CORPORATE POLICY & PROCEDURE

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Serious Incident Policy

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Appendix:

NOTE: This document complements the Adverse Incident Reporting & 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 now 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 and appendices added to reflect the national changes that will be introduced through this new strategy.

1.1. Introduction

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

1.3. 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 behavior existed.

1.4. If a student is involved in a Serious Incident (SI) investigation the Education Department will be informed to liaise with the Higher Education Institute if required.

1.5. 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.

1.6. 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 Investigations Manager, Clinical Governance Lead or other nominated Clinical Directorate manager, who will submit the review to the SI Review Sub Committee. The Sub Committee will comprise of 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 SI Sub Committee will discuss the incident with the relevant Clinical Commissioning Group SI group. If it is declared a SI, the SI Sub Committee will appoint an appropriate Investigations 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.

1.7. 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 time line 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 organisation.

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

1.9. This Policy will be reviewed by the Quality and Safety Committee and SI Review Group every two years and should be read in conjunction with the Trust's Adverse Incident Reporting and Investigation Policy and the Duty of Candor policy (related policy is the Legal Claims policy).

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

2.1. Definition of a Serious Incident (SI):

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 on-going healthcare or maintain 'business as usual'.

The occurrence of a Serious Incident 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**

Serious incidents 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 signaling systemic failures within a commissioning or health system.

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

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

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

2.1.3. **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.**

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

activity.

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

    2.1.6. Chemical, biological, radiological or nuclear incidents (CBRN incidents).

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

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

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

    2.1.10. Incidents affecting large numbers of people.

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

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

    2.1.13. 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.

3.1. Responsibilities of Senior Officers and appointed persons are:

➤ 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.

➤ The **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 Director of Patient Care and other Directors.*
   ✓ *Assurance reports provided by external bodies such as the Care Quality Commission, NHS Protect and the NHS Litigation Authority (NHSLA) etc.*
   ✓ *Monthly Key Performance Indicators reports.*

➤ The **Executive Director of Patient Care and Service Transformation** 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 Service Transformation 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 & Investigation Policy throughout the organisation
- Identifying & interpreting new legislation and Government guidance in relation to risk
- Advising the Chief Executive, Directors and Board on matters of risk management
- Coordinating and obtaining assurances from each of the Executive Directors in relation to risks within their directorate
- Receiving and monitoring risk, adverse incident, claims and complaints reports, identifying trends and producing statistical data for the Trust Board
- Acting as the Trusts designated board and executive level lead for risk
- Acting as the designated Executive lead for Security Management.

➢ **The Executive Directors have delegated responsibility for SI flagging / identification in conjunction with the Adverse Incident Reporting & 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 Service Transformation 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 & Investigation Policy.
- Provide the Trust Board with assurance that any SI Investigations manager / Officer 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.

➢ All Trust managers and supervisors are responsible for implementing and monitoring the SI Policy in conjunction with the Adverse Incident Reporting & 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 carrying out investigations

and monitor the outcome either through presentation of the investigation at the SI Review Group, 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 clinical commissioning group. Delays in completing of the actions must be justified to the 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.

➢ **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.

➢ **Assistant Director of Quality** will be responsible to the Executive Director of Patient Care and Service Transformation 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.

➢ **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.

➢ **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.

➢ **Investigation Managers** will be responsible for carrying out the investigation of SIs, major investigations and complaints as agreed with the Assistant Director of Quality. 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 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 SI Review Panel of the incident and call for a joint conference call where the incident will be reviewed by the SI Review Panel. The SI Review Panel will make the decision of either declaring the incident as a SI, Major Investigation or leave the investigation to the named management team to investigate.
- They will also provide a 72hour report for the respective clinical commissioning group. This will be emailed via the respective CCGs nhs.net email address for SI reporting. The SCAS Assistant Director Care and the SCAS Head of Risk and Security must also receive a copy of the 72-hour report.
- They will also be responsible for recording the SI onto the STEIS reporting system.
- They will also provide the Director Clinical and Patient Care with a brief report for 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/SIRS/SIRI section in the Datix reporting system.
- The Investigations Managers / Officer will populate an aggregated SI report – outstanding actions which will highlight unclosed actions on each open SI. Naming the responsible persons for those actions, this will be submitted before each SI Review Group 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/SIRS/SIRI' option on the incident DIF2 screen. There after 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/SIRS/SIRI option on the incident DIF2 screen.

➢ **All Employees** will:

- Understand and co-operate with the Adverse Incident Reporting & 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;
- 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.
www.dh.gov.uk/publications

4.1. REPORTING OF SERIOUS INCIDENTS (SI) TO THE GEOGRAPHICALLY RESPONSIBLE (LEAD) CLINICAL COMMISSIONING GROUP (CCG)

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 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 CCG will need to be informed of the incident to be able to provide advice and support, but will also deal with the notification other lead authorities and health care providers that could be impacted by the incident. The reporting of a potential SI to the respective CCGs is the responsibility of the Director Transformation, Quality and Patient Care, the Assistant Director Quality or their nominee.

The reporting of a potential SI to the respective CCGs is the responsibility of the Director Quality and Patient Care, 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:

- Clinical Commissioning Groups
- Clinical Support Unit
- Department of Health
- NHSI
- Care Quality Commission (CQC)
- General Practitioners
- Out of hours Providers
- NHS Litigation Authority
- Private Providers
- Police
- Independent Police Complaints Commission
- Coroner
- Social Services
- Medicines and HealthCare Products Regulatory Agency
- Information Governance Commissioner
- Health and Safety Executive
- Public / Health Department
- NHS Protect
- Patient / relative

(This List is not exhaustive)

When required, the Executive Director of Patient Care and Service Transformation/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 CCG where the incident has occurred and the CQC.

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

The Executive Director of Patient Care and Service Transformation will convene a review meeting of Datix incidents identified as 'Potential SIs'. This incident should have had a preliminary investigation undertaken by the IM or Clinical Governance Lead (999, NHS 111 or PTS). The reviewer will then ensure that as much information 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 Datix Review Panel of the incident and call for a joint conference call where the incident will be reviewed. The Datix Review Panel will make the decision of either declaring the incident as a SI, Major Investigation or leave the investigation to the named management team to investigate. The identification and decision to declare a SI may be conducted 'virtually' via an email or telephone discussion by the Datix Review Panel in order to act swiftly.

4.2.   ANY adverse incident that has occurred will require (potential SI or not) 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 happen 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 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 the investigation over, can see at what stage the previous investigating officer / manager was at.

Lock Down: If the investigation is of a sensitive nature, the Datix can be 'Locked Down' which allow 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.

4.3. 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.

Adverse incident occurs - Clinical or Non-clinical in nature - requires reporting and investigation.

The Adverse Incident is reported / completed via **DATIX** by the Reporter. In DATIX, the reporting staff member provides a "Result" and "Severity" - this identifies the impact of the incident and alerts the Primary Investigating Manager and the Risk Management Team to a possible SI incident. A detailed, factual description of what occurred, devoid of hearsay or rumour, is vital.

The Primary Investigating Manager revues the incident, identifies that there is the possibility that the incident could meet SI criteria - the primary investigating manager must (using the email system within **DATIX)** email the **Assistant Director Quality** in the first instance indicating that there is a possible SI.

The Assistant Director Quality will then nominate (usually an investigations manager) a person to undertake a Rapid Review of the incident.

This process does not stop the continued investigation, staff support, management and appropriation of statements, records and chronologies by the primary investigating officer / manager

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" risk 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 have the opportunity; to identify the adverse incident as being serious (possible SI), and requesting the Clinical Directorate – specifically the Assistant Director Quality, to review the incident. Notifications must utilise DATIX internal email system.

(DATIX reporter and primary investigating manager flow chart example found in appendices)

The Assistant Director Quality will review the incident details if the incident meets the SI criteria, a more in-depth incident review will be undertaken (by a person nominated by the Assistant Director Quality). The incident review will provide a report which will be reviewed by the Datix Review Panel to make a decision if a SI will be declared.

If required, the Assistant Director Quality will inform the Executive Directors or Duty Directors who will in turn inform the appropriate Media and Public Relations Managers.

<u>**On-going incident / Major Incident**</u>:

There is <u>no change </u>in how an on-going Major Incident (potential SI or not), is managed. SCAS management / appointed IOs will follow the SCAS Major Incident Policy 04/2007 V2 Revision 4.0.0 March 2016.

The incident is reported on DATIX, all documentation associated with that incident, is added. It is suggested that a DATIX report is undertaken as soon as possible, and that the reference number is then <u>widely communicated</u> to reduce the likelihood of duplicate reports being completed. If this does occur the system allows for reports to be linked to reduce duplication.

The prime importance at that time 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.

In instances where a Major Incident has occurred, and there is a strong potential that the SI criteria has been met, the <u>normal on-call management upward reporting system </u>is used. The escalation of the incident information to the on call Silver / Gold and Directors <u>does not change</u>.

It is at Gold and Director Level that the Executive Director of Patient Care and Service Transformation is informed. The Executive Director of Patient Care and Service Transformation will then cascade the information to the Clinical Directorate (the Assistant Director Quality) if needed.

All incident reports, incident logs, investigation record forms, witness statements and reports from officers involved are to be completed immediately following the incident, scanned if required and uploaded to the relevant DATIX.
*Ensure the SCAS RSO is aware of what documents have been uploaded.
When the report is made to the lead Clinical Commissioning Group (CCG) it should include full details of the incident, including how and why it happened. The 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 CCG. In your telephone call you should provide details of the incident 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, major, 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.

- You should also provide the name and contact details for someone who can be contacted for further information about the incident. When reporting information to the relevant CCG, it is important to remember your 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.

4.4. 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 investigations managers.

4.5. 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 2018 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 investigation managers are the nominated leads to report Serious Incidents to the relevant CCG with an initial 72

Hour Report being sent to the respective CCG. This would be after the incident had been declared a SI on StEIS.

5.1. INVESTIGATION OF A SERIOUS INCIDENT

5.2. 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 iro Action completion
✓ Establish what 'Lessons Learnt' have been identified
✓ Identify any breaches to Trust policies, procedures or directives

5.3. 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.

5.4. 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 to identify the causes, and the most effective solution to prevent / reduce the likelihood of recurrence.

5.5. The analysis of the information gained from the investigation allows the determination of recommendations that will help to prevent another incident of the same kind or one caused by similar issues. The lessons learned through the investigation process will be used to ensure learning takes place 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 CCG body. Actions not completed, or which do not have a justifiable reason for non-completion may cause the CCG reviewing it to keep it open until such time that the action has been completed.

5.6. 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.

6.1.   INVESTIGATION LEVEL OF A SI

NHS England has changed the grading/level of a SI and the investigation timelines. The decision on what level the investigation should be is agreed upon by the SI Sub Committee.

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 comprehensiv e must be completed within **60 working days** of the incident

				being reported to the relevant commissioner.
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	All internal investigation should be supported by a clear investigation management plan
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.

6.2. 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 o t h e r stakeholders to share safety lessons.

6.3. A full and detailed explanation of root cause analysis techniques and how they should be applied can be found at www.npsa.nhs.uk. There is further guidance for managers on investigation and root cause analysis within the appendices of this policy.

6.4. 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.
- 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 SI Review Group. The expert or independent investigator will also be expected to attend, when requested, any CCG Review / SI Closure Group 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.

6.5. For Major Incidents, 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 to either form part of the investigation team or to share lessons learnt.

6.6. The investigations manager 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 Serious Incident Review Group via the Quality and Safety Committee.

6.7. SIs or 'Never Events' reported to the relevant CCG will be investigated by an investigations manager supported by relevant experts within the various SCAS Directorates, depending on the nature of the incident.

6.8. The Serious Incident Review Group will monitor and follow up all action plans developed from SI/Never Events reported to the relevant CCG. The lead manager or departmental director will monitor and follow up action plans developed from a green or yellow risk investigation.

7.1. SUPPORTING STAFF INVOLVED IN SI

7.2. Staff must be made aware by both their own line management and through the appointed SI Manager 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.

7.3. 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.

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

7.5. 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
- TRiM support is offered if applicable
- The staff member is fully aware of the OPTUM support
- Occupational Health Provider referral is utilised where appropriate
- The staff member(s) involved are aware that they have the right to access to the SCAS 'Freedom to Speak Up' guardian if they feel that they are not supported as outlined above. Freedom to Speak Up Policy

8.1. DUTY OF CANDOUR AND BEING OPEN – CORPORATE RESPONSIBILITIES

8.2. 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.

8.3. 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

8.4. 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*'.

8.5. 'Being open' simply means acknowledging g, 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.

8.6. Apologising to a healthcare organisations/teams, patient and/or carers does not constitute a n admission of liability, and should occur

9.1. KEY PRINCIPLES

9.2. 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

10.1. DUTY OF CANDOUR FOR PATIENTS AND RELATIVES

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.

10.2. The incident may be identified by the healthcare organisations, patient, carer or member of staff through a patient experience feed-back 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.

10.3. 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.

10.4. 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.

10.5. 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.

10.6. A face to face meeting should be set up as soon as possible to discuss the incident and establish the level of detail required by the healthcare organisations patients and/or carers as they may not wish to know specific details.

Whenever possible 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.

10.7. 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.

10.8. 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.

10.9. 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.

10.10. 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, the time line 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.

10.11. An investigation into the cause of the incident must be conducted, the level of which will depend on the seriousness of the incident. The Patients and/or carers should be kept updated on progress with the investigation by further meetings, or verbal and /or written correspondence. Information should only be provided to the patient and/or carers once the facts are known and the outcome report has been reviewed by the SCAS Legal Services Manager. 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.

10.12. 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.

10.13. 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 Legal Services Manager before it is sent off.

10.14. Throughout the process it is important that the patient is reassured that any dispute will not detract from future care. Reassurance can be given during face to face meetings with the patient and/or family, and reiterated in any documentation/letters set to the patient/family.

10.15. 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.

10.16. The Head of Patient Experience should be informed of all SIRIs to be able to reconcile these with any associated complaints.

10.17. 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.

Significant incidents will be subjected to full Root Cause Analysis (RCA) as recommended and taught by the NPSA. The Incident Decision Tree is available on the NHS England website for reference.

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 patients experience and the care and treatment provided. The Trust has appointed a non-executive director 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.

11.0. ANALYSIS AND IMPROVEMENT

** See Section 11 of the Adverse Incident Policy, page 19 - 20**

12.1. 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 in where information can be stored. It should be used as the main repository by the investigating manager.

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. 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;
- And why 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 who?
- Any other witnesses?

12.2. 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. The account will help the appointed investigations manager 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.

12.3. Points to remember when taking a Statement:

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 <u>not</u> include any <u>personal</u> 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:
  o Dated.
  o Clearly headed.
  o Complainant, patient's name or incident report (DATIX or SI) number is used in the heading.
  o All pages are numbered.
  o 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.
  o Any statement should be factual and/or evidenced based.
  o Avoid making assumptions, using hearsay or presuming that another person would have undertaken an action – remain factual in respect of what <u>you</u> heard, saw and did.
  o Statement is signed.

12.4. 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 off Netviewer (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 on scene as well.

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

12.5. Root Cause Analysis:

Unless the fundamental, or root causes of adverse events or complaints are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in 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.

- **Full Root Cause Analysis (RCA) will, in the majority of circumstances, be undertaken by the Investigation Panel (IP) (Appendix 3), often with the assistance of the relevant Investigating Officer or other managers with expertise in specific areas. Where necessary, this group will also seek advice from external experts.**

- In conjunction with the Operations 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 SI Panel would 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 Investigation Panel will be on the underlying causes, as described earlier, the m a n a g e m e n t , organisational, cultural and contextual factors. The Investigation Panel will use the Root Cause Analysis Report to summarise their findings and produce an Improvement Strategy.

Improvement strategies should be designed to eliminate the root cause(s).

This may involve changes in training, policies, procedures, equipment etc.

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

12.6. Membership of SI 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 Service Transformation
- 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.

12.7. Quorate of the SI Sub-Committee: The
members will be a combination of:
- Assistant Director of Quality
- Investigation manager, whose investigation is being reviewed
- A Medical Director
- Another manager which will be determined during the SI Review Group. The review by this Sub-Committee will occur when there is additional work to be completed on the SI report, but where the closure date occurs before the next SCAS SI. This will ensure that SI submissions are achieved as per the submission

dates to the CCG Commissioners.
The core business of this Sub-Committee is to provide a final review of a SI report, ensuring that any recommendations/amendments noted in SI SRG have been completed and that the Recommendations and Action Plan have been completed and attached ready for submission to the CCG Commissioners.

12.8 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 CCG on or before the submission date
- The IM / IO will ensure that they utilise DATIX as their main document repository, that the Datix SIRI 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 SRG at least twice before submission to the relevant CCG SI Closure Group
- The accountable IM / IO will ensure that the DRAFT reports are uploaded to the SI Folder in TEAMS by the date posted by the Directorate's Executive Secretary.
- The IM / IO must be present at the SI Review Group to present the Investigation Report and to answer any relevant questions posed by the SRG membership.
- The IM / IO will present the SI report to the relevant CCG SI Closure Group
- Any reports whose submission dates fall before the next SCAS SRG date will have to submit the report to the SRG Sub Group for closure.

13.1. Monitoring

13.2. Compliance with this policy will be monitored by the Assistant Director of Quality.

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

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

14.0. References

RELATED SCAS POLICIES & NHS REFERENCE DOCUMENTS

Adverse Incident Reporting & 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 Whistle Blowing Policy Security Policy
Dignity at Work Policy
Duty of Candor

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

NHSLA Risk Management Standards 2013-14 for Ambulance

Services: www.nhsla.com/Safety/Documents/NHS_LA_Risk_Management_Standards 2013-14 for Ambulance Services.pdf

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

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

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

South Central Ambulance Service NHS
NHS Foundation Trust

Appendix 1: Serious Incidents (SIs) or Never Events

Adverse Incident identified by either external informants or through SCAS DATIX reporting process.

→ Assistant Director Quality informed of possible SI

Decision taken to report SI/Never Event: Executive Director of Patient Care & Service Transformation (EDoPC&ST)

Review of Adverse Incident / Complaint

SI Sub Committee EDoPC & ST /ADQ/Medical Director Membership will depend on type of incident. Assess outstanding risk. Implement urgent improvement actions.

Inform:
Director/Non-Executive Directors CQC Commissioners
EDoPC & ST /Assistant Director of Quality (ADQ)

Submit other reports as appropriate:
NPSA; MHRA; HSE; NHS Protect
Head of Risk & Security/Risk Manager

SI/Never Event reported to CCG on StEIS system Head of Risk & Security/Investigations Managers

Issue Media Alert if required

Investigating Officer appointed EDoPC & ST

Communication with:
Patient/relatives – Patient Experience Manager
Local CCG – Investigating Officer
111 commissioners – ADQ
Coroner (if appropriate) – Investigating Manager/Officer

Investigate incident in conjunction with relevant experts Investigating Manager/Officer

SI Sub Committee:
Review and authorise SCAS closure of SI Report(s) post SRG meeting where amendments required and prior to sending of report to relevant CCG

Prepare report and present to Serious Incident Review Group. Investigating Manager/Officer

Update StEIS Website Investigations Manager

Monitor progress with implementation of improvements. Feedback to SI Review Group Investigations Manager/Officer

RCA Tools – SCAS

Appendix 3

Tabular Timeline

Event date and	Event	Supplementary information	Notable Practice	Care/Service delivery problems

RCA Tools – SCAS

Appendix 4

5 Why's   SIRI: DATIX No:

Issue to be explored:

Why?

    Why?

        Why?

            Why?

                Why?

RCA Tools –SCAS   Fishbone   *Appendix 5*

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

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

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

Communication factors:
Verbal Non-verbal
Written Electronic

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

Problem or issue (CPD/SDP)

Education + Training Factors:
Competence
Appropriateness
Availability Accessibility
Supervision

Equipment + resources:
Equipment supplies
Visual display Integrity
Positioning Usability

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

Organisational + strategic factors:
Organisational structure
Policy, standards, goals.
Externally imported risks
Safety culture priorities

Investigation Report

Serious Incident
(SI)

No: 2019-*****
Version:

Compiled By:

(Investigating Manager/Officer)

Incident date   :

Due Date   :

Level of Investigation:

DATIX No   :

Content	Page
Executive summary	
MAIN Report	
Organisational context	
Incident description	
Chronology of Events	
Terms of Reference	
The investigation team	
Duty of Candour	
Involvement and support of patient and relatives	
Involvement and support provided for staff	
Policy / Protocols / Documents / Records reviewed during investigation	
Detection of incident	
Findings	
Notable practice	

Analysis
    •   Care Delivery Problems
    •   Service Delivery Problems
    •   Contributory, Direct Causes & Human factors
    • Root Cause(s)	

Lessons learned	
Recommendations	
Actions proposed	
Arrangements for shared learning	
Distribution list	
Appendices	

EXECUTIVE SUMMARY

Brief Incident description.
Include what triggered incident (e.g.: patient injury etc.).
Outcome of incident.
Immediate action taken by organisation.
1 page maximum for Level 1 investigation.
1 – 2 pages maximum for Level 2/3 investigation.

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 monopoly 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 3,300 staff who, together with over 1,000 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 integrated urgent care service for the Thames Valley and NHS 111 service for Hampshire from our two 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

Incident Description

Include a time line of main events here. This is main body of report. Any RCAs can be referred to but they (RCAs) to be placed into APPENDIX not in report body.

Chronology of Events

Date	Time	Event	Comment

Terms of reference:

(Below are a set of generic ToRs – remove / add any additional ToRs as required)

1. Obtain all relevant electronic data / documentation related to the incident.
2. Establish contact with the relevant patient / family to ensure Duty of Candour is met.
3. Obtain a summary of event / statement from all persons that contributed / witnessed or were linked to the incident.
4. Obtain the Voice Recording of the call made to the SCAS service, if appropriate to this incident.
5. Obtain call audits of all EOC / CCC / 111 Call Takers or clinicians connected to the incident, if appropriate.
6. Through the audit, establish if the Call Taker (999 or 111) / 999 Dispatcher / Clinical Support Desk Practitioner / NHS 111 Clinician managed the call appropriately and if the minimum standard of Pathways was attained.
7. If any EOC / CCC / 111 Call Taker or CSD Clinician involved have 'Failed' the quality assurance audit – it must be establish:
    i. How long has that person been in employed in that position?
    ii. How many previous call audits have been undertaken on that person over the previous 3 months?
    iii. Is that person on any Action Plan that would be linked to poor performance in this incident?
    iv. If a Clinician, is their Pathways License valid / current?
8. Identify if any SCAS Policy or Procedure breaches.
9. Obtain all documentation related to the SCAS staff members impacted by the incident / investigation relating to:
    ✓ Support by SCAS line management / Occupational Health
    ✓ 1:1 meeting(s) that have occurred
    ✓ Any immediate Action Plan(s) implemented by line management
10. With all of the documentation and statement(s), utilise an appropriate Root Cause Analysis Tool to identify Service and/or Care Delivery Problems.
11. From the Root Cause Analysis, provide recommendations as appropriate.
12. Provide an Action Plan which will identify the relevant Accountable and Responsible persons for each Recommendation.
13. Establish if this type of incident has occurred previously, and if mitigating actions had been taken by the organisation (Have lessons been learnt?).

Investigation Team:

Name	Role	Department

Duty of Candour:

Contact made with patient / relatives within 10 days?

Yes: *(Date, with whom and how (face to face/telephone/email etc.)*

No : *(If not, why not? What is preventing)*

Involvement / contact / support of patient and/or relatives:

Note: Contact dates, times and correspondence to patient / family also **held on Datix.**

1. *Date, how contacted & brief reason….*
2.

Involvement and support provided for staff involved:

Date / who and when?

Policy / Protocols / Documents / Records reviewed during investigation:

A summary list of relevant local and national policy / guidance in place at the time of the incident, and any other data sources used:- (Include:-Title and date of Guidance, Policies, Medical records, interview records, training schedules, staff rotas, equipment, etc.) ADD AS APPENDICES where necessary.

Detection of incident:
Provide/describe sequence of events that led to detection of incident

Findings

CONCISE, numbered and if appropriate divide into specific areas i.e.
    1. EOC:
    2. Operational Ambulance staff:
    3. Residential Home / Nursing Home / A&E:
    4. Police:
    5. Mental Health Team:
    Etc.

Notable practice
Points in the incident or investigation process where care and/or practice had an important positive impact and may provide valuable learning opportunities. (e.g. Exemplar practice, involvement of the patient).

ANALYSIS:

- **Care Delivery Problem(s)**:
A themed list of the key problem points. (Where many problems have been identified the full list should be included in the appendix).

- **Service Delivery Problem(s)**:
A themed list of the key problem points. (Where many problems have been identified the full list should be included in the appendix).

- **Human Factors**:
A list of significant contributory factors (where many contributory factors are identified a full list or 'fishbone diagrams' should be included in the appendix. Human Factors should be considered wherever possible.

- **Contributory factors**:

Patient Factors	
Individual (staff) Factors	
Task Factors	
Communications	
Team Factors	
Education / Training	
Equipment	
Organisational and strategic factors	

- **Root Cause(s)**: *These are the most fundamental underlying factors contributing to the incident that can be addressed. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient.*

Lessons Learned:
Key safety and practice issues identified which may not have contributed to this incident but from which others can learn

Recommendations:
*Recommendations should be directly linked to root causes and lessons learned. They should be **clear but not detailed** (detail belongs in the **action plan**). It is generally agreed that **key recommendations should be kept to a minimum***

where ever possible	
Action Plan:	
See attached Action Plan	
Arrangements for shared learning:	
➢ All interested parties / SCAS Directorates / Heads of Departments will receive the completed SIRI report. ➢ The relevant Heads of Departments / Leads are to share any Lessons Learnt that would be pertinent to their staff within the local Team Meetings, Level 1 & 2 management 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. ➢ EOC Education – feedback through their 1:1 and team meetings with EOC staff.	
Distribution list for report findings:	

Who	How
Executive Director Clinical, Patient Care and Service Transformation Medical Director Deputy Director Patient Care Deputy Director Clinical Director Operations & Clinical Co-ordination Centres Head of Patient Experience Head of Risk & Security Named Safeguarding Lead Safeguarding Team SCAS Legal Services Manager Head of Resilience 999 Clinical Governance (North & South) 111 Clinical Governance (North & South) PTS Clinical Governance (North & South) PA to the CEO Investigations Demand Management Lead Head of Compliance Head of EOC Training and Education Educational Manager Unit 2 Unison Staff side representative Public Patient Representative / Champion	Email
Relevant CCG SRG	Email
Coroner	
Family / patient	
Other Health Care Provider involved	

Report Author	
Job Title	
Date	

Appendices

No	Description
1	Glossary of terms
2	
3	
4	
5	
6	
7	
8	
9	
10	

Appendix 1

Glossary of terms:

Abbreviation / Medical term	Meaning
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 <u>below</u> that of a Paramedic
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 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 – part of 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 CMs. Overall manager for 1-2 Ambulance Resource Centres
CM	Clinical Mentor. A qualified Paramedic who has received additional training to mentor staff and provide clinical advice and guidance for frontline ambulance staff.
CPR	Cardio Pulmonary Resuscitation
DCA	Double Crewed Ambulance
ECG	Electronic Cardio Graph. 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
ePR	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 provide 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 prescribe 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

Datix Completion Process for REPORTERS

When completing a Datix, **always** nominate **your** line manager, and choose **your** directorate /department. If an incident has directly involved 111, Community First Responders or Private Providers select **'Yes'** from the relevant fields. On submission you will receive an email informing you of the Datix number; you should save or take a note of this number.

If the incident is related to 111's service delivery please click **'yes'** to **'does it involve 111?'**.

When severity grading your incident, please refer to the **Risk Descriptor Table & Severity Grading Descriptor** for guidance.

Some categories of incident notify specific managers within the Trust on submission. These categories are: **Vehicle, Medication, Safeguarding, Information Governance, Physical Assault and Control of Infection.**

Additional investigators can be added by your line manager and Risk, as required**.**

Your Line manager will receive an email informing them they have an incident to investigate.

Your line manager has **29 days** from the day you submit the incident to investigate, and provide you with feedback.

When your line manager is satisfied that the investigation they and others have undertaken has answered the issues raised in your Datix, they will feed back to you.

Datix's will not be closed until you have received feedback.

Some incidents require external involvement i.e. from GP surgeries.

Feedback cannot be sent or the Datix closed until feedback has been received from all parties involved.

This may take more than 29 days; but your line manager should keep you informed of any progress in the investigation.

You can challenge this feedback if you feel it does not address your concerns.

The Risk team then review the investigation and the feedback given to you. If the investigation addresses the issues you have raised, the Risk team will close the incident.

If further work is required the investigator is notified and further investigation requested.

An investigation can be re-opened if further investigation is required, for example if new information becomes available.

Potential SI

Identified / Alerted through:

- ➢ **DATIX report submission (Risk Department review DATIX submissions on a daily basis)**
- ➢ **Incident highlighted immediately by SCAS staff (DATIX still to be completed)**
- ➢ **Patient Experience Team – complaint received and review required**
- ➢ **Clinically identified through audit / documentation review**

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*Essentially, a (potential) SI is the identification of an adverse incident that has **already occurred**, and due to the possible impact or seriousness of that incident, may warrant an investigation that is in line with NHS England's Serious Incident criteria 2015.

There is the expectation that if a reportable adverse incident had occurred, that the following would have been undertaken at that time of that incident:

- Attended to the immediate needs / support of patient(s) / member(s) of staff involved
- Actions taken to prevent a further occurrence if possible
- If required – staff members removed from 'Patient Facing' duties or suspended to protect the staff member, the Trust and the public
- **DATIX** completed and add all available documentation uploaded onto DATIX
- Line manager / EOC CCC Duty Manager / Bronze / Silver informed as appropriate
- Assistant Director Quality alert / informed of potential SIRI via the **DATIX** email system. The Primary Investigating Manager on DATIX, is to undertake this action
- Local Directorate involved, investigations / enquiries must NOT stop whilst the potential SIRI is being

---

Initial Review of possible SIRI

- An Investigations Manager or another Manager/Clinician from the Clinical Directorate will usually be nominated by the Assistant Director Quality, to undertake a review of the incident
- The review will be scrutinised by the SIRI Sub Committee which is comprised of at least 2 of the following, but not limited to:
  - **-** Director Quality and Patient Care
  - **-** Assistant Director of Quality
  - **-** Medical Director
- On completion of the Review, if the incident is declared a SIRI, an Investigations Manager will usually be appointed
- Where the incident is technically complex and requires the investigation to be undertaken by a suitably qualified / experienced SCAS person, s/he will be supported by a named Investigations Manager during the SI process
- If incident declared a SI, the Investigations Manager to upload all details onto StEIS
- Investigations Manager to complete 72 hour report and email via nhs.net to relevant CCG group

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If not a SI

- Continued use of **DATIX** as repository for all impact on essential
- Decision on how to proceed decided
- Level of investigation agreed
- Need to involve / inform external organisation? Incident may be related to another Health Care Provider who undertake their own review into the

OUT OF HOURS:

- If incident identified, at that time as being serious with significant main impact on patient, external stakeholders, staff and / or public the documentation is USUAL escalation process is to take place - On Call Silver / Gold notification
- **DATIX** completion
- **DATIX** email to Assistant Director Quality
- **VERY IMPORTANT**: Local investigation / obtaining statements / chronologies / Voice Recordings / Shift Reports must continue. This information must be loaded onto the relevant DATIX within the following 12 hours
- If the incident is of such serious proportions / impact – the Duty Gold / On Call Director will make contact with either the Director Quality and Patient Care or Assistant Director Quality

NOTE: A review cannot be undertaken without all relevant documentation being available to the person(s) reviewing the incident.

SI Subcommittee meeting or teleconference: Potential Serious Incident

Date:…………………..

Time:………………..

Attendees……………………………………………………………………………………
………………..

……………………………………………………………………………………………
…………………………

……………………………………………………………………………………………
…………………………

Datix/PE number …………………………………

How was incident identified (please circle)

- i.   Datix
- ii.   PE team
- iii. External stakeholder
- iv. CCG
- v.   Other

Patient Death   Yes   No

Date of incident…………………………………………….

Time of incident…………………………………………

Division (please circle)
999
111
PTS
Other……………………………………………………………..

Description of incident

Does the incident meet the SI criteria   Yes   No

Level of investigation   1. Concise
                            2. Comprehensive
                            3. Independent

SI
category…………………………………………………………………………
……..

If this incident does not meet the SI criteria and is not to be raised by SCAS what
action is to be taken

Investigating manager……………………………………………………….

Duty of Candour…………………………………………………………..

SI COMPLETION ELEMENTS:
SIRI Panel Form

	Element	Present: Y / N	Comment / Action
2. INVESTIGATION GATHERING AND MAPPING:	a) Did the Investigating Manager collate the appropriate evidence (where it was available) i.e. ePR + Continuation forms/GP, Falls Referral records/ Voice Recordings / Chronologies / written account etc.?		
	b) Were interviews conducted with staff / witnesses / patient or relatives?		
	c) Is there evidence that those with an interest in the investigation were involved (making use of briefings, de-briefings, draft reports, audits, etc.)?		
	d) Has the Investigating Manager evidenced that those affected (including patients/staff/victims/ perpetrators and their families) were involved and supported appropriately by SCAS?		
	e) Has SCAS met Duty of Candour?		
	f) Has the Investigating Manager produced a timeline of events?		
	g) Has the Investigating Manager identified and referenced good and/or best practice guidance and protocols to determine what should have happened?		
	h) Has the investigation identified **any C**are and/or **S**ervice **D**elivery **P**roblems?		
3. ANALYSING THE INFORMATION:	a) Has the investigation evidenced that any Contributory Factors identified, have been explored?		
	b) Has the investigation evidenced that the most fundamental issues/		

		Present:	Comments
	or Root Causes have been considered?		
	c) Have appropriate Lessons Learnt been identified for learning?		
	d) Are there clear procedures for effective communication to facilitate sharing of learning across SCAS and any other linked organisation(s)?		
	e) Has the investigation identified relevant Human Factors?		

Phase of investigation	Element	Present: Y / N	Comments
1. GENERATING SOLUTIONS:	a) Is there an Action Plan for the Recommendations?		
	b) Does the Action Plan reflect all Recommendations?		
	c) Is there a "Responsible person" and "Accountable person" identified for each action?		
	d) Has the Investigating Manger identified a timeframe for completion of the Recommendations in the Action Plan?		
4. Themes / Trends Identified?:			

StEIS NUMBER:		SCAS SRG PANEL DATE:		CLOSED NOT CLOSED
DATIX NUMBER:		Due with CCG Panel – DATE:		

Declaration of a SI: Decision Record

(To be saved with the 72 hour report as a record of the decision making process)

Datix Number of incident:					
Date of panel / meeting / virtual meeting / E-mail:					
Record of Panel / Virtual panel involved in decision making:	1. 2. 3. 4.				
Decision: SI	Y			N	
Investigation manager assigned to:					
Additional comments: Are there any additional terms of reference required?	Please state:				

Please indicate category of SIRI identified by ticking the box (copy & paste): √		
1	Serious untoward incidents involving patients and resulting in death, serious injury, significant injury or significant delay, e.g. medication error, negligence, accidents, patient falls/misplacement during transit, mechanical failures, unexpected clinical (including mental health, obstetric etc.) events, etc.	
2	Suicide or unexpected death of any person on Ambulance NHS premises or within an ambulance vehicle or under the care of a specialist team in the community.	
3	Serious damage to NHS Ambulance property, particularly resulting in injury or disruption of services e.g. through fire, flood or criminal activity.	
4	Incidents associated with infection prevention & control that produce, or have the potential to produce, unwanted effects involving the safety of patients, staff or others.	
5	Significant breakdown of infection control procedures with actual or potential for cross-infection, e.g. release of products from a failed sterilisation cycle, unclean vehicles.	
6	Infected healthcare worker or patient incidents necessitating consideration of further investigations involving outside agencies, e.g. TB, blood borne infections; etc.	
7	Large scale theft, fraud, confidentiality breaches or major litigation.	
8	Patients detained in police/prison custody who abscond from an ambulance vehicle.	
9	Death or serious injury to a person in receipt of NHS care or a member of the public as a result of a Trust vehicles involvement in a Road Traffic Collision (including pedestrian collisions).	
10	Death or serious Injury/harm to a service user that may have resulted from a delay in treatment or transport.	
11	Exclusion/ suspension of a health care professional, or manager if the impact will mean that a service cannot be adequately provided.	
12	A "major incident" - normally used to describe large scale incidents that require a multi-agency response, such as a rail crash, which could place a significant and acute burden on local health services, or that could present a major risk to public health.	
13	A 'Never Event'.	

Supported by:

collaboration   trust   respect   innovation   courage   compassion

40

GLOSSARY

SI – Serious Incident

StEIS – Department of Health's Strategic Executive Information System

RCA – Root Cause Analysis

DATIX – An electronic incident reporting / recording system utilised for all incident reporting with SCAS

RIDDOR – Reporting of Injuries Diseases and Dangerous Occurrences Regulations (1996)

NRLS – National Reporting and Learning Systems

NHSP – NHS Protect

NHSLA – NHS Litigation Authority

IR1 – Incident Reporting Form. This has been replaced by the electronic DATIX reporting system, but is still available for users where they have no SCAS access to the electronic DATIX system.

CCG - Clinical Commissioning Group

CQC – Care Quality Commission

DATIX Reporter – A person reporting an adverse incident / occurrence

Primary Investigating Manager – The DATIX reporter's immediate Line Manager whom is named on the DATIX report

SRG – SIRI Review Group

Equality Impact Assessment Form Section One – Screening

Name of Function, Policy or Strategy: <u>Serious Incident (SI) Policy</u>

Officer completing assessment: <u>Paul Cooke</u>

Telephone: <u>01869 365150</u>

1.	What is the main purpose of the strategy, function or policy?

To provide information and guidance to all SCAS staff in relation to the identification of an Adverse Incident which could possibly be declared a Serious Incidents (SI) as described within the Policy.

To follow the NHS England's SI Guidance, 2015 applying best practice wherever possible.

2.	List the main activities of the function or policy? (for strategies list the main policy areas)

The organisational objectives of this policy are to provide an effective framework to assist the Trust in complying with statutory requirements by ensuring that there are arrangements in place for:
- ✓ Effective implementation of the policy throughout the Trust;
- ✓ To reinforce reporting of Adverse Incidents using the DATIX system which would improve identification of any a possible SI;
- ✓ To provide support, advice and assistance to nominated investigating managers / officers;
- ✓ To encourage a culture of "Being Open" in completion of any investigation without fear of reprisal or rebuke from individuals or the organisation;
- ✓ To encourage "End to end" investigations, expanding the scope of any investigation where appropriate;
- ✓ To provide and encourage investigating managers / officers to utilize the Root Cause analysis tools during the investigation to identify recommendations that would benefit patients, staff, the public or the Trust itself;
- ✓ To encourage engagement with other linked health care or public agencies during the investigation process to provide;
- ✓ To provide a fair and balanced report free from bias

3.	Who will be the main beneficiaries of the strategy/function/policy?

All SCAS staff more specifically named investigating managers / officers.
The policy also clearly identifies responsible persons, managers and senior directorate of their required actions needed during the various stages before and after a SI.

1.	Use the table overleaf to indicate the following:-

    a. Where do you think that the strategy/function/policy could have an adverse impact on any equality group, i.e. it could disadvantage them?

    b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?

		Positive Impact	Negative Impact	Reasons
GENDER	Women	N/A	N/A	Policy covers all inclusively
	Men	N/A	N/A	
RACE	Asian or Asian British People	N/A	N/A	As above
	Black or Black British People	N/A	N/A	
	Chinese people and other people	N/A	N/A	
	People of Mixed Race	N/A	N/A	
	White/white other	N/A	N/A	
DISABILITY	**Disabled People**	N/A	N/A	Policy is to enhance equality of all
SEXUAL ORIENTATION	**Lesbians, gay men and bisexuals**	N/A	N/A	As above
AGE	Older People (60+)	N/A	N/A	
	Younger People (17 to 25) and children	N/A	N/A	
RELIGION/BELIEF	**Faith Groups**	N/A	N/A	
	Equal Opportunities and/or improved relations	N/A	N/A	

Notes:

Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts.

 The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

5.	If you have indicated that there is a negative impact, is that impact:				
		Yes		**No**	
Legal (it is not discriminatory under anti-discriminatory law)					
Intended					
Level of Impact		**High**		**Low**	
If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.					

6(a). Could you minimise or remove any negative impact that is of low significance? Explain how below:
N/A

6(b). Could you improve the strategy, function or policy positive impact? Explain how below:
N/A

7.	If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How?
N/A	

Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.
Signed: *Paul Cooke*
Name: Paul Cooke
Date: 12/08/2019

Equality Impact Assessment Form Section Two – Full Assessment

Name of Function, Policy or Strategy: Serious Incident Requiring Investigation (SIRI) Policy .

Officer completing assessment: Paul Cooke   .

Telephone: 01869 365150   .

Part A

1.   Looking back at section one of the EqIA, in what areas are there concerns that the strategy, policy or project could have a negative impact?

Gender	N/A
Race	N/A
Disability	N/A
Sexual Orientation	N/A
Age	N/A
Religion/Belief	N/A

2.   Summarise the likely negative impacts:-

None Identified.

....

....

....

3.   Using the table below, give a summary of what previous or planned consultation on this topic, policy, function or strategy has or will take place with groups or individuals from the equality target groups and what has this consultation noted about the likely negative impact?

Equality Target Groups	Summary of consultation planned or taken place
Gender	Standard 21 day consultation across the Trust.
Race	Standard 21 day consultation across the Trust.

Disability	Standard 21 day consultation across the Trust.

Equality Target Groups	Summary of consultation planned or taken place
Sexual Orientation	Standard 21 day consultation across the Trust.
Age	Standard 21 day consultation across the Trust.
Religion/ Belief	Standard 21 day consultation across the Trust.

1. What consultation has taken place or is planned with Trust staff including staff that have or will have direct experience of implementing the strategy, policy or function?

    Standard 21 day consultation across the Trust.

    ⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯⋯

2. Check that any research, reports, studies concerning the equality target groups and the likely impact have been used to plan the project and guide or indicate what research you intend to carry out:-

Equality Target Groups	Title/type of/details of research/report
Gender	
Race	
Disability	
Sexual Orientation	
Age	
Religion / Belief	

3. If there are gaps in your previous or planned consultation and research, are there any experts/relevant groups that can be contacted to get further views or evidence on the issues?

☐ Yes (Please list them and explain how you will obtain their views)

....

....

[X] No

Part B

Complete this section when consultation and research has been carried out

7a.　As a result of this assessment and available evidence collected, including consultation, state whether there will be a need to be any changes made/planned to the policy, strategy or function.

7b.　As a result of this assessment and available evidence, is it important that the Trust commissions specific research on this issue or carries out monitoring/data collection?

(You may want to add this information directly on to the action plan at the end of this assessment form)

....

....

....

....

8.　Will the changes planned ensure that negative impact is:

Legal?　　　　　　　　　　　　　　　　　　　　[YES]

(not discriminatory, under anti-discriminatory legislation)

Intended?　　　　　　　　　　　　　　　　　　[NO]

Low impact?　　　　　　　　　　　　　　　　　[YES]

9a.　Have you set up a monitoring/evaluation/review process to check the successful implementation of the strategy, function or policy?

Yes [YES]　　　　　　　　　No ☐

9b.　How will this monitoring/evaluation further assess the impact on the equality target groups/ensure that the strategy/policy/function is non-discriminatory?

Details: The SIRI Review Group members will ensure monitoring and evaluation through its 6-8 weeks meetings identify any impacts on the equality target groups, ensuring that the strategy/policy/function is non-discriminatory.

Please complete the action plan overleaf, sign the EQIA, retain a copy and send a copy of the full EQIA and Action Plan to the Trust's Equality Lead.

Signed: *Paul Cooke*

Name: Paul Cooke   .

Date: 12/08/2019

1.4 EQIA ACTION PLAN

Issue	Action Required	Lead Officer	Timescale	Resource Implications	Comments

Please continue on another sheet if you need to.