Agenda Item 8 v)

NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: 27 January 2016

Title and Author of Paper: Changes to the Serious Incident Process following publication of the Serious Incident Framework

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Paper for Debate, Decision or Information: Information

Key Points to Note:

- The Serious Incident Framework was published in March 2015.
- The fundamental principles of patient safety investigations remain unchanged.
- NTW have addressed recommendations/guidance in practice.
- Incident policy currently under review to catch up with practice.

Outcome required: Noted for information

Changes to the Serious Incident Process following publication of the Serious Incident Framework (Supporting learning to prevent recurrence)

Following publication of the above framework in March 2015 NTW has made changes to the process of reviewing serious incidents; this is now happening in practice and will be formally identified in the policy rewrite.

Serious incidents in health care are events 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 our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again.

The fundamental purpose of patient safety investigation is to learn from incidents and not to apportion blame.

While the fundamental principles of serious incident management remain unchanged, a number of amendments have been made in order to:

- emphasise the key principles of serious incident management;
- more explicitly define the roles and responsibilities of those involved in the management of serious incidents;
- highlight the importance of working in an open, honest and transparent way where patients, victims and their families are put at the centre of the process;
- promote the principles of investigation best practice across the system; and
- focus attention on the identification and implementation of improvements that will prevent recurrence of serious incidents, rather than simply the completion of a set of tasks.

Serious Incidents in the NHS include:

- Unexpected or avoidable death, this includes suicide/self-inflicted death (caused or contributed to by a weakness in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patients illness or underlying condition where this is managed in accordance with best practice.
- Homicide by a person in receipt of mental health care this includes those in receipt of care within the last 6 months (this is a guide and each case should be considered individually).
- Unexpected or avoidable injury that has resulted in serious harm.

- A Never Event.

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

Risk Management and prioritisation

Managing, investigating and learning from serious incidents in healthcare requires a considerable amount of time and resource. Care must be taken to ensure there is an appropriate balance between the resources applied to the reporting and investigation of individual incidents and the resources applied to implementing and embedding learning to prevent recurrence. The former is of little use if the latter is not given sufficient time and attention.

Prioritising

Organisations should have processes in place to identify incidents that indicate the most significant opportunities for learning and prevention of future harm. This is not achieved by having prescribed lists of incidents that count as a serious incident.

Therefore NTW has agreed with Commissioners and following the national guidance to look at varying levels of investigation for serious incidents. This is done on a weekly basis at the Group Business Meeting in discussion with the Executive Director of Nursing and Operations, Executive Medical Director and Group Directors.

The formal Serious Incident process, STEIS reporting and allocation of a dedicated / commissioned Investigating Officer and report presented at panel continues to be followed for every death of a patient in receipt of secondary mental health services, where the underlying cause is other than natural cause as determined by the Coroner or cause of death remains unascertained following post mortem. If cause of death is returned as natural and the SI investigation has been commenced the decision to deescalate the investigation of the care and treatment is taken to Group Business to discuss.

Deaths of patients that are open to Addiction services only are investigated with a local After Action Review and the resultant report and action plan are reviewed by the Head of Clinical Risk and Investigations and the Group Directors for that service.

All other incidents that may / potentially fit the SI criteria are discussed at Group Business and a level of investigation agreed.

All incidents that are investigated are done so with the caveat of escalating into a formal process if concerns / issues are raised that require a more in depth investigation and require reporting to Commissioners.

Learning from incidents

All serious incidents regardless of level of investigation follow the same process for learning within the Trust. These processes are as referenced in the Board Safety Report for October to December 2015.