Board of Directors

28 November 2019

Paper title:	Proposal for Non-executive Director involvement with Serious Incidents	**Agenda item** **20**
Presented by:	Phillipa Hubbard, Director of Nursing, Professions and Care Standards	
Prepared by:	Louise Hussain, Serious Incident Lead	

Purpose of the report		
To outline a proposal of the level of Non-Executive Directors involvement in serious incidents and a framework to support this.	For approval	**X**
	For discussion	
	For information	

Executive summary

In October 2019 a Rapid Process Improvement Week (RPIW) was held to review consider the Serious Incident process, with a specific focus on improving timescales. As part of this the RPIW considered the role of the Non-Executive Directors (NEDs) within the Serious Incident process.

NEDs have been involved in Serious Incident investigations of in-patient deaths. This role was introduced approximately 9 years ago. The RPIW proposed that NED involvement is revised to help support improved timeframes but to enable NEDS to continue to have involvement in the oversight of Serious Incidents in order to provide the Board with the appropriate level of assurance as to the robustness of this process.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes, please set out what action has been taken to address this in your paper
	No	

Recommendation

The Board of Directors is asked to:

- Consider and approve the revised process identified in Section 3.

Strategic vision Please mark those that apply with an **X**				
Providing excellent quality services and seamless access	**Creating the best place to work**	**Supporting people to live to their fullest potential**	**Financial sustainability growth and innovation**	**Governance and well-led**
				X

Care Quality Commission domains Please mark those that apply with an **X**				
Safe	**Effective**	**Responsive**	**Caring**	**Well Led**
X				**X**

Relationship to the Board Assurance Framework (BAF)	N/A
Links to the Corporate Risk Register (CRR)	The work contained with this report links to the following corporate risk(s) as identified in the CRR: • 2614
Compliance and regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Regulation 12: Safe Care and Treatment • Regulation 17: Good Governance

Meeting of the **Board of Directors**

28 November 2019

Proposal for Non-executive Director involvement with Serious Incidents

1 Purpose

The Trust has a process for investigating Serious Incidents which is delivered by the Serious Incident Team. Over the last 5 years the volume of work undertaken by the team has significantly increased with additional responsibilities linked to participation in the Mortality and Duty of Candour group which are outside of the Serious Incident framework, alongside a rising number of increasingly complex Serious Incident investigations.

These issues have impacted on the Trust's ability to meet NHS England's timescales for Serious Incident investigations introduced in 2015 of 60 working days (12 weeks) for the completion of all Serious Incident investigations. Meeting Serious Incident timescales was a *Must Do* in the Care Quality Commission's (CQC) 2018 and 2019 report. To support the team in meeting timescales an administrator was appointed with additional investigators being identified through the Staff Bank.

In line with NHSE's Serious Incident Framework, the Serious Incident Investigation Team is accountable to the Director of Nursing, Professions & Care Standards. Whilst the framework does not require NED involvement, this was a local procedure introduced for Level 2 investigations for in-patient deaths. Level 2 investigations are described by the Serious Incident Framework as comprehensive internal investigations which require a review by a multi-disciplinary team involving experts.

As stated previously, investigations into in-patient deaths at the trust over the past few years have involved NEDs. Participation has varied and has included NEDs reviewing reports, meeting families to hear their concerns and feed back findings, interviewing staff and meeting with the investigation team.

The 2019 CQC inspection highlighted that the Trust had not yet put in place effective systems to ensure serious incidents were reviewed and thoroughly investigated within appropriate timescales. it was therefore agreed that the Serious Incident process would be considered in a Rapid Process Improvement Week.

2 Proposed Outcome

As part of the RPIW, the team considered how best to support NED involvement in Serious Incident reviews, whilst allowing processes and timelines to be streamlined. It was recognised that the Trust Board is required to have oversight of Serious Incidents, investigation processes and learning from incidents, but that it is not a statutory requirement for NEDs to be part of the investigation team. Given this, part of the outcome of the RPIW was a proposal that NEDs are no longer involved in the operational aspects of the investigation process but retain oversight of all investigations with the option of increased scrutiny of Level 2 Investigations.

3 Options

For Serious Incident investigations to progress in a timely way, with a focus on patient safety, the following is proposed:

- When a Level 2 Community Serious Incident occurs the Serious Incident Investigation team will follow the routine notification and investigation process. The Executive Directors will be informed within 1 working day of the incident, and the Trust Board will be informed by the Director of Nursing, Professions & Care Standards at the next Board meeting.
- When a Level 2 In-patient Serious Incident occurs, the Executive Directors will be informed within 1 working day of the incident. The Director of Nursing, Professions & Care Standards will inform the Non-Executive Directors within 2 working days of the incident, providing a copy of the initial review form.
- The Chair of the Trust Board will appoint a NED to undertake a review of the final draft of the report ahead of it being finalised to gain assurance that the Serious Incident Framework has been applied (Appendix A). The NED will liaise with the Serious Incident Team if they require any further information/assurance on the investigation or the process.
- At every private Board meeting, the Director of Nursing, Professions & Care Standards will:
  - Provide an update on the current number of open Serious Incidents;
  - Inform the Board of any investigations where there are delays resulting in the framework timeframe not being met; and
  - Present any completed Patient Safety Reports for assurance that actions in response to an incident are timely and result in improvements. This report will include detail on how the learning has been shared effectively to make improvements.

There is an established Serious Incident review panel which meets weekly. This is attended by the Director of Nursing, Professions & Care Standards, the Medical Director, the Chief Operating Officer and the Serious Incident lead. This meeting will continue to support the Serious Incident process by reviewing completed Serious Incident reports. This panel will also receive updates on all Serious Incidents, progress on statements and coroner's feedback / upcoming coroner's dates to ensure that timescales are met.

In addition to the above process, it is also proposed that a Serious Incident Review panel is established. The panel will meet bi-annually and will undertake a review of a sample of completed Serious Incident investigations. The membership will include the Serious Incident Team, the Director of Nursing, Professions & Care Standards and a NED on a rotational basis. It also suggested that the membership included a member of the Clinical Commissioning Group. The aim of the review will be to gain assurance that the Serious Incident process is well managed, that it follows the 7 key principles of the framework and drives improvement. The NED will be responsible for reporting to Trust Board the outcomes of the panel meetings.

4 Risk and Implications

The revised involvement process provides clarity on the role of the NED in the Serious Incident process. Whilst the proposal reduces NED involvement in the operational aspects of the investigation process in order to support timely investigations, it supports continued Board oversight of Serious Incidents and provides the opportunity to review and comment on Level 2 In-patient investigation reports.

5 Results

If the above steps are approved the process will take effect immediately with the first review panel planned for January 2020.

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Date paper written: 18 November 2019

Appendix A

1. Seven Key Principles

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

Figure 1: Principles of Serious Incident Management

Serious Incident Framework 2015