South Central Ambulance Service
NHS Foundation Trust

Policy and procedure for managing Serious Incidents (SI)

South Central Ambulance Service NHS Foundation Trust
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Contents

DOCUMENT INFORMATION

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1. Introduction

1.1 In accordance with the NHS England Serious Incident Framework (March 2015), Serious Incidents (SIs) in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. This policy describes the circumstances in which such a response is required and the process and procedures for achieving it. This policy will support staff to meet the aforementioned Serious Incident framework requirements with regards to the reporting, investigation and management of all incidents declared as Serious Incidents and the associated learning and improvement.

1.2 The South Central Ambulance Service NHS Foundation Trust (hereafter known as the Trust) provides health services (e.g. 999, NHS111/Integrated Urgent Care, Non-Emergency Patient Transport services) across Berkshire, Buckinghamshire, Hampshire, Oxfordshire, Surrey and Sussex. As a provider of NHS commissioned services, the Trust has a duty to report, investigate and manage incidents, including Serious Incidents, through procedures aligned with the national requirements.

1.3 To fulfil this, the Trust has processes in place for reporting of incidents and the identification and declaration of Serious Incidents.

1.4 Therefore, this policy sets out the arrangements for the reporting, investigation and management of Serious Incidents.

1.5 This document will be reviewed annually or sooner, to ensure it is aligned with any updated documents provided by NHS England/Improvement, which set the national standards for Serious Incident management.

2 Purpose and Scope

2.1 Our overall purpose is to improve the health, wellbeing and independence of all service users, patients and the public. It is a priority of the Trust to deliver care in a safe environment to protect patients, visitors, staff and the organisation from harm.

2.2 All staff have a legal duty to ensure their own safety at work and the safety of others who can be affected by their acts or omissions whilst at work. All healthcare staff have a professional and ethical responsibility to ensure that service users in their care come to no harm. In order to ensure this the Trust has developed a framework for Serious Incident reporting, management and learning which is coordinated by the central Patient Safety and Governance teams but owned by the operational services/directorates.

2.3 The policy has been created to follow the requirements of the NHS England Serious Incident Framework published in March 2015 and the 2019 NHS Patient Safety Strategy.

2.4 The policy provides a definition of a Serious Incident, and direction in reporting, and management of all Serious Incidents. This policy is supported by the Trust's Risk Management Strategy and policy, Incident Reporting policy, Being Open and Duty of Candour policy and Freedom to Speak up policy.

2.5 The framework described within this policy promotes an open and honest safety culture where employees are supported to report all incidents including those which have occurred due to human error. The Trust operates its Serious Incident management framework in a 'just and learning culture' where action against individuals will be considered only if there has been reckless intent, failure to follow Trust Policy or Practice Guidance or have acted outside of their professional boundaries, scope of practice or responsibilities.

2.6 The Trust's approach to investigating and learning from Serious Incidents is focused on what went wrong and what could be improved, and not who is wrong. However, if staff feel unable to report an incident via the Trust's incident reporting system, Datix they should follow freedom to speak up procedures.

2.7 While the emphasis of investigating and learning from Serious Incidents focuses on identifying and addressing failures in systems and processes, in certain circumstances it may be necessary for disciplinary procedures to be initiated, including occasions where:

- The incident has resulted in a police investigation or an investigation by Counter Fraud
- There are repeated occurrences involving the same individual
- In the view of the Trust and/or any professional body, the action(s) causing the incident were far removed from acceptable practice
- There is evidence of an attempt to conceal the fact that the incident occurred or to tamper with any material evidence relating to the incident
- Safeguarding allegations are made against a member of staff.

2.8 This policy should be read in conjunction with these associated SCAS documents:

- Incident Reporting Policy
- Being Open and Duty of Candour Policy
- Freedom to Speak Up Policy
- Safeguarding Policies
- Infection Prevention and Control Policy
- Health and Safety Policy and Procedure
- Mental Health Policy
- Management of Allegations against Staff Policy.

2.9 This policy applies to all staff who work for or on behalf of the Trust, including Community First Responders, contract workers, temporary workers, bank staff and those who work on an honorary basis. It also applies to contractors and Private Providers.

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 where 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 We 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 a 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. Roles and Responsibilities

4.1 Trust Board

4.1.1 The Trust Board will ensure that there are suitable and sufficient arrangements and adequate resources for the effective implementation of this and other associated Trust policies.

4.1.2 It will also ensure that there are suitable and sufficient arrangements for the reporting, investigation and management of incidents, including those identified as Serious Incidents reported on the Trust's Incident reporting system, Datix.

4.2 Chief Executive Officer

4.2.1 The Chief Executive has overall accountability for Patient Safety and Risk Management, with the responsibility delegated to the Chief Nurse as the Trust Executive Lead. The Chief Executive is responsible for:

- Promoting an effective patient and staff safety reporting culture within the Trust
- Ensuring that the Trust fulfils its legal responsibilities, and that the policy objectives are achieved and that there are effective arrangements in place for the reporting, investigation and management of incidents
- Ensuring that there are robust arrangements in place to share all learning from incidents, near misses and issues of concern
- Ensuring that Trust policies are reviewed as appropriate in order to secure continuing compliance with existing policies, current legislation and any changes in the law
- Ensuring the allocation of the resources necessary to maintain robust and efficient incident reporting arrangements
- The effective implementation of this policy within the Trust.

4.3 Executive Directors

4.3.1 Executive Directors are responsible for the effective implementation of this policy and any related policies within their Directorates, and for ensuring that there are adequate resources available to fulfil the requirements of this policy.

4.4 Executive Director of Patient Care and Service Transformation/Chief Nurse

4.4.1 The Executive Director of Patient Care and Service Transformation/Chief Nurse is directly accountable to the Chief Executive and will advise and assist the Trust Board in fulfilling its duties under the relevant statutory legislation. The Director of Patient Care and Service Transformation/Chief Nurse has delegated responsibility for ensuring that there are robust and effective arrangements in place for the reporting, investigation and management of all incidents, near misses or issues of concern, including incidents identified as Serious Incidents.

4.4.2 In particular, the Executive Director of Patient Care and Service

Transformation/Chief Nurse is the effective lead for quality and safety, and is also responsible and accountable for:

- All aspects of Serious Incident Management within the Trust and ensuring that management arrangements / frameworks are in place to comply with this policy.
- Ensuring that there is a robust reporting structure in place via the Quality and Safety Committee and to the Trust board. *This is monitored through: agendas and minutes from Trust Board, Quality and Safety Committee and Patient Safety Group and Incident Review Panels*.

4.4.3 The Executive Director of Patient Care and Service Transformation/Chief Nurse is also the Trust's Accountable Officer for controlled drugs and is responsible and accountable for:

- Sharing information within Local Intelligence Networks (LIN) in relation to controlled drug incidents and/or fraudulent behaviours of relevant people: in this context a relevant person is anyone who prescribes, dispenses, administers or transports medicines, and information will only be shared about those individuals where there are well founded concerns in relation to patient safety. This is in-line with the Statutory Instrument 3148 of the Health Bill in relation to the Accountable Officers Responsibilities.

4.5 The Chief People Officer

4.5.1 The Chief People Officer has a specific responsibility to ensure and provide assurance to the Board and Chief Executive that processes are in place for all staff who are involved in a traumatic or stressful event to be supported throughout and receive continued support after the event, if required.

4.6 Operational Service Directors and Senior Managers

4.6.1 Operational Service Directors and Senior Managers are responsible and accountable for:

- Promoting the importance of this policy to all staff, including temporary staff.
- Developing and maintaining a robust governance framework which ensures:
  - All actions required are fully implemented, evidenced and lessons learned are shared.
  - Serious Incidents are monitored, identifying any trends and outlying events - using this information to support the identification of risks; and providing additional scrutiny and action as required, to address any concerns.
  - Promoting best practice.
- Ensuring the Clinical Governance and Patient Safety team are notified of any service or organisational changes in a timely way to enable

maintenance of reporting structures embedded in the Risk Management System supporting electronic reporting (Datix).

- On-Call Managers and Directors are responsible for informing NHS England of any Major Incident within the Trust.
- As managers they also have the responsibilities listed in section 4.7 below.

4.7 Managers of Teams or Services

4.7.1 Managers of Teams or Services are responsible and accountable for:

- Ensuring this policy and procedure is applied within their area of responsibility; ensuring staff are aware and comply with their responsibilities outlined in this policy.
- Demonstrating that all staff (including temporary staff) have received appropriate training in these arrangements.
- Ensuring appropriate corrective actions are implemented following a serious incident, escalating concerns where management is outside of their area of control or where the incident or its impact may affect others.
- Providing staff, service users or other persons involved in the serious incident with appropriate professional or personal support or access to such support as appropriate.
- Referring any incident where there is any suspicion of fraud, bribery, corruption or a similar offence to the Counter Fraud.
- Ensuring that incidents involving staff or patients that are RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable are additionally discussed with the Trust's Risk Management Team in a timely manner.

4.8 All Staff

4.8.1 All Staff (including agency, bank, students and contractors) are responsible and accountable for:

- Ensuring that they report all incidents, near misses or issues of concern immediately or within 24 hours using the Trust's Incident reporting system, Datix; and/or they use the paper based IR1 system if Datix is temporarily off-line or unavailable and report within the said timeframes
- If staff are unable to report the incident, near miss or issue of concern immediately or within 24 hours they should make arrangements to ensure that their manager is aware of the incident, near miss or issue of concern; and as soon as they are able to, the member of staff should report the incident, near miss or issue of concern
- Taking appropriate action following an incident to prevent or reduce the chance of the incident re-occurring, escalating concerns where needed, and supporting improvements to work processes following incident investigations and recommendations.
- Raising concerns using Trust policies/procedures as appropriate.
- Completing the Trust organisational induction, which includes an overview of incident reporting, and keeping up to date with statutory/ mandatory/

essential training and education.

4.9 The Patient Safety Team

4.9.1 The Patient Safety Team will:

- Provide advice and support to all staff and ensure training, resources and information is available relating to reporting, managing and investigating serious incidents.
- Ensure all serious incidents are reported and investigated in accordance with this policy and procedure, in the spirit of a 'just and learning culture' and work collaboratively with those involved in the serious incident (patients, their families/loved ones/carers and Trust employees).
- Provide a range of reports to different levels within the organisation to enable scrutiny of data, identification of risks and the sharing of learning from all serious incidents.

This is monitored by the Quality and Safety Committee and Patient Safety Group.

4.10 The Clinical Governance Team

4.10.1 The Clinical Governance Team will:

- Provide a review of all Patient Safety Incidents reported onto the Trust's Incident reporting system (Datix) where the Trust has potentially or contributed to harm
- Escalate any incidents to the Incident Review Panel where moderate harm or above has occurred.

5. Definitions of Terms Commonly Used in Serious Incident management

5.1 ***Serious Incident' (SI)*** - Some incidents are classified as Serious Incidents (SIs). As defined in the Serious Incident Framework (2019) In broad terms, serious incidents 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. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.
All incidents declared as "Serious Incidents" have to be reported on the Strategic Executive Information System (StEIS) and investigated within specific timeframes.

5.2 **'*'Duty of Candour' (Being open)*** – This is the legalistic term which describes being open and honest in communication of Patient Safety Incidents that result in moderate harm or death with the patient, service user and family members. By 'being open', the Trust will acknowledge the incident has occurred,

apologise to the patient/service user/family member and explain why the incident occurred and what actions will be put in place to prevent reoccurrence.

5.3 **Strategic Executive Information System (StEIS)** – A reporting system 'hosted' by the Department of Health; all Serious Incidents are recorded on this system by the Patient Safety Managers.

5.4 **SCAS template for Initial incident review at IRP** – A short investigation report which is factual and used to assist decision making as to the level of further investigation required and immediate safety concerns which need to be addressed. The report should be attached to the (Datix) incident. The report is compiled to be presented and discussed at the incident review panel.

5.5 **Root Cause Analysis (RCA)** – Is a formal analysis framework which should be used as part of the methodology when investigating Serious Incidents.

5.6 **Severity of Harm from Incidents** - The severity of the incident is determined from the outcome to the individual due to an act or omission of care, impact on the service or the organisation. NRLS definitions of Harm are: no harm, low harm, moderate harm, Severe harm or death. For further details, see Appendix 7.

6. Identifying a Serious Incident

6.1 Serious Incidents are often triggered by events leading to adverse outcomes for patients, staff and/or the organisation involved. They may be identified through various routes including, but not limited to, the following:

- Incidents identified during the provision of healthcare by a provider;
- Concerns or allegations expressed about a provider by a patient or third party;
- Initiation of other investigations for example:
    - Child Safeguarding Practice Reviews (CSPRs)
    - Safeguarding Adult Reviews (SARs)
    - Safeguarding Adults Enquiries (Section 42 Care Act)
    - Domestic Homicide Reviews
    - Death in Custody Investigations, led by the Prison Probation Ombudsman
    - Information shared at Integrated Care Board Quality Group meetings
    - Complaints and Health Care Professional feedback
    - Speaking up
    - Prevention of Future Deaths (Regulation 28)
    - Reports issued by the Coroner.

6.2 Where a Serious Incident is declared by another NHS provider and the Trust is involved in the delivery of care then the Trust will conduct an investigation in accordance with the terms of reference for the Serious Incident. This will be done to ensure any specific questions are answered and learning actions are identified. When doing this, the Trust would use the External Information

Request template in Appendix 10.

6.3 There is no definitive list of Serious Incidents and lists should not be created locally. Every incident must be considered on a case-by-case basis using the description below. The broad circumstances included in the National Revised Serious Incident Framework (March 2015) in which a Serious Incident must be declared are:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in ***unexpected or avoidable death***. This includes:

  - suicide/self-inflicted death
  - homicide by a person in receipt of mental health care within the recent past (normally within 6 months of discharge from care)
  - death of an individual who was subject to detention under the Mental Health Act 1983.

- ***Unexpected or avoidable injury*** that has resulted in serious harm, or requires further treatment by a healthcare professional in order to prevent death or serious harm
- ***Actual or alleged abuse;*** sexual, physical or psychological abuse, neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern-day slavery where healthcare did not take appropriate action to safeguard against such abuse occurring or where abuse occurred during the provision of NHS-funded care.
- A ***Never Event*** – regardless of whether it resulted in actual serious harm or death. See http://www.england.nhs.uk/patientsafety/serious-incidents/
- An incident that prevents, or threatens to prevent, an ***organisation's ability*** to deliver an acceptable quality of healthcare services, including the following:

  - Failures in the security, integrity, accuracy or availability of information, data loss and/or information governance related issues (relates to SCAS Information Governance Policy)
  - Property damage
  - Security breach/concern (this will include absence without authorised leave for patients who present a significant risk to themselves or the public)
  - Screening and immunisation programme incidents where the potential for harm may extend to a large population
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS)
  - Systematic failure to provide an acceptable standard of safe care.
  - Activation of Major Incident Plan.

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an

organisation.

6.4 It may be appropriate for a ‘near miss’ to be a classed as a Serious Incident. This does not mean that every ‘near miss’ should be reported as a Serious Incident but, where there is a significant existing risk of system failure and potential serious harm, the Serious Incident process should be used to understand and mitigate that risk. Where an incident is considered to have a potentially significant impact, albeit that a near miss occurred, this should be discussed at an Incident Review Panel (IRP).

6.5 Where the Trust has identified an incident that has occurred which involves multiple providers or other agencies, the Patient Safety Team will alert other providers, ICS, and partner organisations as required, in order to initiate discussions in regard to the identification of the lead organisation, scoping and reporting arrangements, organisational Serious Incident report sign off and ICS sign off arrangements.

7. Immediate Action to Undertake When a Serious Incident occurs

7.1 The immediate actions to undertake when a Serious Incident occurs will include:

- Ensuring the immediate safety of all involved in the incident, including the safety of patient(s), staff members and the public
- Informing the local service manager or on call manager of the incident
- Following relevant Trust policies relating to infection control, falls, medicines management and safeguarding
- Reporting the incident on the Trust’s Incident reporting system (Datix).

8. Serious Incident (SI) Investigation Procedure

8.1 The Serious Incident (SI) investigation procedure involves:

- Incident reporting and review of incident by the management and Clinical Governance Teams and Patient Safety Teams.
- Incident Review Panel (part 1)
- Patient Safety Incident Investigation, Root Cause Analysis Report and Improvement Action Plan
- Service Level Clinical Governance meeting
- Corporate assurance and sign off of the Serious Incident (SI) Investigation Report at Incident Review Panel (part 2); please see Appendix 12 for the Serious Incident (SI) Investigation Report Template.
- *ICS sign-off follows these and is managed externally to SCAS.*
- *All identified learning shared across the Trust through various groups and mediums.*

8.2 Terms of Reference for the Incident Review Panel (IRP) is available in Appendix 6.

8.3 **Involvement of patients, families** and loved ones is clearly applicable throughout the investigation process. This level of involvement is more that the legalistic requirement to fulfil Care Quality Commission: Regulation 20 Duty of Candour. This engagement should be personable, honest and open. The Trust is seeking the views of patients and their families about the quality of care provided, in order to understand any concerns. Any concerns and questions identified by the patient or family should be addressed during the investigation process and responses included in the final report. The report should be written in an accessible format to enable it to be shared with patients and their families.

8.4 When writing to the patient, their family or the 'Next of Kin', to fulfil the requirements of the 'Duty of Candour', Investigating Officers should use the Duty of Candour template letter in appendix 8.

8.5 When the clinical records have not identified or listed an accurate 'Next of Kin' contact details for those who have been harmed or died, the investigating manager will actively search for a 'Next of Kin' through other agencies:

- Coroners' Officers
- General Practitioners
- The Police
- Other involved services.

8.6 People will have different needs and the Investigating Manager should assist in signposting people to other services who can provide counselling and more individualised support if it is required.

8.7 Patients, service users, families and loved ones that choose not to engage in the investigation process can choose to re-engage at any point and at any level, and their wishes should be clearly documented at each contact (Datix). Levels of involvement which can be individually decided:

- Ask questions
- Add Terms of Reference
- Review Terms of Reference
- Be interviewed
- Receive a draft copy of the investigation report
- Receive a copy of the investigation report.

8.8 In incidents that have resulted in serious life-threatening harm or death there is never a right time to make the initial contact with the family. The initial contact should be made as soon as possible and should be followed up with contact details of the Serious Incident Investigating Officer in writing.

8.9 An important aspect of the process is the sharing of the final report. Where possible the final report should be shared in person with patient or families to allow questions, discussion about points and to ensure clarity of understanding. This should be organised through a planned appointment at a location where the recipient feels comfortable. Some patients and families may wish to

alternatively receive a letter summarising the key findings and actions rather than the full report.

9. Incident Reporting and Immediate Assessment

9.1 Report and submit all incidents onto the Trust's Incident reporting system, Datix by the end of the shift, or within 24 hours if immediate submission is not practicable.

9.2 If for any reason, Datix goes off-line, then staff can defer reporting the incident until Datix is back on-line. Alternatively, staff can report the incident, near miss, issue of concern using the paper based IR1 forms which are located in all Trust premises.

9.3 The service manager and/or Clinical Governance Lead should assess whether the threshold for escalation to an Incident Review Panel has been met. This would normally be all incidents identified as having a severity of harm of moderate and above and those where learning or impact from a near miss is significant and those where the Trust may have contributed to harm.

9.4 The Clinical Governance Lead responsible for the service area within which the incident was reported should complete the template for an initial incident review within 24 hours of identifying an incident which they have assessed as having a severity of harm of moderate harm or above. A copy of the initial incident review should be attached to the relevant incident on the Datix System. The information will be reviewed at the Incident Review Panel for identification of learning and to direct the level of investigation required.

10. Incident Review Panel (Part 1)

10.1 The panel will consider not only the outcome for the patient, but other factors such as 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. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare, in deciding about the level of investigation required.

10.2 The possible outcomes from the Incident Review Panel (IRP) are:

- No further investigation or local managerial investigation required – the panel will review the learning and make recommendations for sharing that learning with the patient (if appropriate), family/carers and staff.
- Threshold for Serious Incident (SI) not met, but investigation felt to be required for additional learning – the panel will commission an investigation inclusive of Root Cause Analysis – a Detailed Clinical Investigation (DCI), when writing this report, Investigating Officers would use the Detailed Clinical Investigation (DCI) Report template in Appendix 9.

- Threshold for Serious Incident (SI) met.

- Additionally, teams may be required to complete an extended initial review report, the purpose of which is to identify further information in order for the Incident Review Panel to make a determination if an incident is a Serious Incident.

All Serious Incident (SIs) investigations which have declared will be shared with the Company Secretary for onward dissemination to the Trust Board for their oversight of such incidents.

10.3 When a Serious Incident (SI) is identified, local Quality Integrated Care Board (ICB) leads require a 72-hour report. It is the responsibility of the Patient Safety Team to review the 72-hour report, upload a copy onto the Datix system and StEIS and to forward the 72-hour report to the relevant ICB. Please see appendix 11, Serious Incident (SI) 72 hour report.

10.4 The Incident Review Panel (IRP) will be responsible for devising Terms of Reference (ToR) for the investigation.

10.5 Where contact has been made the Incident Review Panel will consider any concerns raised by the patient and family/carers, as appropriate to the circumstances, in devising these terms of reference.

10.6 The Incident Review Panel will need to consider if it is appropriate to meet/discuss with the patient/family/carers, before devising the terms of reference.

10.7 The Incident Review Panel will consider specific issues that may apply to the particular incident, such as it being a 'Never Event' and for investigations requiring input from multiple agencies.

11. Incident Investigation Root Cause Analysis (RCA) and Improvement Action Plan

11.1 If the threshold for a Serious Incident or Detailed Clinical Investigation (internal RCA) incident is met, the Patient Safety Specialist is responsible for allocating an Investigating Officer to undertake the investigation.

11.2 The Patient Safety Specialist is responsible for the following:

- Identifying a lead Investigating Officer (IO) and ensuring that all conflicts of interests are disclosed and recorded
- Meeting with the Investigator on a regular basis to ensure that the investigation is being undertaken in a correct and timely manner
- Sharing of all identified learning via Trust groups and communication mediums.

11.3 The Patient Safety Manager and/or the lead Investigating Officer is responsible for the following:

- Carrying out a full investigation inclusive of appropriate RCA techniques or

tools: report to be stored in the Datix system.

- Highlighting care or service delivery problems identified in the course of the investigation, recording and escalating these
- Establishing causative factors
- Sharing the drafted report in Service Level Clinical Governance meetings to agree actions
- Making recommendations for practice
- Presenting the final report at Incident Review Panel
- Sharing the ToR with the patient, family and carers (as appropriate)
- Agreeing with the patient, family and carers (as appropriate) how often and by what means they wish to be kept informed of the progress of the investigation while it is being undertaken
- Agreeing what form of contact the service will have with the patient, family and carers (as appropriate) during the course of the investigation, including any forms of support
- Sharing the ToR with the staff who will be involved in the investigation
- When the final report is received and approved by the Trust Incident Review Panel, sharing this report with the patient, family/carers (as appropriate) and with the staff team involved in the investigation, along with recommendations, actions and timely updates.

11.4 The lead Investigating Officer (IO) will undertake an investigation and complete the analysis using appropriate RCA tools. This will consider whether any individual, team or organisational processes delivering care or services could be improved to reduce the likelihood of similar incidents occurring in the future and to focus efforts for improvement and learning.

11.5 For Ambulance Vehicle Incidents (AVIs) that are deemed as a Serious Incident, the Driving Standards Department (DSD) will carry out the investigation and liaise with the lead Investigating Officer (IO).

11.6 The resulting action plan will contain actions that are SMART:

- Specific, well defined, clear to anyone
- Measurable, meaningful and attainable
- Achievable, attainable and how the achievement will be evidenced
- Realistic, results orientated and reasonable
- Time-based, tangible, trackable.

11.7 The leads for the service area (such as the Service Manager, Head of Operations, Clinical Co-ordination Centre (CCC) Manager) have responsibility for ensuring that the action plan is monitored, updated and closed in a timely fashion, within local governance forums. Outcomes should be shared with Heads of Operations, area managers and relevant Assistant Directors for assurance that there is a robust system in place to share learning.

11.8 It is important that the report in its entirety is treated as the intellectual property of the Investigator and no changes should be made to it without their knowledge and agreement. Changes may be made to the report at any stage with the

knowledge and approval of the Investigator.

12. Incident Review Panel (Part 2) Final Report Sign Off

12.1 Once the report has been agreed by the service level Clinical Governance meeting it will be submitted to the Incident Review Panel (IRP) by the author.

12.2 The quality of the report will be reviewed and include:

- Checks relating to duty of candour compliance,
- RIDDOR reporting where applicable,
- Safeguarding reporting,
- Final impact grading,
- Overall quality of the report,
- Immediate learning identified to be shared across the Trust.

12.3 If the report is considered completed, it can be closed at this stage and it is the responsibility of the author to upload the final approved report onto the StEIS System for ICB review and close. It is also the responsibility of the report author to update the final grading of the incident on Datix following the decision of the Incident Review Panel.

13. Learning From Incidents

13.1 The purpose of reporting and investigating incidents is to ensure that the Trust learns and prevents and reduces the risk of similar incidents from occurring in the future. Sharing of the learning from investigation is crucial. A variety of learning outputs should be utilized to ensure they have impact with the correct target audience.

13.2 Learning from incidents should be widely shared with staff within their team involved via a variety of different methods:

- Circulation of the final approved investigation report
- Team meetings
- Education and training
- Clinical supervision / one-to-ones / reflective practice.

13.3 Sharing learning across the organisation is crucial and should be undertaken through a variety of methods:

- Hot news
- Quality and Safety meeting
- Immediate Learning from Incident Review Panels – Alerts and memo
- Newsletters
- Hub pages
- Patient Safety Group (PSG)
- Patient stories.

14. Standards for Supporting Staff

14.1 The process of investigation and the procedural issues relating to an incident can occasionally be very time consuming for staff involved. The Trust acknowledges that staff may find the investigation process stressful, it is therefore important that staff are appropriately supported. This applies to all staff, including bank, agency and volunteers and those on work experience.

14.2. Line managers are responsible for providing adequate and appropriate support for staff following an incident.

14.3. Staff must be informed if an investigation is being undertaken into an incident in which they were involved, kept up to date with the progress, and the eventual outcome and learning to be implemented.

14.4. Where a case is to go to inquest or criminal trial, the Legal Services Team must be notified. They can provide support to the staff on the process to be followed. Staff involved in a traumatic or stressful event must inform their manager if:

- They are experiencing difficulties associated with the situation or as a result of the requirement to act as a witness, in order to enable their line manager to support them directly
- Request referral to relevant support services if they are experiencing difficulties
- Time is required away from the workplace to attend any meetings associated with the claim or court proceedings, or, where required, to attend for counselling or support.

15. Standards for Managing Media Interest in Incidents

15.1 Any incident, including a Serious Incident, may result in media or public attention. If a media request for any information is received, the Trust's Communications Team must be informed. It is important that only information is released to the media through the Communications Team to ensure that it is correct and shared in an appropriate format.

16. Integration with Complaints

16.1 It is important that the Trust moves to a status where Serious Incidents (SIs) and associated complaints are seen and investigated through one lens. The skills obtained through the investigation training provide investigating officers with the ability to investigate both complaints and incidents. This patient experience investigation training is delivered by the Patient Experience Team.

16.2 Where a Serious Incident (SI) investigation is already underway and a complaint about the same aspect of service or care delivery is received, the situation must be discussed with the complainant to ascertain, with approval, whether it is appropriate for the questions to be added to the investigation. The complaint would then be closed, and the complainant would receive a copy of

the full investigation report.

16.3 Should a complaint highlight that a Serious Incident has been missed, the Serious Incident process would be triggered and the concerns from the complaint be added to the Terms of Reference for the investigation. The complaint would be closed at this point.

17. Training

17.1 At Induction, all staff receive training on the Trust's Incident reporting system, Datix. They also receive training on how to report an incident, near miss, issue of concern and that the Trust has an 'open reporting culture' and a 'just and learning culture'. The training also includes why they should report the incident and what they should include in the incident report.

17.2 Managers and Team Leaders will receive further training on the Datix system by the Trust's Datix Systems Manager. Sessions are available to staff.

18. Monitoring Compliance

18.1 The effectiveness of this policy will be monitored annually by the Patient Safety Specialist who will provide a report to the Patient Safety Group which will include details on:

a) The number of Serious Incidents reported in a financial year
b) The number of Serious Incidents reported onto StEIS within two days of the Serious Incident being declared in a financial year
c) The number of reported incidents which involved patients, service users, families and loved ones in investigations in a financial year.
d) Trends analysis.

19. Policy Review

19.1 This policy will be reviewed annually aligned with NHS England publications or when there are changes to internal processes.

20. References

- Health and Safety at Work Etc. Act 1974
- Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2013
- National Patient Safety Agency – Safer Practice Notice – 2005
- National Patient Safety Agency – Patient Safety Alert – 2009
- NHS Standard Contract – 2014/2015
- NHS Litigation Authority Francis Report Mid Staffordshire NHS Foundation Trust Public Inquiry – 2013
- National Patient Safety Agency – Seven Steps to Patient Safety – 2003
- NHS England – Serious Incident Framework – 2015
- NHS England – Patient Safety Strategy – 2019

- Health and Social Care Act 2008
- Care Quality Commission (Registration) Regulations 2009
- CQC Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20, The regulation in full.
- NHS England (2015), *Serious Incident Framework* https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf
- NHS England (2016), *Serious Incident Framework – frequency asked questions* https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/03/serious-incdnt-framwrk-faqs-mar16.pdf
- Department of Health (2000), *An Organisation with a Memory*, https://psnet.ahrq.gov/resources/resource/1568
- Department of Health (2002), *Building a Safer NHS*, http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084961.pdf
- National Patient Safety Agency (2004), *Seven Steps to Patient Safety,* http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/
- Department of Health, Social Services and Public Safety (2014) *Controls Assurance*, https://www.dhsspsni.gov.uk/publications/reporting-compliance-controls-assurance-standards
- Serious Incident Framework – Supporting and Learning to Prevent Recurrence March 2015 https://www.england.nhs.uk/patientsafety/serious-incident/
- Department of Health (2014) *Statutory Duty of Candour for Health and Adult Social Care Providers* https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers

21. Appendix 1: Review Table

21.1 This policy is regularly reviewed and updated with information in line with relevant national guidance and legislation. A full 'Review Table of Contents' is available on request.

22. Appendix 2: Responsibility

22.1 The responsibility for this policy is shared between various Policy Groups, Lead Director/Officers, Working Groups and Committee members.

22.2 A full list of all responsible parties can be made available upon request.

23. Appendix 3: Equality impact assessment – Screening

23.1 An initial screening equality impact assessment has been carried out and has identified that the policy does not have an adverse or detrimental impact on any of the proscribed equality groups as the policy is designed to protect all staff who carry out work for or on behalf of the Trust.

23.2 The screening element of the initial 'Equality Impact Assessment' is available on request.

24. Appendix 4: Equality impact assessment form – Section Two – Full assessment

24.1 Due to the outcome of the initial screening equality impact assessment, it has not been necessary to carry out a full equality impact assessment.

25. Appendix 5: Ratification

Policy Title: Policy and Procedure for the Managing of Serious Incidents (SI).

Author's Name and Job Title: Debbie Marrs, Assistant Director of Quality.

Review Deadline:

Consultation From the 14/10/22 to the 24/10/22.

Comments Received? (Y/N): Y.

All Comments Incorporated? (Y/N): Y.

If No, please list comments not included along with reasons: Comments about including restraining in this policy were not applicable.

Equality Impact Assessment completed (date): 13/10/2022.
.
Name of Accountable Group: Patient Safety Group.

Date of Submission for Ratification: 10/11/2022.

Template Policy Used (Y/N): Y.

All Sections Completed (Y/N): Y.

Monitoring Section Completed (Y/N): Y.

Date of Ratification: 17th November 2022.

Date Policy is Active: 23rd November 2022.

Date Next Review Due: November 2023.

Signature of Accountable Group Chair (or Deputy):

Name of Accountable Group Chair (or Deputy): Executive Director of Patient Care and Service Transformation/Chief Nurse.

26. Appendix 6: Terms of Reference for the Incident Review Panel (IRP)

South Central Ambulance Service
NHS Foundation Trust

Incident Review Panel

Terms of Reference

Quality and Safety Committee: 08/09/2022 (v1.0)

Incident review panel final version approved:

Date issued:

Terms of Reference for the Incident Review Panel

1. Authority

1.1 The group is authorised by the Patient Safety Group and reports to the Quality and Safety Committee as a committee to the board.
1.2 The group is authorised to obtain such internal and external information as is necessary and expedient to the fulfilment of its duties.
1.3 The panel has the authority to raise safety concerns to the Executive, the Trust Board, the ICB and the CQC.
1.4 To hold Divisional Management Teams to account regarding completion of actions arising from safety incidents.
1.5 To raise risks to the Trust Risk Register in relation to safety issues identified through the panel process.

2. Role

2.1 Lead and support the development of an open and transparent safety culture.
2.2 Provide Executive leadership and oversight in respect of Patient Safety Incidents occurring within the Trust
2.3 Provide assurance to the Quality and Safety Committee on the process of review and investigation of incidents with significant learning potential.
2.4 Monitor the progress of investigations to ensure that statutory requirements and timescales are met.

3. Duties

3.1 The Panel's duties are to oversee, review, scrutinise, and to provide recommendations for the management of incidents that are brought forward following triage by the Clinical governance team.

3.2 This will specifically include in part 1 of the panel:

- Confirmation of the initial grading for:
  a. Level of harm
  b. Potential for learning
  c. Risk of recurrence
  d. Decision on safeguarding referral requirement
  e. Reflection on any previous incidents relevant to the case

- Confirmation of the level of reporting required, e.g. to STEIS, CQC, Safeguarding.
- Confirmation of the degree and type of investigation required.
- Identification of any immediate actions required to prevent/reduce risk of recurrence.
- Identification of any support required for those involved.
- Identification of key elements of terms of reference for the investigation.
- Ensuring patient and/or family/carer information and involvement (if wished) in the investigation.
- Consideration of all other involved parties and input required from these to the investigation.

3.3 Part 2 of panel (Investigation report approval):

- Confirmation of the final grading for:

  f. Level of harm
  g. Risk of recurrence.

- Confirmation of learning identified:

  a. Scope of learning
  b. Method of dissemination.

- Assurance that relevant risks have been identified and risk registers updated
- Confirmation of sharing arrangements with patient and/or family/carers including compliance with Duty of Candour regulations.

4. Membership

4.1 The membership of the review meeting shall consist of:

- Executive Director of Patient Care and Service Transformation/Chief Nurse (SCAS)

- Medical Director/Chief Medical Officer (SCAS)
- Director of Nursing, Quality and Governance/Deputy Chief Nurse
- Assistant Directors of Quality (SCAS)
- Patient Safety Specialist
- Named Professional for Safeguarding
- Mental Health Lead
- Deputy Director of Nursing (HIOW ICB).

5. Attendance

5.1 The panel may be attended by:

- Any nominated deputy attending in place of a member.
- Any other person who has been invited to attend in connection with a case.

6. Quorum

6.1 A quorum is determined as being three of the members in attendance but must include a minimum of one member of the Clinical Trust Executive.

7. Frequency of Meetings

7.1 Meetings shall be held weekly.

7.2 Additional meetings may be held in exceptional circumstances at the request of the chair or two or more members of the review meeting.

8. Meetings and reporting

8.1 Proforma for each case will be the documentation and saved in shared file.

8.2 The group will report to Patient Safety Group via upward report of the Serious Incident position and key learning which in turn reports to the Quality and Safety Committee by the means of an overview report.

8.3 The draft agenda will be sent out to the panel members one day prior to the meeting date. The confirmed agenda will be presented on the day.

8.4 Papers for part 1 (Incident case decisions) need to be submitted by the end of the working day on the day prior to the panel.

8.5 Papers for part 2 (Final investigation reports for approval) will be sent out to panel members three days prior to the panel and submitted by close of the working day four days prior to the panel.

9. Review

9.1 The terms of reference for the group will be reviewed once a year and ratified by the Quality and Safety Committee.

10. Monitoring

10.1 The Chair of the group will monitor the effectiveness of the terms of reference by:

- Recording the attendance of members and how often they send a representative.
- Number and frequency of meetings in line as per section 7.
- Monitor the objectives and duties of the group.
- Reviewing the upward reports.
- Actions from the meeting will be documented.

27. Appendix 7: Grading an Incident – NRLS Harm Definitions

27.1 The Trust uses the NRLS definitions for harm, which are:

- **no harm** – a situation where no harm occurred: either a prevented patient safety incident or a no harm incident.
- **low harm** – any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.
- **moderate harm** – any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.
- **severe harm** – any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.
- **death** – any unexpected or unintended event that caused the death of one or more persons.

27.2 In addition to the above NRLS levels of harm, the Trust also includes a '**near miss'** level of harm for reporting purposes on Datix. The definition of '**near miss**' is : Any incident that had the potential to cause harm but was prevented (by chance or appropriate intervention) and resulted in no harm.

27.3 Potential Severity should be graded using a standard 5x5 Risk Matrix, definitions for Impact and Likelihood follow. Potential severity is subjective and is best graded by someone who knows the service user, staff, environment and specific circumstances of the incident.

27.4 The four potential severity gradings are Minor/Green, Moderate/Yellow, Major/Amber, and Catastrophic/Red

27.5 The colour appearing in the risk matrix corresponds to each of these 4 gradings. Guidance on choosing the impact and likelihood in the risk matrix can be found below.

	Likelihood				
Impact	Extremely unlikely	Unlikely	Possible	Likely	Almost Certain
Negligible					
Low					
Moderate					
Major					
Catastrophic					

28. Appendix 8: 'Duty of Candour' Template Letter

South Central Ambulance Service NHS Foundation Trust

Southern House
Sparrowgrove
Otterbourne
Winchester
SO21 2RU

PRIVATE & CONFIDENTIAL

patientexperience@scas.nhs.uk
Tel: 0300 123 9280

Our ref:

xxxxxx 2022

Dear xxxx

Firstly, may I extend my sincere apologies / condolences for the passing of / the incident which involved Mr/Mrs/Ms on the _____. I am sorry for any additional distress which you and your family may have experienced / are experiencing at this difficult time.

Your *[Mother/Father/Son etc)* recently received care from South Central Ambulance Service NHS Foundation Trust and as ***(Name and Designation)*** explained to you *(brief description of the incident andwhat has previously been discussed)* whilst your *[Mother/Father/Son etc]* was in our care.

I would like to take this opportunity to express my sincere apologies that this event has occurred while *[name of patient)* were under our care and to reassure you that the Trust aims to provide a quality service to all our patients. We are therefore, undertaking a full investigation into the incident in an effort to understand exactly what happened and to find out whether there is something that we could do differently in future to prevent this happening to anyone else.

The investigation process can take up to 60 working days to complete. At this stage *(I/ Staff member contact details on top of page)* will be acting as your lead contact for the duration of this process. This investigation is expected to be with the external commissioning body for their consideration no later than_____.

Please be reassured that no patient identifiable information will be included in the report.

SCAS tries to ensure that any investigation includes the staff involved, the patient (if appropriate) and the patient's family in the process.

In the past, we have found that patients, families or relatives respond to this offer in a variety of ways. Usually, relatives / families engage with us so that we can try to provide answers to their questions, and we include these in our terms of reference for the investigation. Some patients / families do not feel that they want to be informed or engage with the SCAS investigation; some only wish to be given the final investigation outcome report. The choice to engage with SCAS, and to what extent is entirely for you to decide upon and is a decision that we will fully respect.

In our telephone conversation you confirmed the following:

1. *level of engagement you would like with the Investigations Manager / Investigating Officer.*
2. *you would like to receive correspondence regarding the investigation.*
3. *your preferred contact method, i.e. email / telephone / post*
4. *who will act as the main point of contact during the investigation, i.e. with whom should the investigating manager / officer make contact.*
5. *whether you / the family wish to be contacted during the investigation with updates and if so, how often would they prefer to be contacted?*

If you would like to receive a copy of the full investigation report, please be mindful that the report will contain detailed information surrounding the incident which could be upsetting due to the amount of detail included. Please be reassured there is no intent to cause upset at all, and as such we can (if you prefer) provide an abridged version of the report, keeping to the key issues found and what actions were taken to resolve them in order to try to ensure that such an incident does not happen again.

If you would like any advice from an independent advocacy service in your area, we can give details to support you further if required. Advocacy services can be found online or if you would like this information please contact patientexperience@scas.nhs.uk or telephone 0300 123 9280 and they would be happy to provide you with the contact information.

The choice of communication you would like to receive will be yours.

Yours sincerely

Name etc

29. Appendix 9: Detailed Clinical Investigation (DCI) Report Template

South Central Ambulance Service
NHS Foundation Trust

Detailed Clinical Investigation Report (DCI)

Version:

Compiled By:

Incident Date:
Date CG Team reviewed incident:
Date Incident Review Panel reviewed incident:
Date declared a Detailed Clinical Incident:
Date and service line Clinical Governance Committee review of draft report:
Date of final report approval:
DATIX No:

Contents **Page**

Incident Description

(*Description of actual events in a format patient/family can understand avoid jargon and ensure acronyms are fully explained before continuing their use in the report – Use Event Chronology for the list of dates / times of events that occurred*)

When? Where?
Why did the patient/carer/family etc contact SCAS and which service (NHS111 / 999 / telephony / servers crashed etc)?

What was the SCAS response to the reported incident? (Passed to OoHs / passed to 999 / ambulance allocated / delayed allocation etc?

Action on arrival / treatment care given / on-call telephony and/or ICT?

Treatment/management plan for this episode of care/event (e.g. transport to hospital/refer to GP, ICT system provider notified etc)?

Referral to whom, what time and how achieved?

Outcome of patient / condition at hand-over? Telephony re-set, temporary patch etc?

Main Report

Organisational Context
South Central Ambulance Service NHS Foundation Trust provides a range of emergency, urgent care and non-emergency healthcare services, along with commercial logistics services. The Trust delivers most of these services to the populations of the South Central region – Berkshire, Buckinghamshire, Hampshire and Oxfordshire – as well as non-emergency patient transport services in Surrey and Sussex.

SCAS is a sole provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas); all other services the Trust delivers are tendered for on a competitive basis. With the expansion into Surrey and Sussex, we now serve a population of over seven million people across the six counties. We employ 4,500 staff who, together with over 1,100 volunteers, enable us to operate 24 hours a day, seven days a week.

What we do:

- Receive 999 calls in our clinical coordination centres in Bicester, Oxfordshire, and Otterbourne, Hampshire

- Respond to 999 calls by arranging the most appropriate resource from community first and co-responders, to rapid response vehicles, ambulances, air ambulances or a combination, and sometimes all, of these

- Provide the NHS111/Integrated Urgent Care service for the Thames Valley and Hampshire and Surrey Heath from our clinical coordination centres

- Take eligible patients to and from their hospital appointments and treatments with our non-emergency Patient Transport Service (PTS)

- Provide a commercial logistics service across Oxfordshire.

Detection of Incident

Through Datix, complaint to PE Team or commissioners etc.

Chronology of Events

Date	Time	Event	Comment

The Investigation Team

Duty of Candour

Date and time. Was this within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 recommended time frame.

Yes: (*Date, with whom and how (face to face/telephone/email etc.)*
No: *(If not, why not? What is preventing)*

Involvement and Support of Patients and Relatives

Date contact made. Medium used initially, confirm followed up by DoC letter and patient / carer or family's response and preferences for further contact.

Following Duty of Candour conversations, what are the concerns and/or questions of the patient or their Next of Kin/family/representative?

Terms of Reference
(From the Incident Review Panel)

List Policy / Protocols / Documents / Records reviewed during investigation
1.
2.
3.

Support provided to those involved

Findings

Notable Practice

Analysis

Care Delivery Problems:
Service Delivery Problems:
Contributory Factors e.g. (delete as applicable)
Patient Factors
Individual (staff) Factors
Task Factors
Communications
Team Factors
Education / Training
Equipment
Organisational and strategic factors

Root Cause/Significant Contributory Factors

Learning Identified

Recommendations

Action Plan

	Action (From Recommendations)	Action owner	Accountable Lead	Deadline	Date Completed
1					
2					
3					
4					

Arrangements for Shared Learning

- ✓ All interested parties / SCAS Directorates / Heads of Departments will receive the completed DCI report.
- ✓ Draft investigation reports and final action plans will be reviewed and tracked via the service line Clinical Governance committees.
- ✓ The relevant Heads of Departments / Leads are to share any learning identified that would be pertinent to their staff within the local Team Meetings.
- ✓ The relevant Heads of Department / Leads are to add any additional shared learning to the incidents relevant Datix – evidencing that learning has been shared.
- ✓ The relevant action owner is to complete and upload evidence of learning to the Datix.
- ✓ Education – Learning to inform training content and publications.
- ✓ Learning identified will be shared Trust wide through:-
  - Learning events (virtual/face to face)
  - The Hub Patient Safety Page
  - Weekly/monthly newsletters, bulletins, patient safety messages/learning matters
- ✓ System learning - Learning identified will also be shared with our system partners (other NHS/public sector organisations).

Distribution List for Report Findings

Who?	How?

Closure Checklist

Has the patient or their relative/representative been sent a copy of the investigation report and been offered meeting? (If they declined involvement this must be recorded here and in Datix.)	
Has the report been submitted and closed by IRP?	
Have the actions been uploaded onto Datix with named action owners?	
Have the action owners been notified of the actions that have been assigned to them?	
How has learning been shared across organisation if relevant to other departments? (Clinical / Operational Memo, Staff Directive, an agenda item on a specific Staff Group Meeting, SCAScade etc)	
Report and all associated documents uploaded onto Datix?	
Date agreed CLOSURE and (if appropriate) sent to reviewing ICB?	
Copy of Report sent to Legal Services Manager if required (Coroner or litigation purposes)	

Appendices

1. Glossary of Terms

Appendix 1
Glossary of Terms used
In Report

Abbreviation / Medical term	Meaning
AAP	Associate Ambulance Practitioner- a person trained via a higher education route and classed as a clinician at a level below that of a Paramedic
ACA	Ambulance Care Assistant. A person who is employed within the SCAS Non-Emergency Patient Transport Services. These staff are **not** clinicians.
AT	Ambulance Technician – a person trained by the ambulance service and classed as a clinician at a level below that of a Paramedic, same scope of practice as an AAP.
A&E	Accident and Emergency (Hospital)
Ambulance Nurse	A nurse who is registered with the Nursing and Midwifery Council (NMC), who has also received training within the ambulance service to work on an ambulance
BP	Blood Pressure – a measurement of a patient blood pressure using blood pressure reading equipment
BPM	Beats per minute – heart rate
BVM	Bag Valve Mask. A piece of equipment used by ambulance staff to inflate a patient's lungs with air and supplementary oxygen – this is hand operated.
CCC	Clinical Co-ordination Centre –Collective term for the SCAS 999/111 call centres. Includes the SCAS Emergency Operations Centres where clinical support / care for patients is signposted by clinicians within the centre.
COM	Clinical Operations Manager – Line manager to TLs and CTEs. Overall manager for 1-2 Ambulance Resource Centres.
CPR	Cardiopulmonary Resuscitation.
CTE	Clinical Team Educator. A qualified Paramedic who has received additional training to mentor staff and provide clinical advice and guidance for frontline ambulance staff.
DCA	Double Crewed Ambulance
ECG	Electronic Cardio Gram. The recording of a patient's cardiac activity through the use of a cardiac monitor carried on RRVs and DCAs
ECA	Emergency Care Assistant. A person who forms part of an ambulance crew and who is trained in use of ambulance equipment and provides assistance or drives ambulances. This person is **not** a clinician.
ED	Emergency Department (Hospital)

EOC	SCAS Emergency Operations Centre. Where 999 and health care professional calls are taken and ambulances dispatched.
*e*PR	Electronic Patient Record. (A paperless electronic tablet which is utilised to record all patient details, findings, vital signs and care given to a patient)
HCPC	Health Care Professions Council. The registering body for Paramedic and other health care providers. A Paramedic has a Code of Conduct which s/he has to ensure that they abide by this code of conduct. Should a Paramedic's conduct be called into question, s/he may be referred to the HCPC for investigation. This registering body has the right to strike the Paramedic off the register effectively preventing that person from practising as a Paramedic. All Paramedics working for SCAS or through a Private Provider are required to be registered with the HCPC.
HOO	Head Of Operations – manages an operational node. Line manager to a COM.
JRCALC	Joint Royal Colleges Ambulance Liaison Committee. A professional body which provides clinical advice and guidelines for the UK ambulance services.
MDT	Mobile Data Terminal. Equipment installed in ambulances and RRVs which receives and can transmit incident information.
Paramedic	An ambulance person who is registered with the HCPC and is classed as a clinician.
PCR	Patient Clinical Record (paper based)
PP	Private Provider (Contracted to supply services on behalf of SCAS)
RRV	Rapid Response Vehicle
SCAS	South Central Ambulance Service, Foundation Trust.
Specialist Paramedic	A Paramedic who has received addition clinical training and can administer and supply additional medications for patients.
TL	Team Leader. A front-line operational manager who leads a team of ambulance staff from a SCAS Resource Centre – all are qualified Paramedics or Ambulance Nurses.

30. INTERNAL STAFF FORMS

Many of our policies have an 'Internal staff form' attached that is relevant to the document. For security and accessibility reasons they are only available on our Staff Intranet.