

STANDARD OPERATING PROCEDURE PATIENT SAFETY INCIDENT ANALYSIS USING SWARM HUDDLE METHODOLOGY

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	19 Oct 23	<i>New SOP. Required to implement National Guidance (Patient Safety Incident Response Framework). Approved at QPaS (19 October 2023) with the proviso that the next review of this SOP is done within a 6 month timeframe.</i>
1.1	16 May 2024	<i>6 month review. Update chair and lead responsibilities and timeframes. Approved at Quality and Patient Safety Group (QPas) (16 May 2024).</i>

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1. INTRODUCTION

Effective investigations enable the Trust to identify any risks within its activities and to take actions to reduce, prevent or mitigate those risks. Effective investigations also ensure learning from incidents can take place and that learning is shared to improve safety across all areas of the Trust.

Under the Patient Safety Incident Response Framework, the Trust can use several different tools to understand and learn from patient safety incidents, a Patient Safety Incident Analysis using Swarm methodology is one of these tools.

A Swarm Huddle was developed by NHS England and is designed to be used as soon as possible after a patient safety incident occurs. This SOP will describe how the Trust will utilise this methodology to ensure that patient safety incidents are investigated swiftly, using the SEIPS methodology* and ensuring patients and their families can contribute to the learning.

2. DEFINITIONS

Initial Incident Review	Initial Incident Review (72 hr report) A staff debrief to ascertain rapid gathering of facts and areas of immediate safety actions and learning ensuring that urgent action is taken to address risks. Report produced.
Patient Safety Incident Analysis Utilising Swarm Huddle methodology	A review using the Swarm Huddle methodology, where a report is produced and shared with the patient/family to outline good practice/what has been learnt through the IIR and Swarm Huddle and any learning actions. The Swarm Huddle uses the SEIPs Framework* and is designed to be initiated after an event and involves an MDT discussion with the lead reviewer. Staff come together to gather information about what happened and why it happened as soon after the incident as possible and decide what if anything, needs to be done to reduce the risk of the same thing happening in the future. It is non-punitive and a safe space to examine a patient safety incident and deliver learning.
Patient Safety Incident investigation (PSII)	An in-depth investigation of a single patient safety incident or cluster of incidents which may be complex (ie involving more than one team) where it appears significant learning is required to understand, what happened and how using systems based methodology to identify good practice and any improvements in care delivery that are required.

* SEIPS is a framework for understanding outcomes within complex socio-technical systems. Ref: [B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf \(england.nhs.uk\)](#)

3. FLOW CHART FOR PATIENT SAFETY INCIDENT ANALYSIS (PSIA UTILISING SWARM HUDDLE METHODOLOGY)

A PSIA utilising Swarm Huddle **methodology** should be undertaken when:

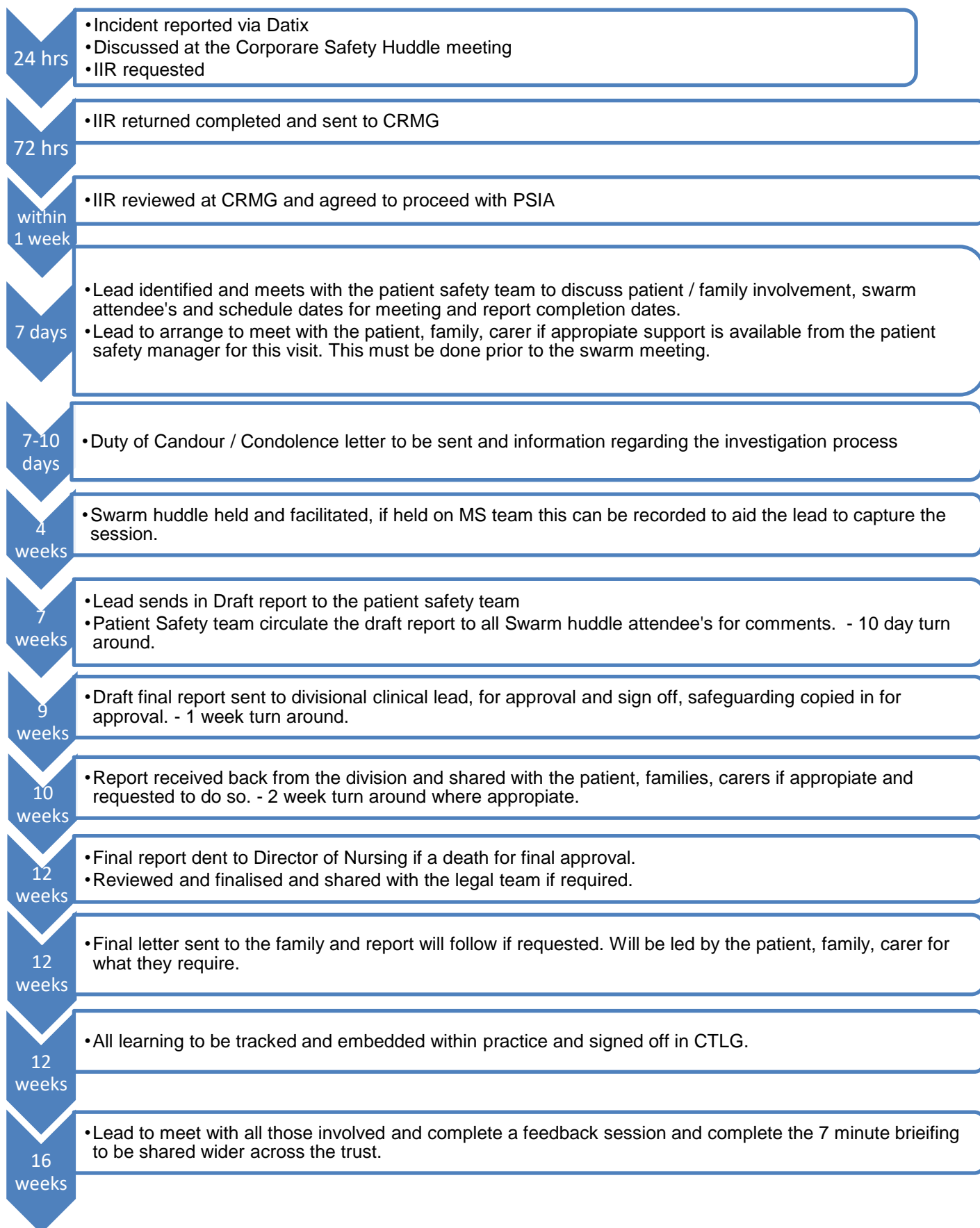
- Care has not gone as planned resulting in a patient safety incident
- Care has gone well in complex circumstances to identify good practice that can be shared

PSIAs Swarm will take place after an Initial Incident Review (IIR) has been completed and reviewed via the Trust patient safety team processes and it is felt a further review of care is required to maximise opportunities for learning and an in-depth Patient Safety Incident Investigation is not required.

PSIAs using Swarm Huddles enable insights and reflections to be quickly sought and generate prompt learning following a PSI. They can prevent:

- those affected forgetting key information because there is a time delay before their perspective on what happened is sought
- fear, gossip, and blame; by providing an opportunity to remind those involved that the aim following an incident is learning and improvement
- information about what happened and 'work as done' being lost because those affected leave the organisation where the incident occurred.

See flow chart on next page:



Week one

A SWARM preparation meeting will be coordinated by the Engagement lead with the Identified Lead of the PSIA to discuss patient, family involvement, swarm attendee's and schedule dates for meeting and report completion. Letter to be sent to the patient, family / carer informing them of the review.

Week two/three

The lead reviewer contacts the family to explain the review that will be undertaken and to ask if they have any question areas that can be considered in the Swarm huddle. A face-to-face meeting can be arranged by the lead, supported by the engagement lead if appropriate.

The Patient Safety Administration Team will circulate to those attending the Swarm Huddle the IIR report, Navigating Difficult Events at Work Booklet, the PSIA using Swarm methodology SOP and the Swarm Ground rules, so that they can prepare for the session.

The Patient Safety Administration Team will prepopulate the PSIA template with information from the IIR and a SWARM Template will also be sent to the Lead Reviewer for use in the meeting to draft any notes.

Week Four-Undertaking a SWARM HUDDLE

A senior member of the Patient Safety Team will chair the Swarm Huddles on behalf of the lead reviewer

The PSIA Lead and Chair will make notes of the Swarm Huddle to support the writing of the report.

The lead reviewer will have access to a Swarm Huddle template to be used during the huddle- this will serve as an aide memoire for the reviewer and will also support capturing initial learning for immediate action.

Following the Swarm Huddle, unless the case has been escalated to the Director of Nursing, AHP and Social Work Professionals for further investigation the lead reviewer should complete the PSIA report (see template appendix 4)

Week Seven

The Patient Safety Team send the draft report to Swarm huddle attendees for feedback. They will then coordinate feedback from the Swarm Huddle attendees and liaise with the lead investigator re any changes. 10 days turn around.

Week Nine

Draft final report sent to the divisional clinical lead and safeguarding for approval and sign off – 1 week turnaround.

Week 10

Report received back from the division and shared with the patient, families and carers if appropriate and requested to do so – 2 week turn around where appropriate.

Week 12 Approval of PSIA Reports

The final draft of the report will be sent to the Director of Nursing if a death for final approval. Report reviewed and finalised by the patient safety team shared with the Clinical Risk Management Group (CRMG) Final letter will be sent to the patient, family, or carer with a copy of the final report if requested and a face-to-face feedback session offered to the family.

Week 12 -16

Lead reviewer to arrange a feedback meeting with all those involved in the investigation to discuss findings and learning from the incident including good practice. The lead will also complete the 7-minute briefing for wider circulation.

Time scales for the investigation must be flexible to meet the needs of the patient, family and carer engagement. Some cases will be very complex and may require more time to complete, if timescales are not adhered to for any reason this must be escalated to the patient safety team, who will liaise with the director of Nursing to extend the deadlines.

PSIA report

The template used for a PSIA will lift the chronology and other pertinent data from the IIR, it is a requirement for the lead of the PSIA to make sure the chronology is correct and any unanswered questions from the review by CRMG. The extract of the minutes where the IIR was reviewed by CRMG will be sent to the Lead by the Patient Safety Team Administrator.

The report will clarify areas raised by the family and CRMG and focus on presenting what was learnt from the Swarm Huddle capturing good practice and any additional learning.

Escalation to a Patient Safety Incident Investigation (PSII)

If during the Swarm huddle more information arises indicating that the incident more likely than not arose due to significant problems in care/ the incident is complex i.e. involving multiple teams/external partners this must be captured in the Swarm report template and the senior member of the Patient Safety Team supporting the Swarm Huddle must raise with the Director of Nursing, Allied Health & Social Care Professionals/Deputy in their absence for consideration of undertaking a Patient Safety Incident Investigation.

4. SCOPE

This SOP applies to all permanent (clinical and non-clinical) staff, locum, agency, bank and voluntary staff and students working within the Trust.

All Trust staff with responsibility for managing patient safety incidents must follow these procedures to ensure incidents are reviewed accordingly.

5. DUTIES AND RESPONSIBILITIES

Director of Nursing, AHP & Social Care Professionals/Medical Director

The Director of Nursing has overall responsibility for patient safety and both the Director of Nursing, and the Medical Director can commission a patient safety incident analysis using Swarm huddle methodology.

The Director of Nursing will ensure the SOP is complied with and monitor through appropriate committees.

Deputy Director of Nursing, AHP & Social Care Professionals

As the Chair of CRMG, the Deputy Director of Nursing can commission a patient safety incident analysis using Swarm huddle methodology and will facilitate a Swarm Huddle when required. They will be available to support staff involved in the process both before and after.

The Deputy Director of Nursing will sign off the final PSIA report in circumstances where the patient has not died, following approval by the Divisional Clinical Lead.

Assistant Director of Nursing (ADoN)

The Assistant Director of Nursing can commission a patient safety incident analysis using Swarm huddle methodology, will facilitate a Swarm Huddle when required. They will be available to support staff involved in the process both before and after.

The Governance and Patient Safety Team - will provide advice, support and training on the process and will facilitate the setting up of Swarm Huddles. They will collate themes and disseminate learning as agreed at CRMG.

Governance and Patient Safety Administrator- will arrange Swarm Huddles, send out documentation to support patient safety incident analysis using Swarm huddle methodology, which includes.

- Swarm Huddle agenda
- PSIA Template prepopulated from the IIR for completion by the Lead Reviewer
- Completed IIR
- Send the Lead of the PSIA the extract of the minutes of CRMG where the IIR was reviewed
- Information regarding the process and support booklet for staff

They will also ensure the completed PSIA form is circulated to the DON and the Clinical Director and the appropriate Divisional General Manager and Clinical leads and that the report is sent for inclusion on the next CRMG meeting.

Divisional Clinical Leads- will collaborate with the patient safety team and lead on the following for their division:

- Identifying a lead reviewer for the PSIA
- Identify with the lead which staff should be involved in a PSIA Swarm Huddle, offering support to those who are attending the meeting.
- Ensuring staff have received a copy of the Navigating Difficult Events at Work booklet prior to the Swarm Huddle
- Ensuring that staff who are attending a Swarm Huddle have been offered a debrief, appropriate psychological support in preparation for the Huddle
- Ensuring staff have access to appropriate support following a Swarm Huddle
- Final approval of a PSIA report
- Ensuring the learning is shared across their clinical areas and division
- Monitoring actions arising from PSIA's and ensuring they are implemented and signed off at CTLG.

Divisional General Managers- as above

Matron/Line Manager/Team Leader- as above

Matron/Line manager/team leader is responsible for ensuring:

- Staff are familiar with this procedure and adhere to the instructions referred to
- Staff attend training applicable to their role
- Staff are given the Swarm Huddle leaflet prior to the Swarm huddle
- Support is offered to the person/s involved in the Swarm huddle and is documented.
- Staff are given a copy of 'Navigating Difficult Events at Work' booklet.

Chair of Swarm Huddle

The chair's role is to create a safe and brave space where the staff involved in a recent patient safety incident feel able to speak up and share their recollections without feeling blamed.

Facilitating a Swarm requires a facilitator who:

- models the values of a just and learning culture.
- has excellent active listening, emotional intelligence, and facilitation skills.
- is confident they can support a multi-disciplinary team to openly reflect on what happened and why soon after a patient safety incident.
- is inclusive and who will encourage everyone's voice and recollections to be shared, irrespective of their level of seniority, professional background and/or personality type (e.g., introvert or extrovert).
- will calmly and respectfully shut down conversations of blame and who recognises and acts on non-verbal and verbal cues that staff members are struggling with the Swarm conversation.
- can clearly communicate the Swarm's aims.
- is curious and open-minded, encouraging others to explore a work system.

Lead Reviewer

The lead reviewer will be agreed by the clinical division and divisions. The lead reviewer can be from the division in which the incident occurred however divisions will have reciprocal arrangements in place between each other to lead a Patient Safety Incident Analysis on behalf of each other when it is felt necessary, to support a level of independence from the clinical area within which the incident occurred.

The Lead Reviewer is responsible for:

- Meeting with the person and or family member/carer to discuss the review and any concerns or areas they wish to be considered as part of this.
- Work closely with the engagement lead and follow the Engaging and Involving patients, families and staff following a patient safety incident policy and procedure.
- Keep the person and or their family up to date on the progress of the review in a timeframe agreed with them.
- Consider the care delivered against statute, national (NICE) and local guidance (policies and procedures)
- Produce a report using the Trust PSIA report template, which is informed by the Swarm Huddle
- Provide a verbal update to the division on the findings prior to the completion of the report and subsequent action plan
- Complete the review within the timescales agreed
- Ensure the Patient Safety Team has copies of all investigation supporting documentation,
- Meet with the family following completion of the review and share a draft approved report
- Feedback the outcome of the investigation to all staff involved in the process
- Attend coroners court as the lead investigator where required

Attendees of Swarm Huddle

People are invited to Swarm huddles based on their involvement with the patient/ family/ carer, and/or their expertise is requested, and/or they can offer insights and contributions valuable to learning. Individuals are responsible for:

- Prioritising attendance at the Swarm huddle
- Demonstrating respect, curiosity and compassion for others
- Knowing the details of the case, through reading the IIR and records
- Avoiding blame language or hindsight bias
- Being open and transparent in the interests of learning
- Following the ground rules
- If finding it difficult to speak up in the Swarm, contacting the lead author at the break or at the end to raise things for consideration

6. GOVERNANCE ARRANGEMENTS

Corporate Safety Huddle

- Group undertakes reviews of all reported patient safety incidents submitted over the preceding 24 hours (Monday to Friday).
- Incident category and severity reviewed and amended if required in line with National Reporting and Learning System (NRLS) guidance.

Clinical Risk Management Group (CRMG) – meets weekly to review all the Initial Incident Review (IIR) reports and commissions Swarm huddles. Reports to QPAS. CRMG may request more information on an incident in order to confirm level of investigation required.

- Theming up of learning and actions
- Identify the key areas of focus for a Swarm Huddle to be included in the terms of reference for the PSIA

Closing the Loop Group- meets six weekly- reports to QPAS

- Signs off closure of action plans
- Receives evidence from divisions to close actions from patient safety investigation and determines if evidence is adequate to close action or if further evidence is required
- Determines need and method for monitoring actions embedded into practice, i.e clinical audit
- Every quarter invites ICB to share learning from incidents and improvements as a result of learning

Quality and Patient Safety Group (QPAS) Reports to the Quality Committee

- Ratifies closure of action plans
- Overseeing process and receives a bi monthly report on learning themes

Quality Committee - Board Sub-Committee

- Receives assurances that effective systems are in place across the organisation in relation to patient safety
- Encourages learning to take place from the consideration of themes arising from patient safety investigations

7. PROCESS AND PROCEDURES

When should the process be applied?

Once an IIR has been completed and reviewed and it is deemed by the DON/ DDN/ADM that further investigation is required to enable identification of learning.

A Patient Safety Incident Analysis should be completed within 16 weeks as per the flowchart in section 3.

A Swarm Huddle will be held no later than 4 weeks following receipt and review of an IIR in CRMG.

Completed PSIA reports will be submitted to

- Director of Nursing, Allied Health & Social Care Professionals
- Medical Director
- Deputy Director of Nursing, Allied Health & Social Care Professionals
- Assistant Director of Nursing, Patient Safety, and compliance
- Clinical Director
- Divisional Clinical Leads
- Divisional General Managers
- All staff involved in the Swarm huddle

Divisional governance processes will monitor safety actions.

Learning themes will be captured and collated by the Patient Safety Team and reported to QPaS quarterly.

CRMG will discuss and agree where in the organisation learning from the Swarm will be shared.

All staff involved in the process will also be sent a short questionnaire by the Patient Safety Team to be completed within 14 days of Swarm huddle feedback from this will be collated and reported quarterly to QPaS.

8. PATIENT AND FAMILY INVOLVEMENT

The Lead reviewer for the PSIA will contact the patient and/or the family, explain the review being undertaken and provide an opportunity for the patient/family to raise any areas of concern or questions they wish to be explored in the review, linked to the Engaging and Involving patients, families and staff following a patient safety incident policy and procedure.

Where a patient has died in unnatural and unexpected circumstances the family will be written to by the Director of Nursing to offer condolences as soon as the notification of the persons death has been received. The family will be offered an opportunity to contact the Trust.

The Trust seeks to promote a culture of openness, which is a pre-requisite for improving patient safety and the quality of healthcare systems. For further information, please refer to the Trust Duty of Candour Policy which can be accessed at this link.

On completion of the PSIA the Lead reviewer supported by the engagement lead if required, will make arrangements to share the report with the patient/family and go through any questions they may have.

9. TRAINING REQUIREMENTS

All staff in the Trust are required to undertake Patient Safety Level 1a mandatory for all staff from November 2024.

PSIA awareness sessions will be available for all staff to attend. These are aimed at lead reviewers and those who may participate in a SWARM Huddle.

Board Members and Senior Leads are required to complete Patient Safety Level 1b mandatory for all Board members and Senior Leads.

All Lead Reviewers must complete Systems Approach to Learning from patient safety incidents 2 days course. Lead Reviewers will also receive in house training on chairing Swarm Huddles and offered a shadowing session.

10. REFERENCES

Patient Safety Incident Response Framework- August 2022

Overarching policies/plans the SOP links with:

- [The Patient Safety Incident Reporting Plan \(PSIRP\)](#)
- [Risk Management policy](#)
- [Incident Reporting Policy and Procedure \(N -038\)](#)
- Engaging and Involving patients, families and staff following a patient safety incident policy and procedure

APPENDIX 1 - TIPS FOR FACILITATING A SWARM HUDDLE



How to carry out an effective Swarm huddle

An effective Swarm involves six steps:

- Introduce all participants so everyone knows each other's name and their role in the Swarm.
- Create a safe and 'brave' space by reassuring participants that the purpose of the Swarm is to identify what happened and why by exploring the systems and contexts in which patient care was being delivered.
- Replay the events that led to the patient safety incident.
- Explore what happened and why, through the lens of the Swarm work system prompts (appendix 3).
 - Identify safety actions, and where feasible, assign specific deliverables and completion dates to leads.
 - Identify where else in the organisation the learning from the Swarm may be relevant.

SWARM Huddle Ground Rules

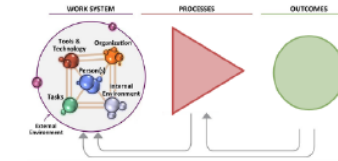
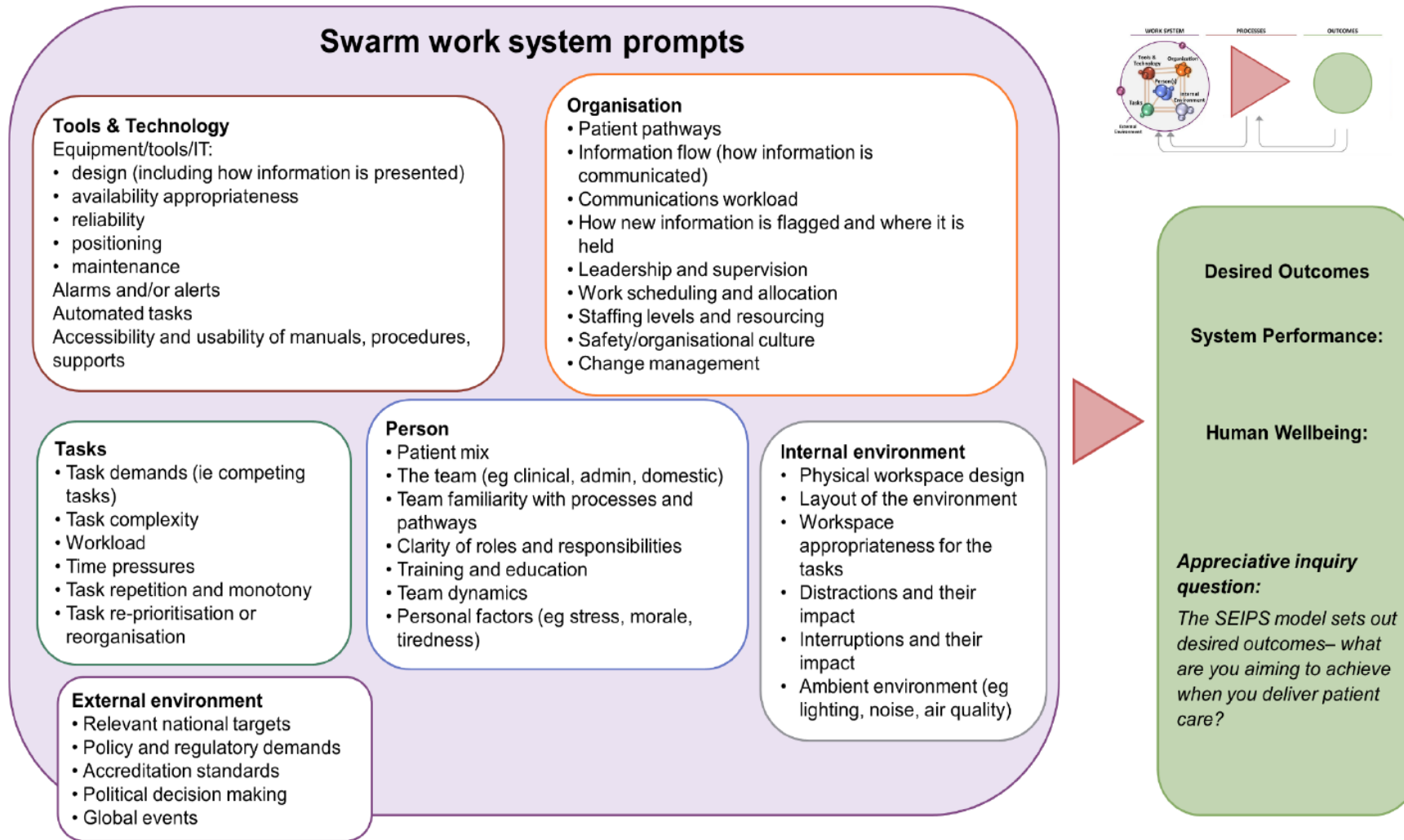
- Behave in line with a trauma informed approach- we do not know individuals' personal histories or how someone can respond to a particular incident so we will be mindful
- **Actively listen, listen to hear rather than listen to respond**
- **Take turns, everyone gets a say**
- Demonstrate respect to others and their perspectives and thoughts
- **We are all peers and there is no place for hierarchy within the room, everyone's unique contribution is valued**
- **Value diversity of opinions, experience and roles**
- Acknowledge feelings and treat each other with compassion
- **Incisive questioning, based on curiosity rather than assumption**
- Be mindful of hindsight bias and challenging ourselves when we fall into that place
- **Ignite thinking- this is a time to think and move beyond initial ideas to deeper thinking and creative solutions, so don't be afraid to share ideas**

Prepare for the SWARM prior, read the notes, IIR and SOP



Caring, Learning
& Growing Together

APPENDIX 3 - SWARM WORK SYSTEM PROMPTS



APPENDIX 4 - PATIENT SAFETY INCIDENT ANALYSIS TEMPLATE

[Patient Safety Incident Analysis Template](#)

APPENDIX 5 - SWARM TEMPLATE TO SUPPORT PSIA REPORT WRITING

The way in which information is gathered during a Swarm Huddle is based on the use of the SEIPS model.

Areas to explore:

Domain	Question	Notes
Tasks	What technology is being used, how is this working/ supporting, any challenges? What equipment have people access to, is it what is needed? How is it access used? How are people supported to use it? Are there procedures in place, how are they understood, applied in practice, any challenges? What are demands on the individual of the task, is it complex, complicated, have they competing demands? Are there any time pressures as a result of demands or the task and how does this impact? What is the workload, capacity, demand Is the task repetitive, if so what impact does that have on concentration? How are people prioritising?	
Tools and technology	What technology is being used, how is this working/ supporting, any challenges? What equipment have people access to, is it what is needed? How is it access used? How are people supported to use it? What resources do staff have? What equipment have they and how does it help/ hinder? How is work allocated/ monitored? What do people have to help them with the job being asked? What electronic systems are in use, how do they work in respect of the incident?	
Organisation	What is the patient pathway How is information shared and with whom What is the leadership? How are people supported/supervised?	

	<p>What are the staffing levels and resources available? Any challenges eg sickness What is the culture, how is this defined/ understood Where is safety, how is this understood Any changes impacting or disruptions How are issues escalated/ flagged?</p>	
Person	<p>Consideration around patient mix Issues around team, newness, maturity of team, cohesion? Anything affecting individuals, personal factors (link with Just Culture appendix 6) What are the roles and responsibilities, who is responsible for what and how is this understood? What training and education is provided/ available Any team dynamics to consider</p>	
External environment	<p>National targets KPI's Policy or legislation changes Accreditation National issues affecting services e.g., pandemic, national inquiry</p>	
Internal Environment	<p>Physical landscape, layout, how does it lend itself to the job/ task/ safety Workspace consideration, what supports/ hinders Any distractions for people and what is the impact Interruptions for people and what is the impact Ambient environment (noise/ temperature) Anything from the environment that impacts on decision making eg, due to limitations staff have to work in a particular way</p>	

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- A **just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- A **just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- A **just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?



Yes

Recommendation: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?



Yes

Recommendation: Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier.

END HERE

2b. Are there indications of physical ill health?
2c. Are there indications of mental ill health?



Yes

Recommendation: Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier.

END HERE

if No to all go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?
3b. Were the protocols/accepted practice workable and in routine use?
3c. Did the individual knowingly depart from these protocols?



If No to any

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

END HERE

if Yes to all go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?
4b. Was the individual missed out when relevant training was provided to their peer group?
4c. Did more senior members of the team fail to provide supervision that normally should be provided?



If Yes to any

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

END HERE

if No to all go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?



Yes

Recommendation: Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

END HERE

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

APPENDIX 7 – EQUALITY IMPACT ASSESSMENT

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Swarm Huddle Standard Operating Procedure**
2. EIA Reviewer (name, job title): **Colette Conway**, Assistant Director of Nursing, Patient Safety and Compliance
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Standard Operating Procedure**

Main Aims of the Document, Process or Service – To support the implementation of the Patient Safety Incident Analysis using Swarm methodology.			
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma			
Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?	
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern (Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice	
Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Sex	Men/Male Women/Female	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Marriage/Civil Partnership		Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Pregnancy/ Maternity		Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Race	Colour Nationality Ethnic/national origins	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
Sexual Orientation	Lesbian Gay men Bisexual	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.

Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	Review of this policy has taken place to ensure no group is adversely affected by this policy.
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Summary

<p>Please describe the main points/actions arising from your assessment that supports your decision.</p> <p>This SOP will be adopted system wide within the Trust and is applicable to all members of staff. The procedures detailed will be applied unilaterally across the organisation.</p>	
<p>EIA Reviewer: Sadie Milner</p>	
<p>Date completed: 21-03-24</p>	<p>Signature: S. K. Milner</p>