the Investigation Manager will again complete the required information as seen on the NRLS/RIDDOR/SI option on the incident DIF2 screen.

6.12 All staff

6.12.1 All staff must:

- Understand that a SI investigation is not a disciplinary process, although the process of any additional support / learning / suspension / disciplinary actions will take place if needed by that person's own line management – while ensuring that the Just Culture ethos is followed;
- Understand and co-operate with the Adverse Incident Reporting and Investigation Policy;
- Co-operate in any investigation relating to a SI, adverse incident, claim or complaint to ensure an appropriate conclusion;
- Use the Trust's incident reporting system to report any incident that involves actual harm, near misses, a never event or where the Trust has failed to provide a service for which it is commissioned;
- Where concerned and the employee wishes to discuss any reportable issue in confidence, that they utilise the Freedom to Speak Guardian who will listen and provide advice / direction / support;
- Inform their line manager and seek support for any concerns around incidents, claims and complaints and any required appearance in court.

The process for reporting and investigation of a 'Never Event' is the same as for a SI. https://www.england.nhs.uk/publication/never-events

7. Reporting of serious incidents (SI) to the geographically responsible (Lead) in Integrated Care Boards (ICB) / CCG

7.1. This section of the Policy outlines the procedures which are to be adopted by senior officers and appointed person(s) of the South Central Ambulance Service NHS Foundation Trust, when dealing with a clinical or non-clinical serious incident.

There may be instances where the Trust will need to notify the lead ICB/CCG of **a potential** SI which may be happening at that time - for example, a live or on-going incident. These are defined as incidents which, because of their seriousness or nature, may attract adverse national or regional media attention. In these instances, the lead ICB/CCG will need to be informed of the incident to be able to provide advice and support but will also deal with the notification of other lead authorities and health care providers that could be impacted by the incident. The reporting of a potential SI to the respective ICB/CCG is the responsibility of the Executive Director of Patient Care and Clinical Transformation/Chief Nurse, the Assistant Director Quality or their nominee.

All reports from South Central Ambulance Service NHS Foundation Trust on serious incidents will be reviewed by the Trust and made available to the appropriate stakeholders. Such stake holders may include:

- Integrated Care Boards (Clinical Commissioning Groups)
- Department of Health
- NHSE/i
- Care Quality Commission (CQC)
- General Practitioners
- Out of hours Providers
- NHS Resolutions
- Private Providers
- Police, fire and rail services/coastguards
- Independent Office of Police Conduct
- HM Coroner
- Local authorities
- Medicines and HealthCare Products Regulatory Agency
- Information Governance Commissioner
- Health and Safety Executive
- UKHSA
- NHS Counter Fraud Authority Patient / relative
  (This list is not exhaustive)

If required, the Executive Director of Patient Care and Clinical Transformation/Chief Nurse / Assistant Director of Quality will review all potential serious incidents and where appropriate will ensure that they are reported to the lead commissioner for the respective ICB/CCG where the

incident has occurred and the CQC.

Other incidents or complaints which are serious but are not reportable to the respective ICB/CCG will be investigated internally by an investigations manager or another manager as appointed.

The Executive Director of Patient Care and Clinical Transformation/Chief Nurse will convene a review meeting of Datix incidents identified as 'Potential SIs'. This incident should have had a preliminary investigation / review undertaken by the Patient Safety Manager or CG Lead (999, NHS 111 or PTS). The reviewer will then ensure that as much information as possible has been collated and added to the **'Clinical Team'** folder, then into the sub folder **'Investigations'** and added to the Excel spreadsheet named as **'Reviews of Datix Incidents'**. Once this has been completed the person conducting the review will alert members on the Incident Review Panel (IRP) of the incident and a joint IRP Microsoft TEAMS meeting will then review the presented incident information. The IRP will make the decision of either declaring the incident as a SI, a Detailed Clinical Investigation or leave the investigation to the local named management team to investigate. The identification and decision to declare a SI may be conducted 'virtually' via Microsoft TEAMS, an email or telephone discussion by the Incident Review Panel in order to act swiftly when required.

7.2. ANY adverse incident (potential SI or not) that has occurred will require a **DATIX** report being completed as soon as is possible.

All associated documentation must be added to the **DATIX** report. If the incident is to be considered as a 'Potential SI', then for an informed review must take place, all statements, patient clinical records, call audits, shift reports, linked emails and actions that have been undertaken in an attempt to prevent or reduce the incident from happening again, must be uploaded into the **DATIX** report as soon as possible.

Once an incident has been reported on Datix, irrespective of which SCAS Directorate is then nominated to investigate and provide a report / outcome, all documentation, statements, chronologies and evidence will be uploaded and retained in the respective Datix report.

The nominated Investigating Officer / Manager will also maintain the 'Progress Notes' section in DATIX to ensure that should there be a situation where the nominated Investigations Officer / Manager is unable to complete the investigation, that the new person taking over the investigation, can see what stage the previous investigating officer / manager had reached.

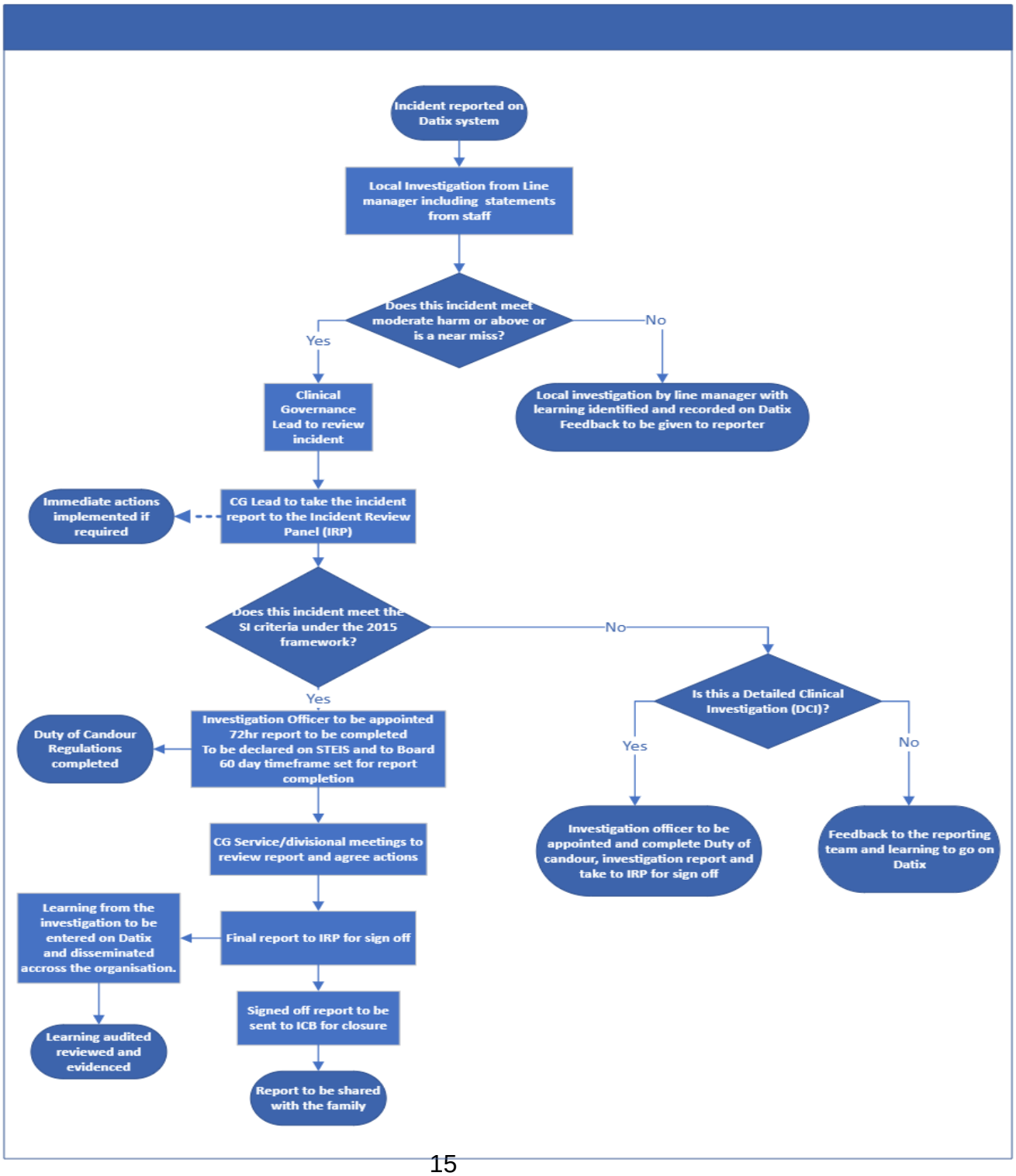
Lock Down: If the investigation is of a sensitive nature, the Datix can be 'Locked Down' which allows only specific named person access to that Datix report. This will therefore negate any retention of investigation documents on

other SCAS IT equipment such as personal issued laptops or on personal SCAS accounts.

Datix is the Trust's core incident documentation repository.

7.3. Potential SI reporting process:

The process of reporting a potential SI is exactly the same as for any other Adverse Incident – completion of a DATIX report.



A DATIX report is to be completed by the member of staff (if that person cannot undertake the reporting, then their line manager must ensure that the incident is reported). The reporter has the opportunity to provide a detailed account of the incident and also an initial "Severity and Result" with harm grading. Staff should be encouraged to provide as much information as possible at that time, recording detailed factual information devoid of hearsay or rumour.

The reporter identifies his/her line manager that is identified on the DATIX report as the primary investigating manager. The directorate is also identified as well as the operational area and location of the incident.

It is at this point that the primary investigating manager has the opportunity; to identify the adverse incident as being serious (possible SI) and requesting the Clinical Directorate Clinical Governance lead to review the incident. Notifications must utilise the DATIX internal email system.

The Executive Director of Patient Care and Clinical Transformation/Chief Nurse or Medical Director will review the incident details of a potential SI under the national framework (2015) in a weekly incident review panel (IRP). If the incident meets the SI criteria a StEIS entry will be completed and an investigation manager appointed.

The Assistant Director Quality will inform the trust board.

Each report in final draft will be reviewed at the service level governance meetings to create an agreed action plan.

The final report and actions will be signed off by the director led IRP.

An on-going incident negatively affecting / impacting the usual business of SCAS / or a declared Detailed Clinical Investigation Incident:

The incident must be reported on DATIX, and when the incident review has been completed and all staff debriefed, all documentation associated with that incident, must be added to the 'documents' section of that DATIX report. It is suggested that a DATIX report is opened as soon as possible, and that the reference number is then widely communicated to reduce the likelihood of duplicate reports being completed. If duplication does occur the system allows for reports to be linked.

The prime importance while the Incident is being investigated is to ensure that patients, staff, stakeholders and the public receive the appropriate care, protection and ambulance response / support, to limit or prevent any further injury or damage occurring.

It is at Gold Director Level that the Executive Director of Patient Care and

Clinical Transformation/Chief Nurse is informed. The Executive Director of Patient Care and Clinical Transformation/Chief Nurse will then cascade the information to the Clinical Directorate (the Assistant Director of Quality) if required.

All incident reports, incident logs, investigation record forms, witness statements and reports from officers involved are to be completed immediately or as soon as practically possible following the incident, scanned if required and uploaded to the relevant DATIX report.

*__Ensure the SCAS Resilience Officer is aware of what documents have been uploaded.__

When the report is made to the lead Integrated Care Board (ICB)/ CCG it should include full details of the incident, including how and why it happened. The ICB / CCG will also require information on how the Trust is managing the incident, including media handling arrangements, if appropriate. Contact details and a full report prepared for the lead ICB / CCG. In the telephone call details of the incident should be provided including:

- The date of the report.
- The name of the reporting organisation.
- The name, job title, telephone number and email address of the reporting individual.
- Apparent outcome of the incident in terms of harm (e.g. none, detailed clinical investigation, catastrophic).
- When the incident occurred (date and time).
- Where the incident occurred (specialty and locations).
- Who was involved (patient descriptions – **not names** – including gender, age, ethnic group; staff descriptions – **not names** – including job titles).
- What happened (including medical devices, equipment and or medicines involved)?
- What immediate action was taken (including an assessment of the actual and potential media interest)?

- What action has been taken to support and inform patients (or their relatives/carers) who have been or may be affected by the incident?

- Whether the incident has been or will be notified to any other organisations.

- Provide the name and contact details for someone who can be contacted for further information about the incident. When reporting information to the relevant ICB / CCG, it is important to remember the organisation's duty of confidentiality to patients and staff and to work within the six principles of Trust Information Governance Policy, Caldicott and the Data Protection Act.

7.4. Once an adverse incident has been declared a SI, the incident will be recorded onto the Department of Health's Strategic Executive Information System (StEIS).

The incident should be entered onto StEIS no later than two working days i.e. within 48 working hours after the incident has been declared a SI.

Declaring a SI on the StEIS system can be undertaken by the Head of Risk and Security or one of the Trust's Patient Safety Managers.

7.5. Serious incident investigations and reporting processes must be undertaken and completed in line with the NHS England's 'Serious Incident Framework' - Supporting Learning To Prevent Recurrence, 2018. In order to simplify the process of serious incident management, two key changes have also been made by NHS England:

- **Removal of grading** – NHS England has found that incidents were often graded without a clear rationale. This caused disagreement which led to incidents being managed in an inconsistent and disproportionate manner. Under the new NHS England 2015 framework serious incidents are not defined by grade. All incidents meeting the threshold of a serious incident must be investigated and reviewed according to principles set out in the new NHS England Serious Incident Framework.

- **Timescale** – a single timeframe (60 working days) has been agreed for the completion of investigation reports. This will allow providers and commissioners to monitor progress in a more consistent way. This also provides clarity for patients and families in relation to investigation timelines.

The Trust's Head of Risk and Security and Patient Safety Managers are the nominated leads to report Serious Incidents to the relevant ICB / CCG with an initial 72 Hour Report being sent to the respective ICB / CCG. This would be

after the incident had been declared a SI on StEIS.

8. Investigation of a serious incident

8.1 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?
- ✓ Determine the impact on patients and/or staff
- ✓ Provide 'Recommendations' to prevent or reduce the risk of a recurrence
- ✓ Provide an 'Action Plan' with responsible and accountable persons for Action completion
- ✓ Establish what 'Lessons Learnt' have been identified
- ✓ Identify any breaches to Trust policies, procedures or directives

8.2 Human error is frequently seen as a 'Direct' or a 'Contributory' cause of an incident. However, the Root Cause is often more complex involving series of factors which may 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 not addressed and rectified similar incidents could recur. Improvement strategies aimed solely at individual practices are unlikely to be successful in preventing a recurrence.

8.3 The structured and systematic review of events leading up to an adverse incident facilitates the identification of the direct, contributory and root causes.

- **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.
- **Human Factors** is defined as the study of how humans behave physically and psychologically in relation to environments, people or procedures. The investigator should, through investigation, identify any errors, if they were intended or unintended and identify the causes, and the most effective solution to prevent / reduce the likelihood of recurrence.

8.4 The analysis of the information gained from the investigation allows the determination / type of recommendations that will help to prevent another incident of the same kind, or one caused by similar issues. The identified

learning through the investigation process will be used to ensure learning takes place by individuals, teams or the organisation. Any recommendations made in the SI report will form the action plan. The relevant Directors of the Directorate(s) involved will have the responsibility for ensuring actions have been responded to, and where possible, completed before the SI report is sent to the relevant reviewing ICB / CCG body. Actions not completed, or which do not have a justifiable reason for non-completion may cause the ICB / CCG reviewing the SI report it to keep it open until such time that the action has been completed.

8.5 Incidents do not need to be investigated to the same extent or depth. Each incident is assessed against the risk grading matrix, and the level of investigation and analysis effort should be expended in relation to the level of risk and whether the incident has resulted in harm to patients or staff.

9. Investigation level of a SI

The incident review panels (IRPs) will decide on levels of investigations as defined by NHSE below

.

Level:	Application:	Product/ outcome:	Owner:	Timescale for completion:
Level 1 **Concise internal investigation**	Suited to less complex incidents which can be managed by individuals or a small group at a local level	Concise/compact investigation report which includes the essentials of a credible investigation	Provider organisation (Trust Chief Executive/relevant deputy) in which the incident occurred, providing principles for objectivity are upheld	Internal investigations, whether concise or comprehensive and must be completed within **60 working days** of the incident being reported to the relevant commissioner. All internal investigation should be supported by a clear investigation management plan
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable	Comprehensive investigation report including all elements of a credible investigation	Provider organisation (Trust Chief Executive/relevant deputy) in which the incident occurred, providing principles for objectivity are upheld. Providers may wish to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny/objectivity	

Level 3 **Independent investigation**	Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved.	Comprehensive investigation report including all elements of a credible investigation.	The investigator and **all** members of the investigation team must be independent of the provider. To fulfil independency the investigation must be commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated.	6 months from the date the investigation is commissioned.

9.1 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 the monitoring of trends. It may be appropriate to establish any causes or contributory factors. Where trends are identified this information should be shared with other departments, locations or other stakeholders to share safety lessons.

9.2 A full and detailed explanation of root cause analysis techniques and how they should be applied can be found at www.npsa.nhs.uk.

9.3 The investigation may 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, ICT etc.
- Someone with specialist knowledge to provide an objective view.
- Someone from the training department.

Where an expert or external independent investigator has undertaken the SI report, whether having been supported by a SCAS investigations manager or

not, that expert or external independent investigator will be expected to attend all presentations of that case to the incident review panel (IRP) chaired by the Medical Director or Executive Director of Patient Care and Clinical Transformation/Chief nurse or allocated deputy. The expert or independent investigator will also be expected to attend, when requested, any ICB / CCG Review / IRP as required. This requirement is due to the complexities and technical descriptions of incidents that would require the expert to discuss, describe and answer any questions that an investigations manager would not be able to answer due to specialist or technical content.

9.4 For detailed or system, for example where death or serious injury has occurred, where a criminal investigation may result or where there has been a serious failure of equipment; external agencies such as the Health and Safety Executive, Medicines and Healthcare Regulatory Agency, CCG, National Health Service Improvement (NHSI) or Police should be communicated with so that relevant information can either form part of the investigation team or to share lessons learnt.

9.5 The investigating managers may be able to take remedial action immediately for any underlying causes but will more usually make recommendations for possible solutions to prevent a recurrence. If they are of a wider scope, which require additional resources / finances 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 to the Incident Review Panel via the Quality and Safety Committee.

9.6 SIs or 'Never Events' reported to the relevant ICB will be investigated by an investigating manager / officer / CG Lead, supported by relevant experts within the various SCAS Directorates, depending on the nature of the incident.

9.7 The Incident Review Panel will monitor and follow up all action plans developed from SI/Never Events reported to the relevant ICB. The lead manager or departmental director will monitor and follow up action plans developed from a green (low) or yellow (moderate) risk investigation.

10. Supporting staff involved in a SI

10.1 Staff must be made aware by both their own line management and through the appointed SI Manager / IO that the SI process is not a disciplinary process, and that the investigation is to establish where either Policy, Procedures or actions caused or contributed to the incident. The investigation will identify recommendations / actions that may need to be taken to help ensure that a similar incident does not occur again. The investigation also looks to establish if organisational learning can take place and how best to share that learning to add to best practice.

10.2 The investigation will, however, identify any person / persons that may have breached any Policy, Procedure or action that s/he may have taken or omitted to undertake. Any support / retraining or Disciplinary procedures will be

undertaken by the staff member's own line management / Directorate and not the SI Investigations Manager.

10.3 Staff can contact the SI Investigating Manager / Officer to obtain clarity or provide any additional information that would be relevant to the investigation should they so wish.

10.4 The SCAS staff members that may be involved in a SI must be provided with the support mechanisms and pathways that are available at that time, to ensure that help is given as soon as possible by that staff member's line management:

- A named line manager is appointed as the staff member's Welfare Officer
- Trauma Risk Incident Management (TRiM) support is offered if applicable
- The staff member is fully aware of the OPTUM support (Employee Assistance Scheme)
- Occupational Health Provider referral is utilised where appropriate
- The staff member(s) involved are aware that they have the right to access the SCAS 'Freedom to Speak Up' guardian if they feel that they are not supported as outlined above. Freedom to Speak Up Policy

11. Duty of Candour and Being Open – corporate responsibilities

11.1 The Duty of Candour Policy, which incorporates Being Open, describes how the Trust should meet its contractual and ethical obligations to healthcare organisations or teams, patients and/or their carers by being open and honest about any mistakes that are made in the way patients have been cared for and treated.

11.2 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 (NPSA) document 'Being Open: Communicating patient safety incidents with patients and their carers'. The document is available at www.nrls.npsa.nhs.uk/beingopen

11.3 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'.*

11.4 'Being open' simply means acknowledging, apologizing and then explaining what happened to patients and/or their carers that have been involved in a patient safety incident (moderate, severe harm). This process only applies to those incidents where a patient has been harmed.

11.5 Apologising to a healthcare organisations / teams, patient, family and/or carers does not constitute an admission of liability and should occur whenever applicable.

12. Key principles

12.1 Communicating effectively with healthcare organisations, patients and their carers plays a vital part of the process of dealing with errors or problems with care and treatment. Effective communication reduces distress caused by the incident. It also reduces the likelihood of legal action 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, 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 NPSA 'Being Open' document details ten key principles that should be adhered to when communicating with patients and/or carers about an incident. These are:

- Acknowledgement of the incident.
- Truthfulness, timeliness and clarity of communication.
- Apology, verbal and written.
- Recognition of patient and carer expectation.
- Professional support.
- Risk management and systems improvement.
- Multidisciplinary responsibility.
- Clinical governance.
- Confidentiality.
- Continuity of care.

13. Duty of Candour for patients and families

Candour is the quality of being open and honest. Patients should be well informed about all elements of their care and treatment, and all staff have a responsibility to be open and honest to those in their care.

13.1 The incident may be identified by the healthcare organisations, patient, carer or member of staff through a patient experience feedback via the Trust internet, telephone or verbal complaint, or an incident report from a member of staff. All concerns will be taken seriously, and patient concerns should never be dismissed without further investigation.

13.2 Following the occurrence of a patient safety incident (moderate or severe harm) 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 made on the patient record.

13.3 The initial information given must be truthful, unambiguous and based solely on the facts known at the time. There must be no speculation as to possible causes, attribution of blame or criticisms made. The patient should be informed that they will be updated through face to face meetings, verbal and 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 opportunities for further questions and a single point of contact.

13.4 An incident report form on the Trust's incident reporting system Datix, must be completed and brought to the attention of the line manager. Staff and patients can be affected by their involvement in an incident. The line manager must ensure that the staff involved are fully supported after the incident and throughout any subsequent investigation.

13.5 A face to face meeting is usually the optimum method in which to meet and discuss the incident with patients / relatives. The IM / IO must consider the feelings of the patient / family that they wish to speak to, particularly if there has been a death involved in the incident. Contact in the first instance may be achieved by telephone. This call should include an introduction and reason given why the call is taking place. During the call, offer to hold a meeting or, if the family is still grieving or do not want a face to face meeting, ask if there is an alternative route that would be acceptable and possibly less intrusive / stressful to them i.e. via email, physical letters through the post or even via Microsoft TEAMS if they have the IT equipment to facilitate that. The important issue is to establish what they want and to try to get the patient / family engaged in the investigation. The IM / IO should also warn the patient / family of the level of detail in that will be found in the report, which is required by the healthcare organisations, may cause unintentional upset to the patient / family but this is to ensure that all specific details will be recorded to provide an open and honest account of the incident.

Whenever possible, when it has been agreed that a face to face visit is to take place, the IM / IO should be accompanied by another member of SCAS staff to provide corroboration of the meeting and any agreed outcomes.

This may be relevant if there has been a severe injury or death where the recollection of the incident could still be very emotional, and as such support must be available to all concerned at the meeting. 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.

13.6 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. 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, in Datix.

13.7 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 Patient Experience (PALS) service and complaints procedure should be provided.

13.8 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.

13.9 During these meetings the patient and/or carers may express feelings of anger, confusion or anxiety and these should be dealt with appropriately. A letter must be sent to the patient / relative or family after the initial meeting. It will confirm what is taking place and the timeline given to complete the investigation. The letter must also contain the agreed pathways and communication routes that the patient / relative and/or carers stated in the meeting.

13.10 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 – dependent upon how they have agreed to be communicated with. Information should only be provided to the patient and/or carers once the facts are known and the outcome report has been reviewed by the Incident Review Panel and if required by the SCAS Head of Legal Services. Regular contact with the patient and/or carers must be maintained to reassure them that the investigation is still underway, as agreed in the initial meeting / contact made with them.

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

13.12 When the investigation is complete a letter should be sent to the patient and/or carer. This should include an explanation of why the incident occurred, the results of the investigation, any actions that have been put in place to prevent recurrence and a clear statement of apology. 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. The letter to the patient and/or carer must be sense checked by another manager or by the SCAS Head of Legal Services before it is sent.

13.13 Throughout the process it is important that the patient is reassured that any dispute/legal actions that they may wish to undertake will not detract from future care. Reassurance can be given during face to face meetings, correspondence or telephonic discussion with the patient and/or family and reiterated in any documentation/letters set to the patient/family. All documentation is again to be added to the DATIX report.

13.14 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.

13.15 The Head of Patient Experience should be informed of all SIs to be able to reconcile these with any associated complaints or feedback.

13.16 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 Reporting and Learning Systems (NPSA) in line with National Guidance.

The Trust is committed to increasing the reporting of patient safety incidents and providing an open culture for staff to report incidents and receive feedback. This will encourage reporting from staff and will enable them to feel safe to admit errors or near misses. The Trust reviews patient safety incidents to improve the patient's experience and the care and treatment provided. The Trust has appointed a non-executive director (NED) to the role of patient safety champion. This NED is a member of the Quality and Safety Committee as well as the Operational Health, Safety and Risk Group.

14. Analysis and improvement

**** See Section 11 of the Adverse Incident Policy, page 26 - 27****

15. Summary and report writing guidance

Staff:
Any person involved in an incident which may be declared a SI will, at some stage be required to provide a "Summary of Event", and if required by the appointed Investigating Officer – a statement providing further details or information relating to the event/incident.

If a member of staff has been involved in an incident or was a witness to the event, then a Summary of Event or statement should be written as soon as possible.

The Trust's Incident reporting system allows for any related paperwork (statements, Chronologies etc.) to be uploaded onto that specific incident's record. This ensures one central, secure point where information can be stored. It should be used as the main repository by the investigating manager.

The staff member writing any statement or Summary of Event must

understand that this document may be read by the coroner, family or other persons who may gain access to such paperwork. Clinicians must be aware that their statements may well be given as an appendices' to the Health and Care Professions Council (HCPC) or other registering body – the statement should thus be of a high standard and not contain any hearsay or rumour, just facts.

The "Summary of Event":
This is to be completed by the person(s) involved in, or linked to, an event or incident that has been reported through the Trust incident reporting system and which has triggered an alert for a possible SI, where the reporting person or witness may have specific information relevant to the incident. The summary should be in their own words and the use of a statement template is strongly advisable. This should also include:

- How the event started off – this could be from the time that a call was received;
- What s/he did or was allocated to do at the incident;
- What s/he saw at or during the incident;
- What s/he didn't do or what was not possible to undertake;
- Whether s/he did not do a specific treatment / action, and why,
- What s/he may have been instructed to do by another person;
- What happened after the incident and did they report the incident (if not done already) and to whom?
- Any other witnesses?

15.1 Purpose of the initial Summary of Event:

The aim of obtaining an account of the incident immediately, or as soon as possible after the incident is to reduce the loss of possible vital information surrounding the incident (memory fade). The account of what happened will help the appointed IM / IO to deal with the investigation more quickly and allow a better understanding of exactly what occurred at the time of the incident.

The Summary of Event will also allow the investigator to use this summary at a later stage, (Coroner's Inquest etc.) allowing for a better referencing document to recall after the incident if required to provide or give evidence in respect of that incident.

It is important to get this Summary of Event from staff immediately (if possible), as off duty / annual leave or sickness could delay the investigation and important information may be lost due to memory fade.

The attending Duty Officer / Team Leader / Clinical Mentor can include the Summary of Event with other documentation. The staff member(s) must be informed that if the investigation requires further details, that the investigating manager would then contact the person concerned and arrange a meeting.

The member of staff can take advantage of having a friend or counsel from a

Union representative whenever making either a Summary or Statement, this option should always be offered to the member of staff.

15.2 Points to remember when taking a collating facts:

Read the Best Practice Guidelines for Investigations (available on the intranet). This sets out clear objectives and explains the responsibilities of the investigating manager / officer:

- Any statement should be written in clear and unambiguous style.
- The person recording the statement should not include any personal assumptions.
- Ensure that all appropriate rights have been afforded to the person from whom the statement is being taken and the offer of a friend or Union Representative to be present.
- All statements remain the property of the Trust. The statements can be shown or produced to a panel, court or to complainants under the Freedom of Information Act.
- The author of any statement may be required to rely on such statement in a court, ensure the statement is:
    - Dated.
    - Clearly headed.
    - Complainant, patient's name or incident report (DATIX or SI) number is used in the heading.
    - All pages are numbered.
    - When referring to any clinical care, reference should be made to the Patient Clinical Records / Policy or Guidelines to ensure any statement made, is correctly reflected.
    - Any statement should be factual and/or evidenced based.
    - Avoid making assumptions, using hearsay or presuming that another person would have undertaken an action – remain factual in respect of what you heard, saw and did.
    - Document is signed.

15.3 Initial documentation required:

- The incident report (DATIX) (or complaint letter registered through Patient Experience Team if via public).
- Summary of Event from staff members concerned if raised through staff member.
- Incident Summary and Unit Summary from iNetviewer (or EOC) if an Operational incident / investigation being undertaken.
- Any attending manager - Bronze or Silver / Team Leader / Clinical Supervisor who obtains Summary of Events or takes a statement should also supply a summary of what they found in respect of the incident or event if they were also on scene.

The above are the basic requirements/information that would be needed to start an investigation.

15.4 Root Cause Analysis RCA):

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 risk. 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.

In conjunction with the service/ department, staff members involved in a SI should be given the opportunity to contribute to the RCA process at an early stage.

The purpose of the analysis exercise is to identify the Direct, 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:

The CG service groups will initially review the investigation report for the incident and confirm the identified causal factors from the Investigations Manager / Officer's incident report on DATIX and complete a RCA Checklist and then analyse all the factors to identify possible risk treatments. The ultimate focus for the incident review panels 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 plan.

Any improvements 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.

15.5 Membership of the incident review panel:
Membership of the 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:

- Executive Director of Patient Care and Clinical Transformation/Chief Nurse
- Medical Director or deputy
- Assistant Director of Quality
- Investigating Officer
- Other managers as appropriate

The subcommittee will inform the Communications Team of a decision to declare a SI. Other members will be called at an ad hoc basis as they are

required. This will always include the investigating officer who investigated the incident(s) to be reviewed.

15.6 The nominated Investigation Managers (IM) / Investigating Officer's (IO) responsibilities:

- The named IM / IO will note the SI's submission date and work to that time scale to complete the investigation so that the report is submitted to the respective ICB / CCG on or before the submission date
- The IM / IO will ensure that they utilise DATIX as their main document repository, that the Datix SI section is updated weekly and that the 'Progress Notes' are utilised to maintain a running update of any contacts or actions taken, or response to any queries
- The DRAFT report will be reviewed by the SCAS Incident Review Panel at least twice before submission to the relevant ICB / CCG SI Closure Group
- The accountable IM / IO will ensure that the DRAFT reports are uploaded to the Incident Review Panel Folder in Microsoft TEAMS by the date posted by the Directorate's Executive Secretary.
- The IM / IO must be present at the Incident Review Panel meeting to present the Investigation Report and to answer any relevant questions posed by the Incident Review Panel membership.
- The IM / IO will present the SI report to the relevant ICB SI Closure Group or Quality Board as required.

16. Monitoring

16.1 The compliance with, and the effectiveness, of this policy will be monitored by the Assistant Director of Quality and incident review panel members.

16.2 This policy will be reviewed every two years by the document lead.

16.3 Where risks, deviations or failings to adhere to this policy are identified, this will be escalated to the Executive Director of Patient Care and Clinical Transformation/Chief Nurse and the Trust Chief Executive.

17. Training

All staff will be encouraged to undertake HEE level 1 training on the OLM platform. Other training will include partner organisations, conferences, HEE levels 2-5 and collation of facts training.

18. Equality and diversity

18.1 An initial screen equality and diversity impact assessment has been carried out on this policy, it is available on request.

19. Consultation and review

19.1 A consultation exercise on the policy will be carried out with the stakeholders if there are any relevant changes to legislation or best practice.

20. Implementation (including raising awareness)

20.1 The policy will be implemented and communicated to managers and staff within the Trust via the weekly newsletter, Staff Matters. Emails will also be sent to senior managers and area managers asking them to bring the existence of the policy to their staff.

21. References

RELATED SCAS POLICIES AND NHS REFERENCE DOCUMENTS
Adverse Incident Reporting and Investigations Policy Risk Management Strategy Health and Safety Policy & Procedures Patient and Public Experience Policy Information Governance Policy Freedom of Information Policy
Risk Management Strategy
Freedom to Speak Up policy
Security Policy
Dignity at Work Policy
Duty of Candour policy
NHSE (2015) SI
framework

Note: All SCAS Foundation Trust Policies can be accessed on both the staff intranet and public internet - www.southcentralambulance.nhs.uk

National Patient Safety Agency – "*An Organisation-wide Document for the Reporting and Management of Incidents Including Serious Incidents*": www.npsa.nhs.uk

Never Events: http://www.england.nhs.uk/ourwork/patientsafety/never-events/

21.1 The NHS Patient Safety Strategy, July 2019**:**

https://improvement.nhs.uk/resources/future-of-patient-safety-investigation

22. Associated documentation

22.1 There are also the following documents associated with this policy:

- Adverse Incident Reporting and Investigation Policy
- Strategy Health and Safety Policy and Procedures
- Patient and Public Experience Policy
- Information Governance Policy
- Freedom of Information Policy
- Risk Management Strategy
- Freedom to speak up policy
- Security Policy
- Dignity at Work Policy
- Duty of Candour

- **Note:** All SCAS Foundation Trust Policies can be accessed on both the staff intranet and public internet - www.southcentralambulance.nhs.uk