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Sherwood Forest Hospitals
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THE DECISION TO INVESTIGATE

(MAKING MORTALITY MORE MEANINGFUL)

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Executive Medical Director

NHS England

Serious Incident Framework

Supporting learning to prevent recurrence

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1. Seven Key Principles

This Framework endorses the application of 7 key principles in the management of all serious incidents:

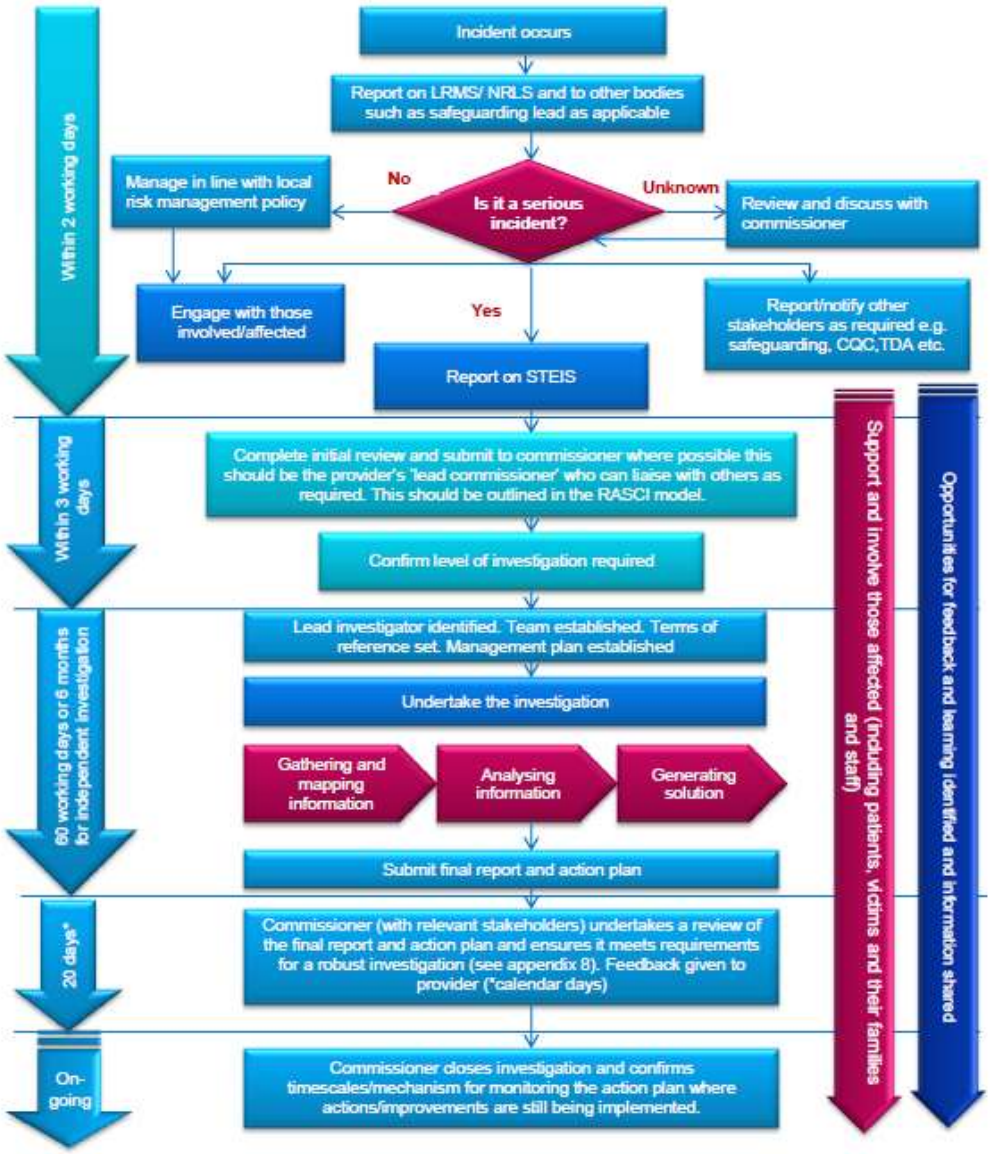
NHS Improvement

Our plans for NHS patient safety investigation

Dedicated to Outstanding care

Part Three: The Serious Incident Management Process

1. Overview of the Serious Incident Management Process



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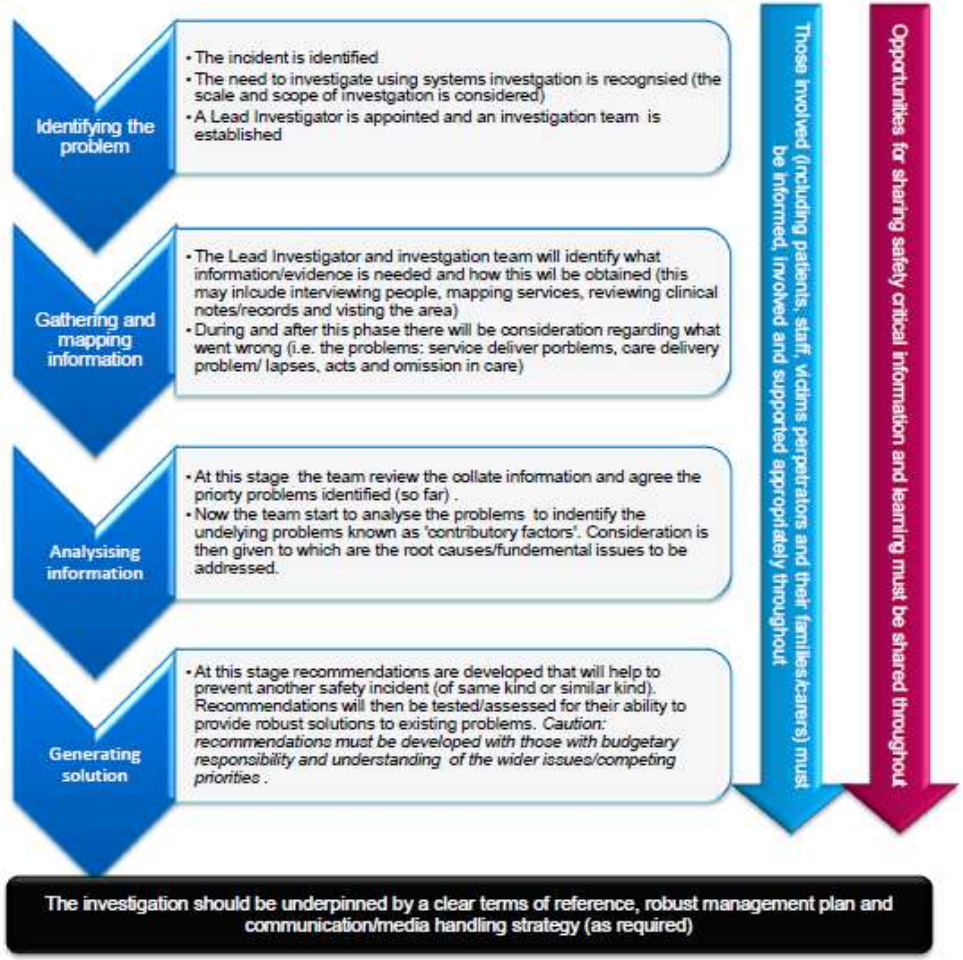
The Framework is split into three parts;

- **Part One: Definitions and Thresholds** - sets out what a serious incident is and how serious incidents are identified. This section also outlines how the Framework must be applied in various settings.
- **Part Two: Underpinning Principles** - outlines the principles for managing serious incidents. It also clarifies the roles and responsibilities in relation to serious incident management, makes reference to legal and regulatory requirements and signposts to tools and resources.
- **Part Three: Serious Incident Management Process** - outlines the process for conducting investigations into serious incidents in the NHS for the purposes of learning to prevent recurrence. It covers the process from setting up an investigation team to closure of the serious incident investigation. It provides information on timescales, signposts tools and resources that support good practice and provides an assurance Framework for investigations.

4. Overview of the investigation process

This schematic provides a brief overview of a systems investigation for investigating serious incidents in the NHS. It requires a 'questioning attitude that never accepts the first response',[vii] and uses recognised tools and techniques[41] to identify:

- The problems (the what?) including lapses in care/acts/omissions; and
- The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and
- The fundamental issues/root cause (the why?) that need to be addressed.



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OFFICIAL

Stage 2 – Provider focussed internal investigation and 60-day investigation report

- The relevant commissioner (typically the quality lead within the CCG) will ensure that the service provider undertakes a robust and thorough internal investigation. The Regional Investigations Team will be available to support and help develop the terms of reference with the commissioner and other stakeholders as necessary. An opportunity must be given to the family members of the victim and the alleged perpetrator to have input in to the terms of reference and raise concerns where possible.
- The internal investigation should be completed within 60 working days (from the date in which the incident is reported), be of good quality and underpinned by clear terms of reference. It should demonstrate the application of robust investigative methodologies which result in effective recommendations to prevent recurrence as outlined in part three of the main Framework.
- All investigative material should be retained and be readily available to share with the Independent Investigators if required.
- In addition to established local reporting procedures the 60 day report should also be shared with the CCG lead, sub-region quality lead and the Investigation Team and affected families.

WHAT IS HARM ?

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- **Severe harm** (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care)
- **Chronic pain** (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery) or
- **Psychological harm**, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days)

WHAT IS AN INCIDENT?

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Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- **Unexpected or avoidable death of one or more people**. This includes
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past
- **Unexpected or avoidable injury to one or more people** that has resulted in serious harm
- **Unexpected or avoidable injury to one or more people that requires further treatment** by a healthcare professional in order to prevent:—
  - the death of the service user or
  - serious harm
- **Actual or alleged abuse**; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring

A Never Event

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

- Failures in the security, integrity, accuracy or availability of information often described as **data loss and/or information governance related issues**
- **Property damage**
- Security breach/concern
- Incidents in population-wide healthcare activities like **screening and immunisation programmes** where the potential for harm may extend to a large population
- **Inappropriate enforcement/care under the Mental Health Act** (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
- **Systematic failure to provide an acceptable standard of safe care** (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services) or
- **Activation of Major Incident Plan** (by provider, commissioner or relevant agency)

Level	Application	Product/ outcome	Owner	Timescale for completion
Level 1 **Concise internal investigation**	Suited to less complex incidents which can be managed by individuals or a small group at a local level	Concise/ compact investigation report which includes the essentials of a credible investigation	Provider organisation (Trust Chief Executive/relevant deputy) in which the incident occurred, providing principles for objectivity are upheld	Internal investigations, whether concise or comprehensive must be completed within 60 working days of the incident being reported to the relevant commissioner All internal investigation should be supported by a clear investigation management plan
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable	Comprehensive investigation report including all elements of a credible investigation	Provider organisation (Trust Chief Executive/relevant deputy) in which the incident occurred, providing principles for objectivity are upheld. Providers may wish to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny/objectivity	
Level 3 **Independent investigation**	Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved (see Appendix 1 and 3 for further details)	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

- **NOTIFY INCIDENTS WITHIN 72hrs**
- **COMPLETE INTERNAL INVESTIGATIONS WITHIN 60 DAYS**
- **COMPLETE EXTERNAL INDEPENDENT INVESTIGATIONS WITHIN 6 MONTHS**

DoGov, MD, DoN
HoG, Div Gov Leads
Safeguarding, PET
Divisional Reps
Presenters
Meets Mon, Wed and Fri

DoG, MD, DoN
HoG, Div Gov Leads
Safeguarding, PET, Legal
Divisional Reps
Presenters
Meets BiWeekly

GOVERNANCE SUPPORT UNIT

HoGov, HoRisk,
Divisional Governance Lead
2PA Clinical Divisional Lead
Legal Team
Patient Experience Team

Pool of 25 NCAS trained clinicians with 0.25PA job planned time

SI SCOPING MEETING

SI SIGN OFF MEETING

PATIENT SAFETY QUALITY GROUP

QUALITY COMMITTEE

Level of response
Ensures Duty of Candour
Outlines ToR
Immediate actions
- Rapid review
- Safety Summit
- If relevant notify Med School or Deanery
- Professional bodies
- Notifications int and ext
- Support

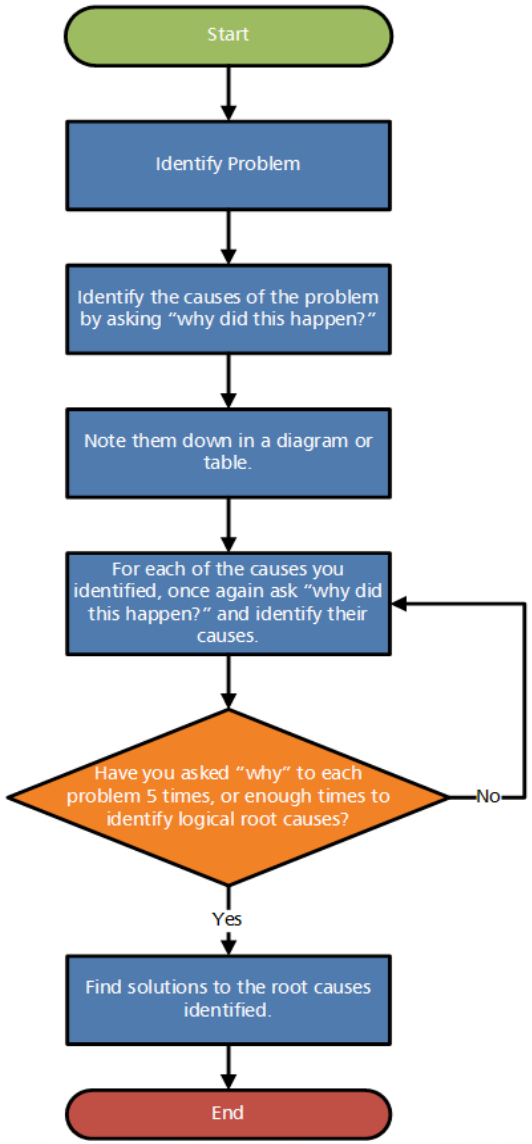
Track
- DoC compliance
- 60 Day completion time
- CCG sign off and closure
- Completion of actions

Reports to PSQG and QC
Learning
- iCare/Learning Matters
- Divisional Govenance Mtgs
- Divisional Saefty Mtgs
- Grand Rounds

THINGS TO CONSIDER …

- How do you track incidents reported after discharge
- How do you track and investigate incidents where the service user transfers to another provider in the same episode of care
- How do you track and investigate incidents where the service user has been discharged and admitted to a different provider in a separate episode of care

5-why Process Flowchart



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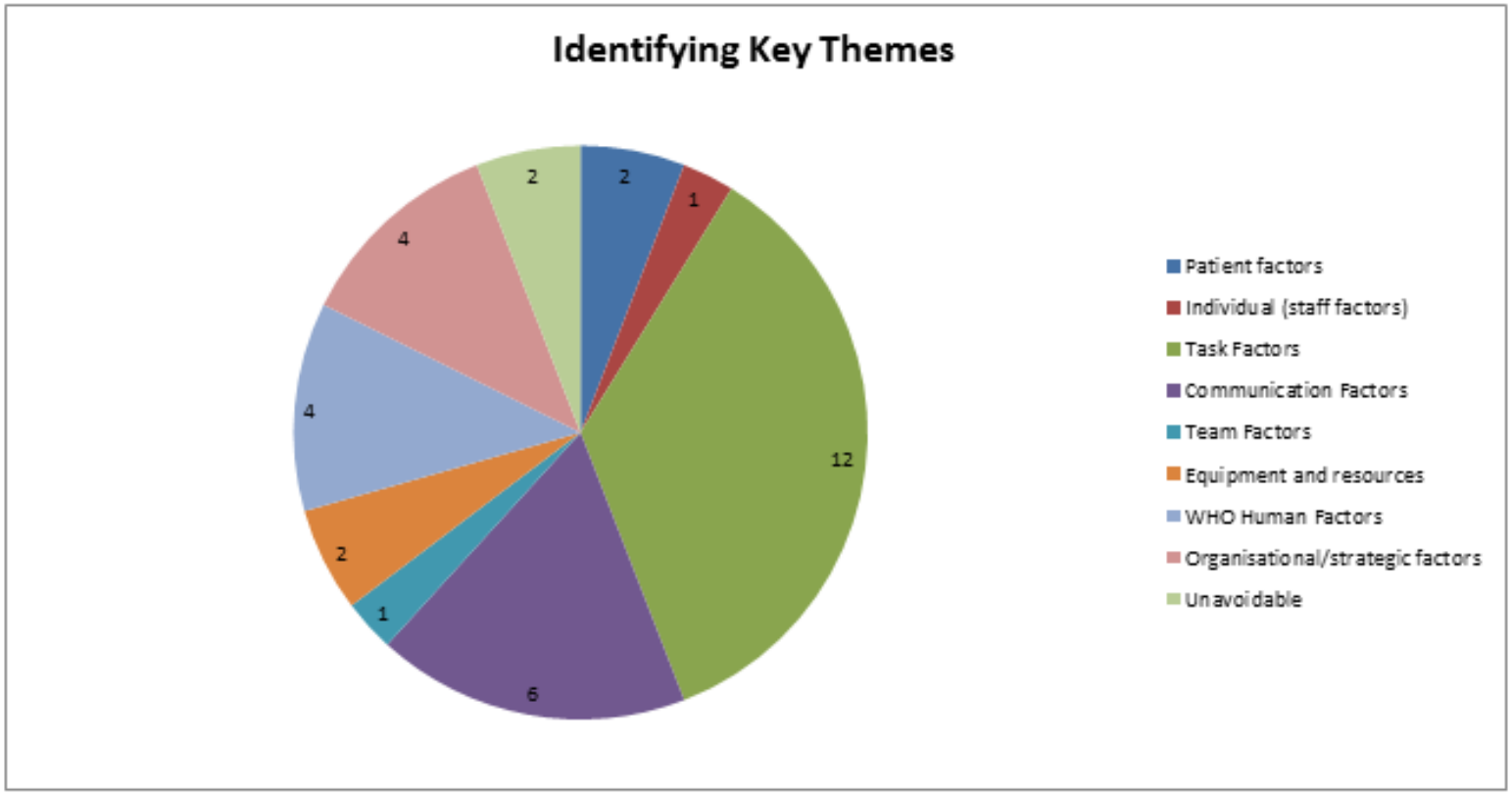
ROOT CAUSE ANALYSIS

V

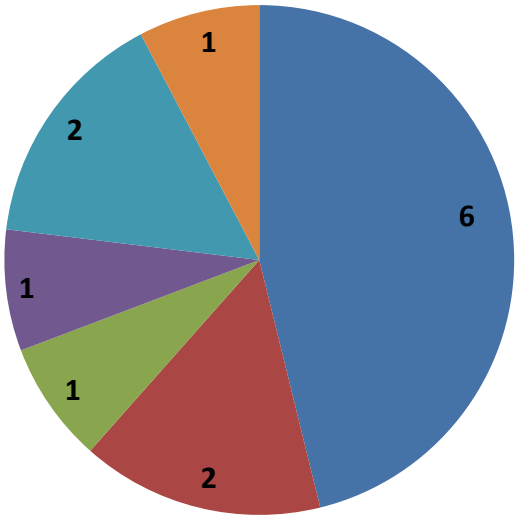
EMERGING THEMES

Key Themes Identified

From the 14 reports, 34 root causes were identified. Factors were themed using the National Patient Safety Agency Contributory Factor Classification Framework to enable those most frequently occurring to be identified which will enable any intervention to be targeted. The top two themes **Task Factors** and **Communication Factors**, accounted for 53% (18) of the total root causes as detailed in the chart below.

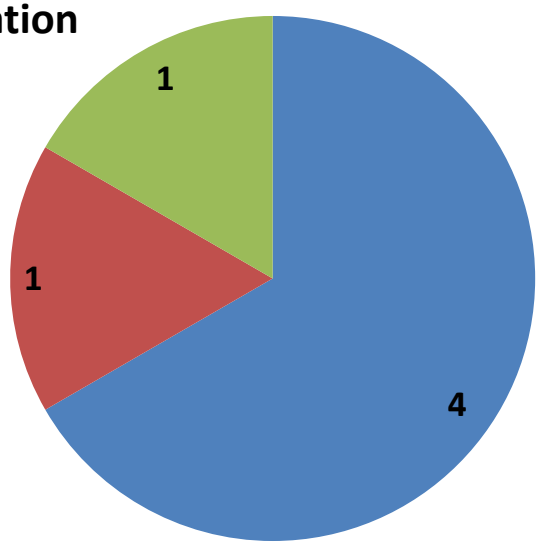


Failure related to Task Factors



- Task description not sufficiently defined
- Design of task creates opportunity for errors
- Poor planning of workload
- Failure to appropriately assess patient need
- Failure to appropriately plan patient care

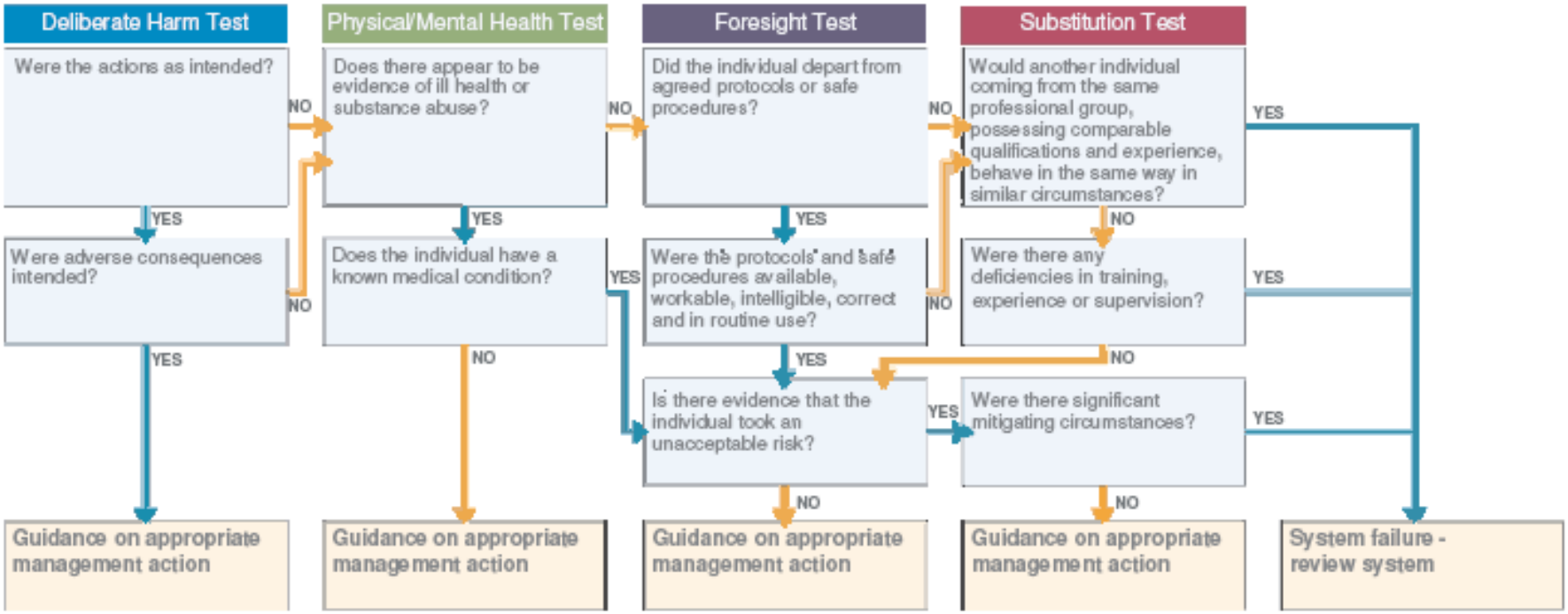
Communication



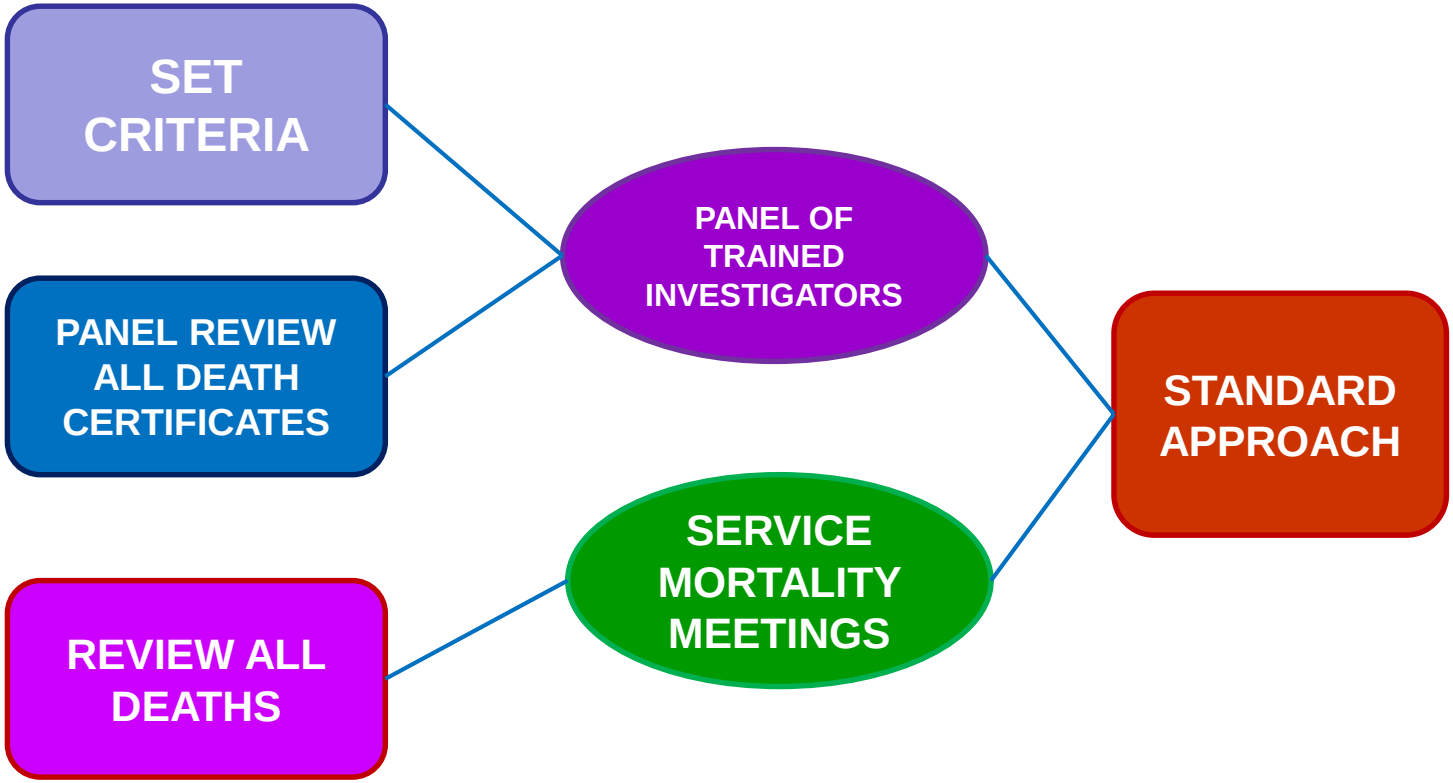
- Written communication
- Verbal communication
- Poor communication between staff

Incident Decision Tree

National Patient Safety Agency



Based on James Reason's Culpability Model.


SET CRITERIA
PANEL REVIEW ALL DEATH CERTIFICATES
REVIEW ALL DEATHS
PANEL OF TRAINED INVESTIGATORS
SERVICE MORTALITY MEETINGS
STANDARD APPROACH


MDT MORTALITY REVIEW MEETINGS
MORTALITY SURVEILLANCE MEETING
PATIENT SAFETY QUALITY GROUP
QUALITY COMMITTEE

MORTALITY REVIEW TOOL

- **Aim to get 100% of deaths on Bereavement Centre database reviewed**

Structured Judgement Review

- **Use agreed criteria and standard template**
- **Enters on to MRT**

AVOIDABILITY ASSESSMENT

- **Standardised**
- **All discussed at MSG**

QUALITY ASSURANCE

STRUCTURED JUDGEMENT REVIEW

- Any death reviewed by Mortality Meetings where care was suboptimal
- All Learning Disability deaths
- All Sepsis related deaths
- All deaths subject to Coroners inquest
- All deaths involved in a Serious Incident
- All stillbirths and neonatal deaths
- All deaths subject to a complaint

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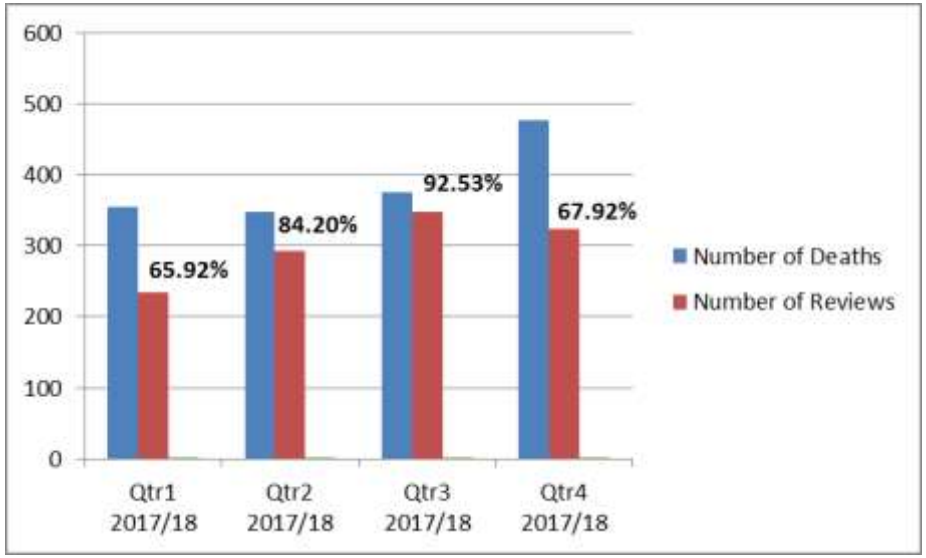
Learning from Deaths Dashboard Quarter 4 2017/18

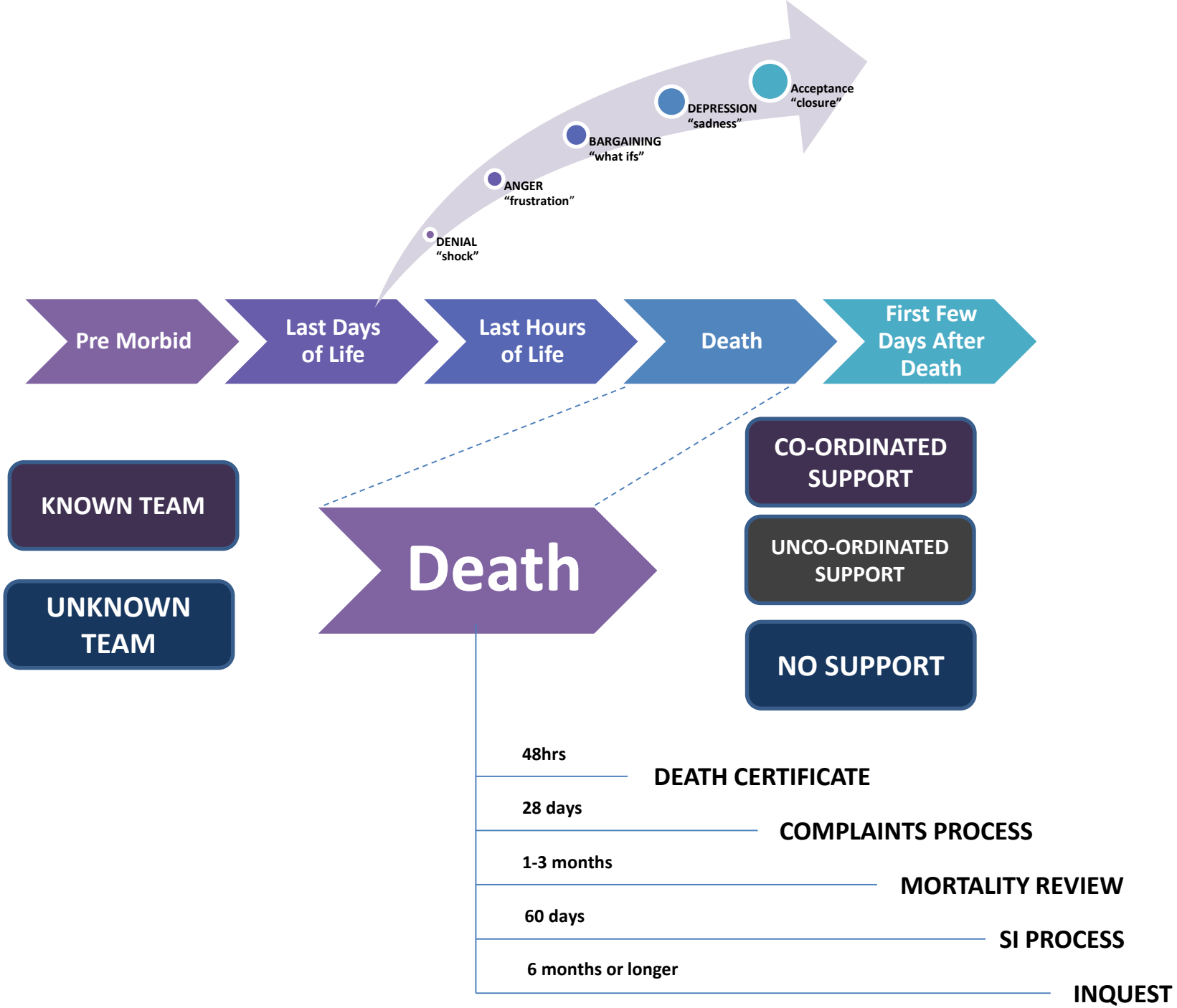
Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Qtr 1	355	234	65.92%	9
Qtr 2	348	293	84.20%	5
Qtr 3	375	347	92.53%	5
Jan-18	188	159	84.57%	0
Feb-18	134	105	78.36%	1
Mar-18	155	60	38.71%	1
Qtr 4	477	324	67.92%	2
Year 17/18	1555	1198	77.04%	21

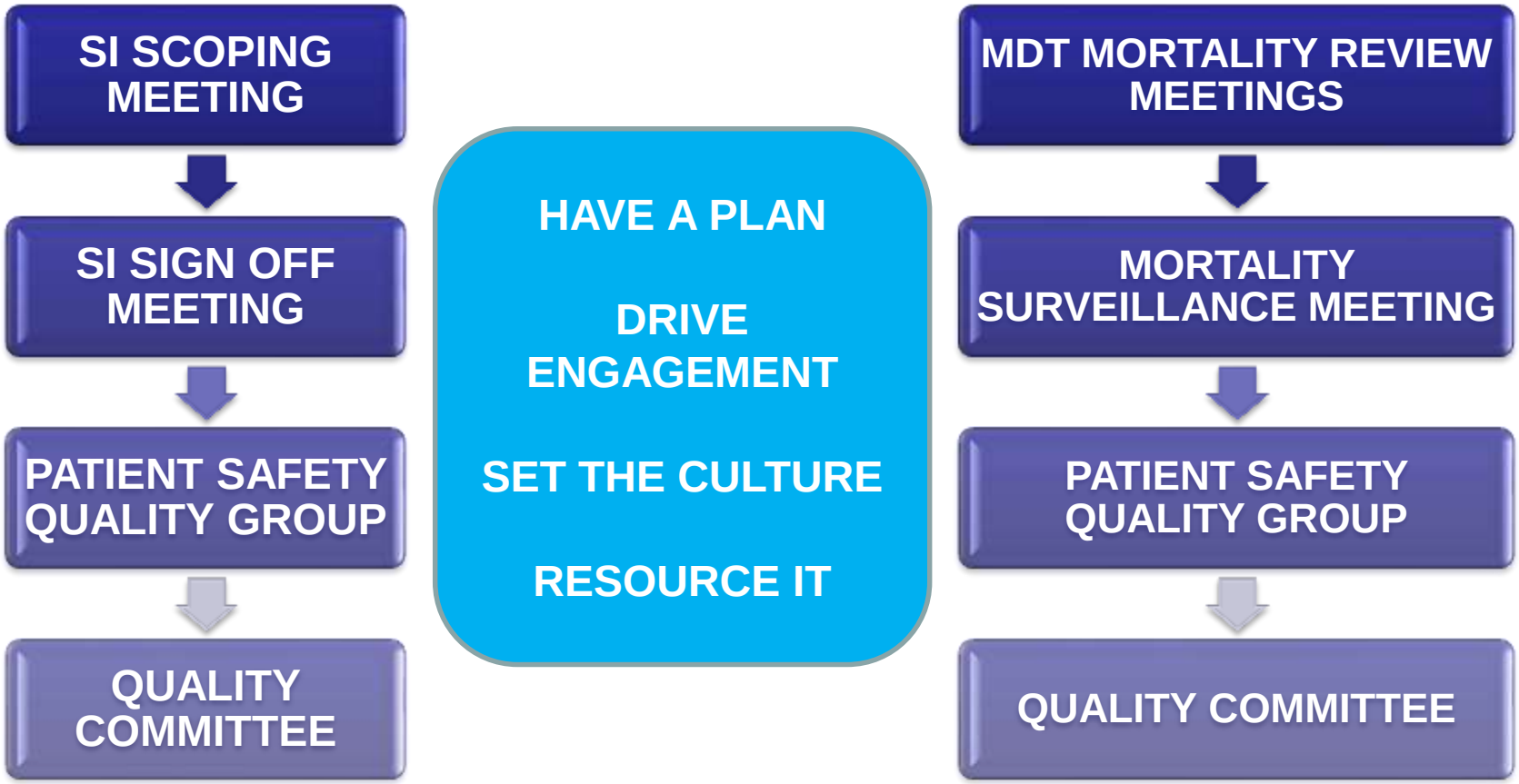
Deaths in groups under special focus Qtr4

Group	Total
Learning Disability / Mental Health Patients	2
Deaths accepted by the coroner	70
Coroner's Inquest	7
STEIS SI	3
Internal Investigations	6



General Learning/Themes identified	
Ceilings of Care	Ceilings of Care and early discussions with the patient and family about what to expect and how best to manage the last few weeks and/or days of life – this issue will be addressed through the implementation of the ResPECT Tool.
Responding to the Deteriorating Patient	There appears to be some disparity in understanding of appropriate escalation when a patient deteriorates. This has been compounded following the implementation of NerveCentre. A review of the Observation and Escalation Policy has been undertaken and additional training put in place. Monitored through the Deteeriorating Patient Group


DENIAL
"shock"
ANGER
"frustration"
BARGAINING
"what ifs"
DEPRESSION
"sadness"
Acceptance
"closure"
Pre Morbid
Last Days of Life
Last Hours of Life
Death
First Few Days After Death
KNOWN TEAM
UNKNOWN TEAM
Death
CO-ORDINATED SUPPORT
UNCO-ORDINATED SUPPORT
NO SUPPORT
48hrs
DEATH CERTIFICATE
28 days
COMPLAINTS PROCESS
1-3 months
MORTALITY REVIEW
60 days
SI PROCESS
6 months or longer
INQUEST


SI SCOPING MEETING
SI SIGN OFF MEETING
PATIENT SAFETY QUALITY GROUP
QUALITY COMMITTEE
HAVE A PLAN
DRIVE ENGAGEMENT
SET THE CULTURE
RESOURCE IT
MDT MORTALITY REVIEW MEETINGS
MORTALITY SURVEILLANCE MEETING
PATIENT SAFETY QUALITY GROUP
QUALITY COMMITTEE

SHARING THE LEARNING (QUICKLY)

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THE GOVERNANCE STRUCTURES

COMMUNICATE AT EVERY OPPORTUNITY

- The Emergency department have a staff WhatsApp group to communicate changes rapidly
- Findings are presented to Grand Rounds, Learning Events and Risk Summits
- Emails are sent to reach large groups of staff
- Learning Matters and iCare bulletins are distributed by the communication team
- Key messages are relayed within comm cell, board rounds and safety huddles
- The reporter of an incident receives an Incident feedback email
- All wards and departments have Live Divisional / Specialty / location Datix Dashboards including lessons learned reports
- The Datix Manager is working with the Surgical division on a (pilot) daily incident huddle to review the previous days incidents, this Datix dashboard will also include a weekly safety message
- Patient Safety Programme; Kitchen Table meetings

BENEFITS

- We are about to implement a health economy wide End of Life pathway in our ICP
- We are implementing RESPECT across the wider health economy
- We were able to review all deaths in ED and EAU in a busy winter within 4 weeks and gain assurance about quality of care
- We have reviewed all LD deaths in 17-18 with SJR and LeDer. We need to improve care around aspiration, epilepsy and make care plans visible
- We identified issues with Death Cerification accuracy for AKI and Sepsis

BENEFITS

- The quarterly Divisional Patient Safety Summits start with a LfD case presentation
- We have a 3 way Provider Forum (both acute, community including mental health) to discuss LfD
- The Coroner has commented on the value of LfD in cases coming to inquest
- We have visibility of deaths from complaints, claims, incidents and coroners inquests

LEARNING FROM DEATHS

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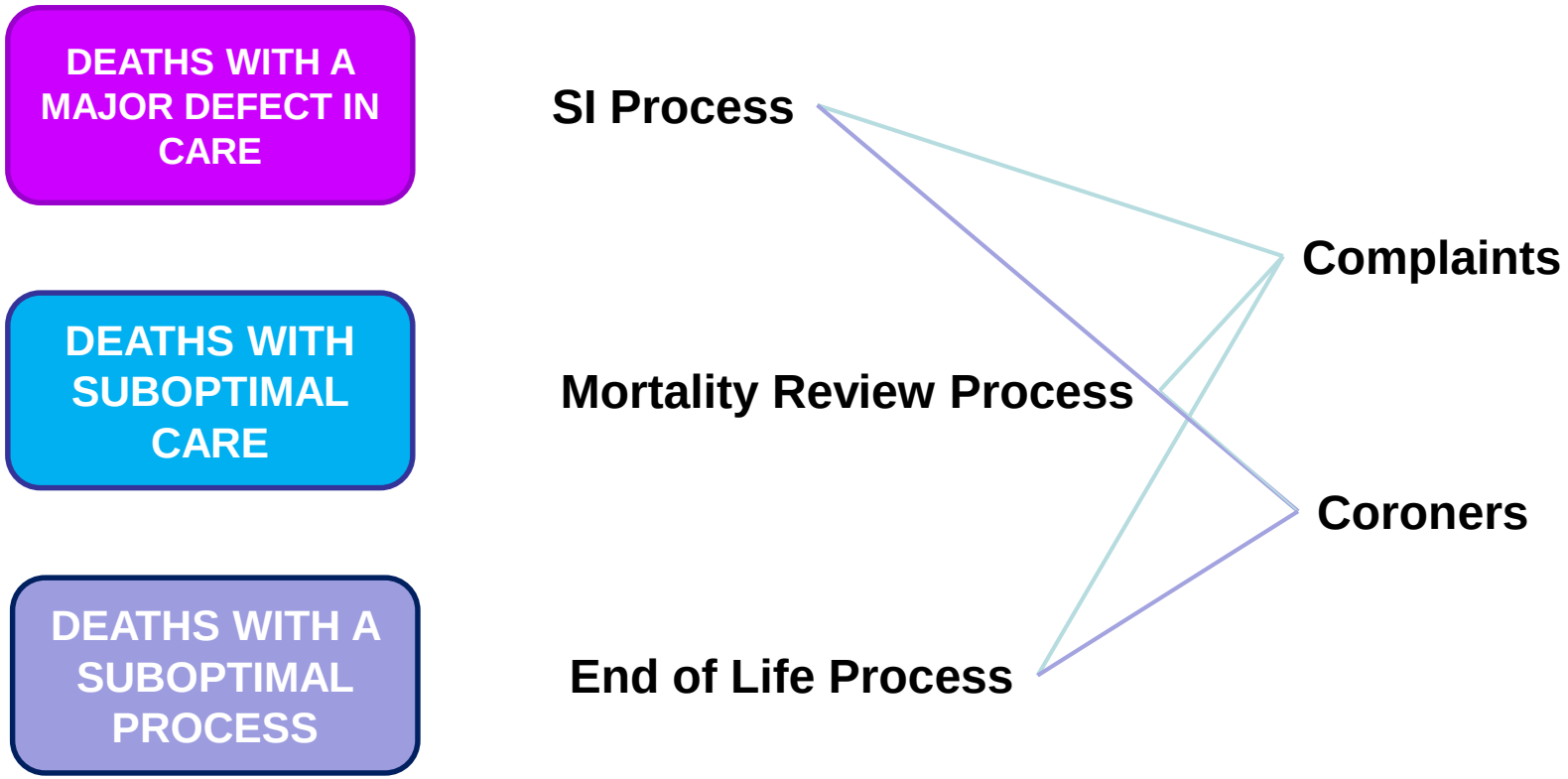
- **MORE**
  - Open, transparent
  - Seeking Learning
  - Multidisciplinary
  - Expected of team
  - Take learning quickly
  - System awareness
  - Focus on opportunity
  - Family needs
  - Learning from excellence
- **LESS**
  - Defensive
  - Closing down
  - Medically dominated
  - Ownership unclear
  - Prolonged timescale
  - Organisational focus
  - Focus on numbers
  - Healthcare needs

WHAT WE NEED TO DO BETTER

- **Family Involvement**
  - Agreeing ToR for SI investigations
  - Supporting the sharing of reports
- **Citizen Involvement**
  - Representation on PSQG and MSG
- Recognising, responding and supporting patients at the **last 12 months of life**
- Improving **Human Factors** and even more focus on learning

LEARNING FROM DEATHS HIERARCHY



Quotes from docs

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THE SHERWOOD JOURNEY

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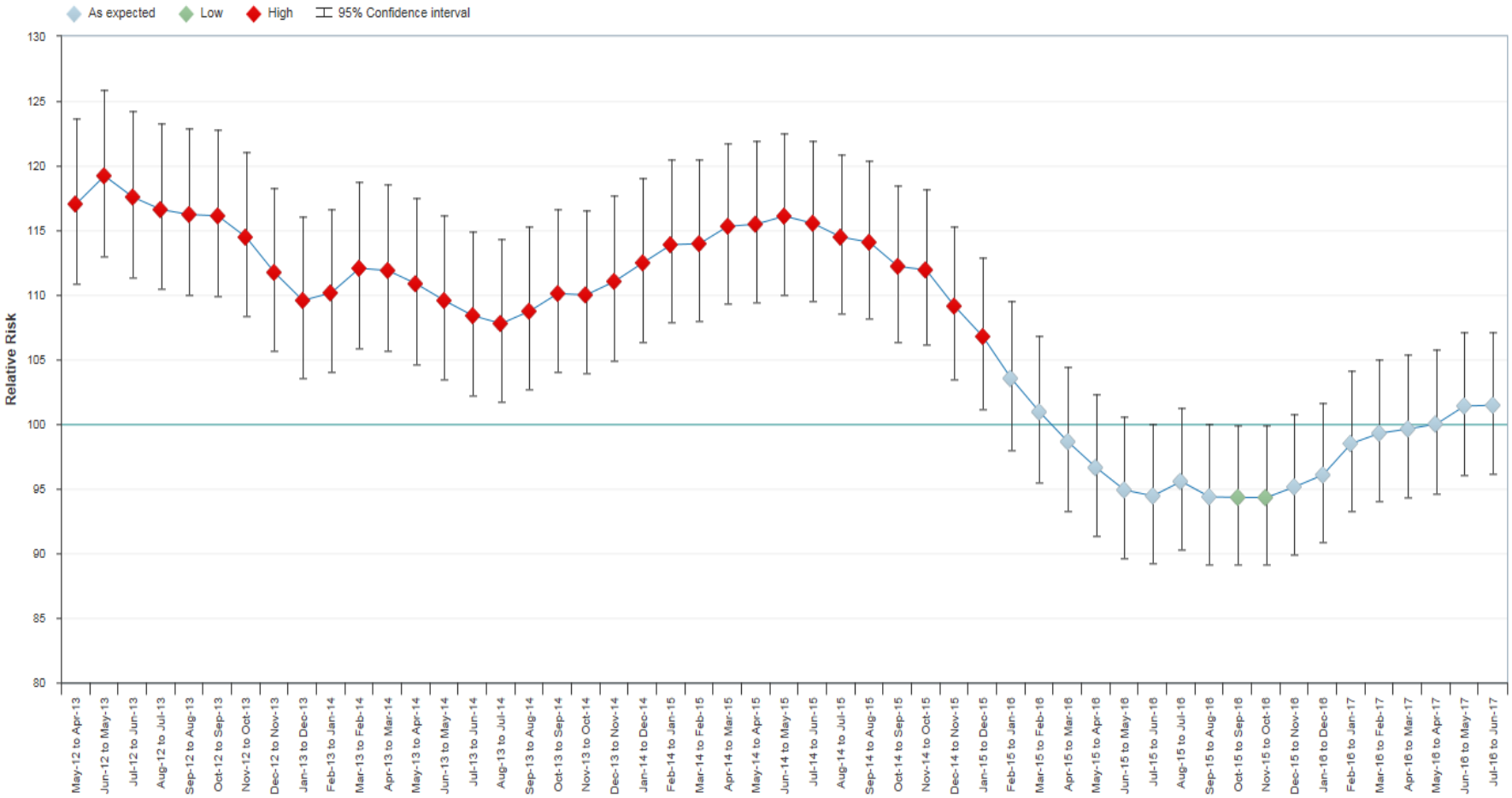
Diagnoses - HSMR | Mortality (in-hospital) | Apr-13 to Jun-17 | Trend (rolling 12 months)

Period Rolling 12 months



Drivers for Change & Improvement

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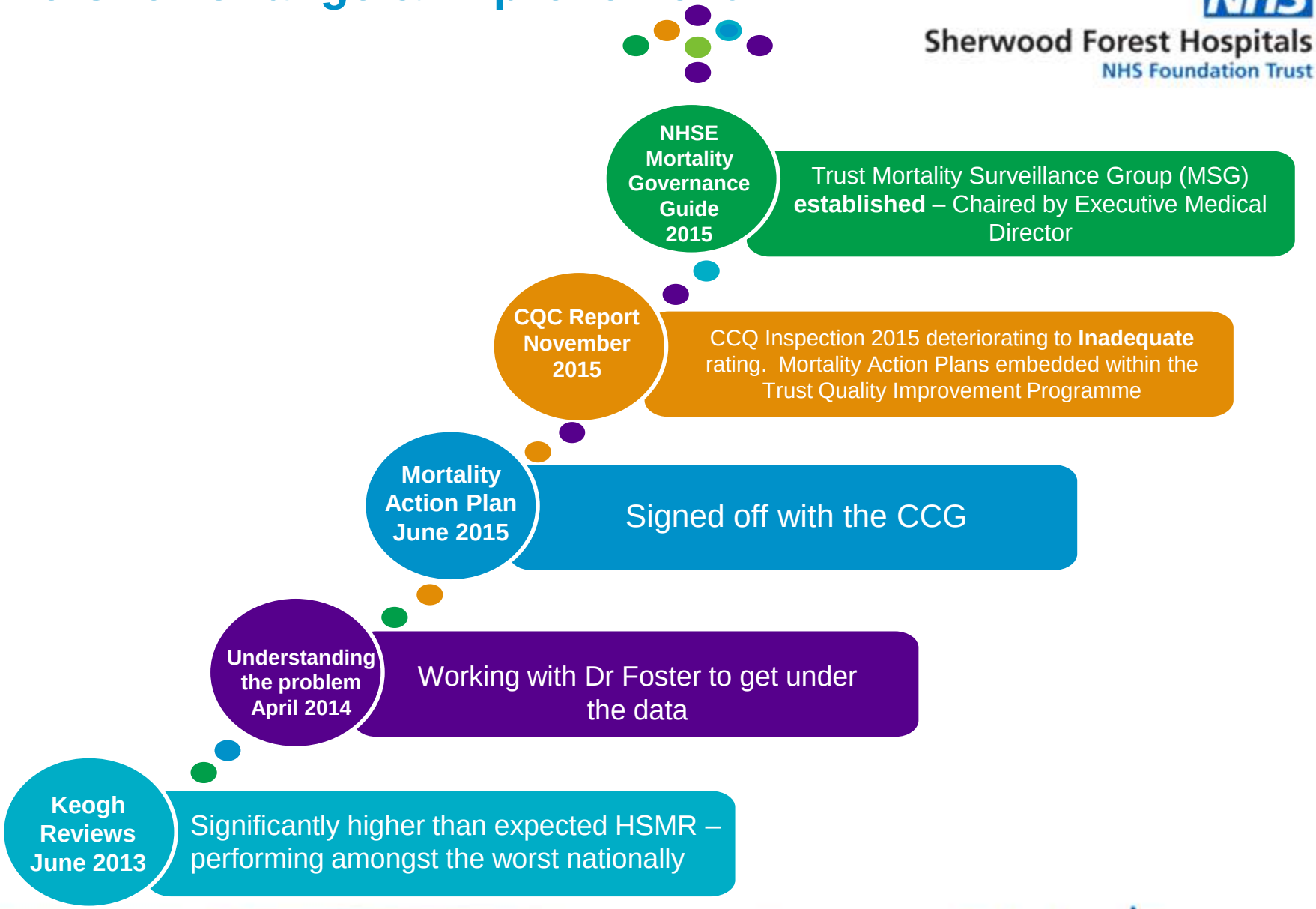

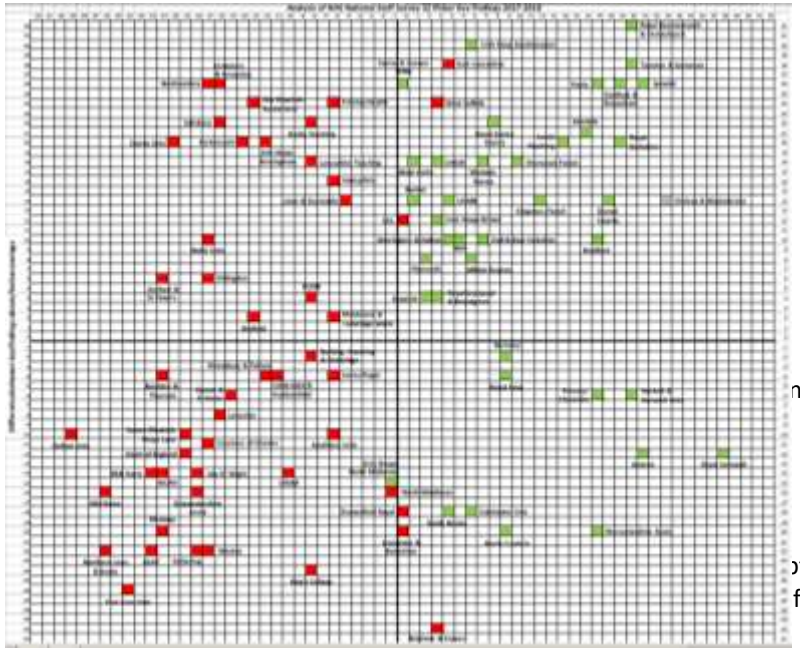

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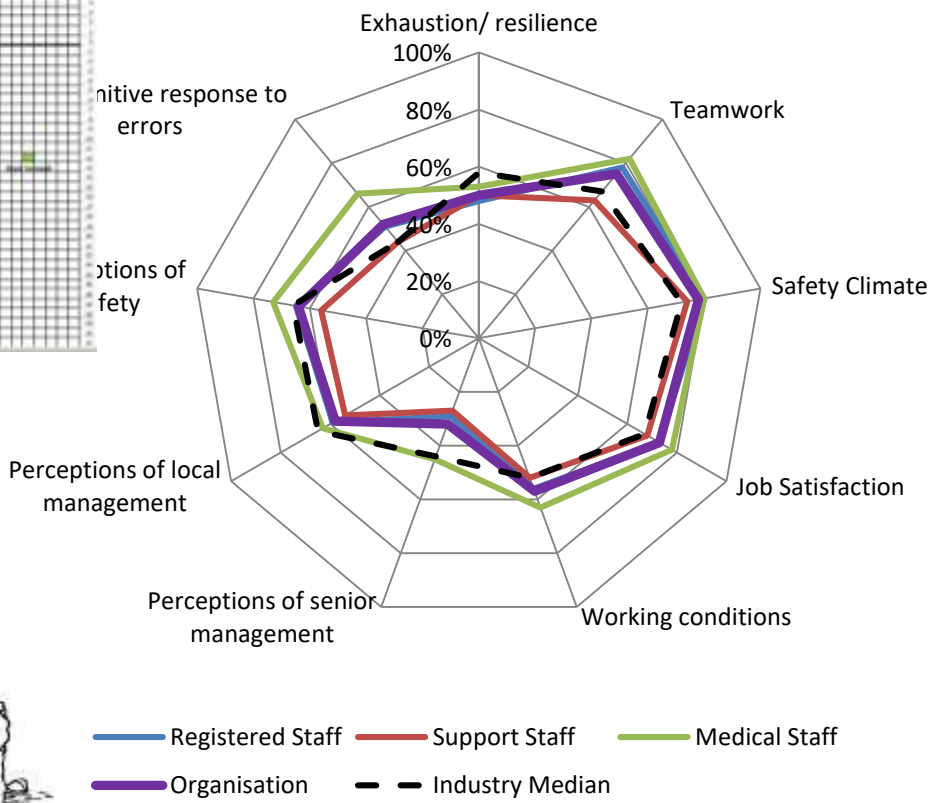
Domains by Staff Group - KMH



ABSTRACT

A minority of incidents in healthcare are driven by true negligence. The majority are failures of individual accountability, responsibility or the systems these operate within. Serious Incident investigation and Learning from Deaths represent a significant opportunity for organisations to create an open culture which engages staff to identify and mitigate risks to patient safety within “business as usual” practice. Involving patients, families and citizens offers the public assurance and provides “expert testimony”. Sherwood Forest Hospitals Trust is on this journey and whilst there is still much to do, in sharing our experience I will highlight some of our learning