Meeting of the Board of Directors - Public
8 July 2021

Paper title:	Independent Review of Serious Incidents	Agenda item 16
Presented by:	Phillipa Hubbard, Director of Nursing, Professions and Care Standards	
Prepared by:	Beverley Fearnley, Deputy Director of Patient Safety, Compliance and Risk	

Purpose of the report		
The purpose of this report is to present the outcomes of the review into Serious Incidents commissioned in October 2020, and the management response to the recommendations made.	For approval	
	For discussion	X
	For information	

Executive summary		
In 2019 the Trust Board commissioned an independent review of suicides of patients within the Trust. As part of the learning that came out of that review the Board committed to an annual process of review. Due to delays relating to management of the COVID pandemic, the second in this series of reviews (covering the period 2019/20) was not commissioned until October 2020, and, as a result of further delays, was not completed until April 2021, when the Trust Board received the report in draft. This report considered all 29 serious incidents from the period, not just suicides. The findings and recommendations of the report are split into two sections – 1. Findings relating to the quality of the investigations and 2. Findings relating to the trends and themes identified within the report The Trust has agreed a response to each of the recommendations and the implementation of these will be overseen by the Patient Safety and Learning Group.		
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' No	If yes please set out what action has been taken to address this in your paper

Recommendation
The Board of Directors is asked to: • Note the recommendations of the Independent Review of Serious Incidents; • Note the management response to the recommendations made; and • Take assurance from the oversight arrangements described.

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				X

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

Relationship to the Board Assurance Framework (BAF)	The work contained with this report links to the following strategic risk(s) as identified in the BAF: • SO3
Links to the Supporting Operational Risk Register	The work contained with this report links to the following risk(s) as identified in the Supporting Operational Risk Register: • 2417
Compliance and regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • n/a

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Independent Review of Serious Incidents

1 Purpose

The purpose of this report is to present the outcomes of the review into Serious Incidents commissioned in October 2020, and the management response to the recommendations made.

2 Background

In 2019 the Trust Board commissioned an independent review of suicides of patients within the Trust. As part of the learning that came out of that review the Board committed to an annual process of review. Due to delays relating to management of the COVID pandemic, the second in this series of reviews (covering the period 2019/20) was not commissioned until October 2020, and, as a result of further delays, was not completed until April 2021, when the Trust Board received the report in draft. This report considered all 29 serious incidents from the period, not just suicides.

Due to the delay in commissioning and receiving this report the recommendations have only recently been finalised, and plans agreed to respond to them, and it is these that are described within this report.

3 Findings of the report

The findings and recommendations of the report are split into two sections –

1. Findings relating to the quality of the investigations and
2. Findings relating to the trends and themes identified within the report

It is noted that due to the delay in commissioning the report, the Trust had already taken actions which in full or part address many of the recommendations of this report.

3.1 Quality of serious incident investigations

Finding	Recommendation		Management Response
A failure to identify the patient's ethnicity	In future SI reports to ensure details of a patient's ethnicity is contained within the report.		The initial Review template contains a field for Ethnicity. This will be followed up (where known) and report writers reminded to include in the final report.
Within the respective SI reports, on a number of occasions a failure to fully set out in the Executive Summary a sufficient account of events.	The Trust should ensure that investigators have the knowledge and skills to address the gaps and quality identified in this report and are supported to implement them. In this regard, the Trust may consider a refresher workshop for investigators, reflecting this review, would be appropriate.	To review the process for review and sign-off of reports.	Actions underway: SI team development plan agreed an in place - measures for success include: 1. Reviews/investigations will be collaborative and support involvement of staff and service users/families 2. Lead investigators will have access to identified subject matter expertise 3. Investigations will demonstrate a systems based approach to patient safety improvement 4. The style of reports will reflect the language of human factors principles, demonstrate human factors analysis 5. The services and frontline individuals involved in investigations will feel supported by a compassionate and just approach 6. Service users/families where appropriate will feel supported by, and involved with the SI process (with advocacy access) 7. Findings and recommendations are drawn and flow from the evidence and analysis, are supported by facts and are sufficient to address the underlying circumstances that led to the event 8. Reports are written succinctly and in plain English Action Owners: Head of Patient Safety, Compliance and Risk Timescale: Training and standards to be in place by December 2021 Actions Outstanding
Failures on occasions by Investigators who have identified issues to explore with the staff why those care and service delivery problems arose.			
A failure within SI reports to fully set out where conclusions are reached that failures are not causative or contributory to the death the reasons for arriving at those conclusions.			

			Implement additional quality assurance processes using an MDT approach to review SI reports Action Owner: Head of Patient Safety, Compliance and Risk and SI manager Timescale: July 2021

3.2 Trends and themes identified within the investigations

Finding	Recommendation	Management Response
Failures by staff to properly record clinical information in patients' records.	The Trust should assure itself that expectations around record keeping are clearly set out and shared with staff and that robust processes are in place to oversee actively the quality of record keeping. As part of this recommendation, the Trust should consider whether a review the training programme in respect of staff record keeping is required.	Work on this is already underway in a number of workstreams; namely: 1. Work has been undertaken to improve the quality of case management supervision in CMHTs – this is being overseen by the MH Care Group QuOps 2. Following an RPIW in October 2020, there has been a focused piece of work standardizing the care plan and risk assessment templates on S1 and in training staff how to use these. These templates have now gone live and their use will be audited through the MH Care Group QuOps – the first report (30 day report out) on this goes to QuOps this week, with a further report out at 60 and 90 days post launch. 3. revised record keeping guidance was issued in summer of 2019 which is underpinned by local induction, local policies, procedures and SOPs relating to specific elements of record keeping. Actions outstanding: Action 1: PSLG to commission a review of caseload management across the trust to ensure that it a. Is based on a common set of standards and guidance b. That there is a clear process for caseload management that will ensure these (and other) issues are identified and responded to robustly as part of this process c. That there is a process for auditing caseload management against those standards as part of local audit supported by quality and safety visit assurance Action Owner: PSLG will delegate to named leads to review, revised and implement any revised standards / templates or guidance and develop audit mechanisms

Finding	Recommendation	Management Response
		Timescale: This programme of work will be commissioned in the July PSLG and will report back every 2 months. Development of any new processes / guidance and their roll out to be completed within 6 months (so by January 2022 if not sooner) which will include a plan for routine audit.
Failures by staff at appropriate times to update and review patients' care plans and risk assessments.	To address issues regarding a failure to update and review patients' care plans and risks assessments, the Trust should consider whether those staff tasked with the responsibility for those documents are afforded some protected time for the purpose of completing those	Actions underway 1. Following an RPIW in October 2020, to understand the issues with care planning / risk assessment there has been a focused piece of work standardizing the care plan and risk assessment templates on S1 and in training staff how to use these. These templates have now gone live and their use will be audited through the MH Care Group QuOps – the first report (30 day report out) has been received by QuOps, with a further report out at 60 and 90 days post launch.
Failures by staff to properly record and continue to update within patient records contact details for the patient and their family. It is not clear whether that could or should be extended to any close friends or acquaintances of a patient.	The Trust should assure itself that each service has in place robust standards and processes for checking and updating patient contact details and those of their family and that these are clearly communicated to staff and compliance is audited.	Actions outstanding PSLG to commission a review of each service's SOP relating to updating contact details to ensure this is robust and clearly communicated with staff and that there is a process in place to audit compliance with local standards. Action Owner: PSLG will delegate to named leads to review, revise and implement any revised SOPs and develop audit mechanisms Timescale: This programme of work will be commissioned in the July PSLG and will report back every 2 months. Development of any new processes / guidance and their roll out to be completed within 6 months (so by January 2022 if not sooner) which will include a plan for routine audit.
Uncertainties regarding the knowledge and application of Trust policies when patients go missing / AWOL.	Reflecting that it is not clear from the findings of the SI reports if training in respect of the Trust's policies regarding patients going missing/AWOL is an issue, the Trust should ensure that the specific learning from the reports where the patient going missing late returns / AWOL'S	Actions outstanding: PLSG to commission the creation of a practical learning exercise / simulation to reinforce learning from AWOL incidents. This will be built into the training available for inpatient staff. Action Owner: PSLG will delegate to named leads to develop and implement the training

Finding	Recommendation	Management Response
	were not managed in line with standards is shared with staff using a practical simulation exercise where staff are presented with specific scenarios to reinforce their understanding of the Trust policies in this regard.	Timescale: This programme of work will be commissioned in the July PSLG and will report back every 2 months. Development of the training and its roll out to be completed within 6 months (so by January 2022 if not sooner).
Apparent inabilities by Trust supervisors / managers to identify these issues on audit / clinical supervision.	In respect of clinical supervision/ case load management, for the Trust to consider the development of a clinical supervision /case load management template.	Actions outstanding: PLSG to commission the creation of a practical learning exercise / simulation to reinforce learning from AWOL incidents. This will be built into the training available for inpatient staff. Action Owner: PSLG will delegate to named leads to develop and implement the training Timescale: This programme of work will be commissioned in the July PSLG and will report back every 2 months. Development of the training and its roll out to be completed within 6 months (so by January 2022 if not sooner).
Possible issues in terms of timescales for appointments following initial assessments. This conclusion should be treated with some caution given that the writer has not reviewed Trust policies across the various services involved to identify whether at the material times of the respective investigations what the timescales were and whether these were being complied with.	No formal recommendation made	
Reflecting some of the care and service delivery problems that have been highlighted, whether there are broader training issues for Trust staff.	Reflecting this conclusion / theme, the Trust should review the suite of role specific training and ensure that it covers the training staff should complete.	Actions outstanding: Heads of Professions to review the suite of role-specific training aligned to their professionals and ensure that there are no gaps / omissions relating to areas identified in these reports Action owner: Heads of Professions Timescale: Review to be completed by October 2021

Finding	Recommendation	Management Response
Arising from certain reports, possible issues with SystmOne in that assessments are not being downloaded properly and / or training issues for staff regarding ensuring that entries are saved and downloaded onto SystmOne.	The Trust should ensure that optimisation of SystmOne is recognised within all QI activity but staff have appropriate training and that the clinical systems group has a direct line of sight of staff concerns and issues which inform their programme of work.	Actions underway: All staff currently receive training on SystmOne as part of their role specific training. This is overseen through DLM and QuOps, as well as forming part of the data pack shared at Quality and Safety Committee and as part of the Board IPR. The Clinical Systems Group has representation from both Care Groups which informs their programme of work. SystmOne optimization is considered as a part of RPIWs and other improvement activity.
Issues on occasions regarding the availability of acute beds and the absence of acute beds within the Trust's Bed Estate.	No formal recommendation made	
Not aligned to a specific finding	The Trust should review all of the action plans that were agreed in response to the SI investigations and assure itself that the actions have been completed and the outcomes intended. As part of this, the Trust should review how local audits and assurance is conducted to ensure the outcome of investigations are followed up and overseen	Actions outstanding: 1. The Deputy Director for Patient Safety, Compliance and Risk will meet with the AGMs and service managers who are responsible for outstanding actions to review progress and evidence of impact. Action owner: Deputy Director for Patient Safety, Compliance and Risk Timescale: Meetings to be arranged before the end of June 2021 2. The Deputy Director for Patient Safety, Compliance and Risk and deputy Director of Nursing will work with the General Managers for both Care Groups to agree how outcomes of investigations are embedded within local quality improvement plans and the assurance around this. Action owner: Deputy Director of Patient Safety, Compliance and Risk Timescale: process to be embedded by January 2022

4 Next steps

The actions described within this report will be overseen by the Patient Safety and Learning Group as part of this group's oversight of quality improvement plans across the Trust.

5 Recommendations

The Board of Directors is asked to:

- Note the recommendations of the Independent Review of Serious Incidents;
- Note the management response to the recommendations made; and
- Take assurance from the oversight arrangements described.

Beverley Fearnley, Deputy Director of Patient Safety, Compliance and Risk
15 June 2021