DAC BEACHCROFT

A new dawn for NHS incident investigations? Have your say by 12 June 2018

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Summary

With learning from incidents being seen as the key to safer care, the government, CQC and NHS Improvement are currently channelling a lot of energy into how the quality of patient safety investigations can be improved.

The latest development is a plan to revise the existing Serious Incident Framework by the end of this year.

In this briefing, we look at the changes being suggested and how you can have your say on what goes into the new framework.

Serious incident framework - Why change it?

The patient safety team at NHS Improvement (NHSI) is currently inviting views - via an online survey - on how the national Serious Incident Framework (issued in 2015) could be changed for the better.

To accompany the survey, NHSI has produced a discussion document - *The future of NHS patient safety investigation* - which focuses on 5 key factors contributing to poor investigations:

- *Defensive cultures/lack of trust* - especially in relation to patients/families and staff feeling shut out of the process and unsupported, leading to feelings of distrust and blame;
- *Inappropriately using the serious incident process* - e.g. as a performance measure or to satisfy a set procedure for particular types of incident, rather than just for the purposes of learning as it should be. NHSI also want to see a move away from investigations grappling with 'preventability' or 'predictability', which can detract from the goal of learning/improving;
- *Oversight/assurance process* - performance metrics used by commissioners tend to be process-related (e.g. numbers of SIs and compliance with time deadlines), rather than focusing on quality/learning;
- *Lack of time/expertise* - this is perhaps the issue felt most acutely in practice, with managers and clinicians often having to undertake investigations on top of their day jobs, with limited support behind them. Also, NHSI says, too much of the 60 day time period allocated for completing SIs can be spent getting investigations 'signed off' via internal committees at the expense of time spent doing a good investigation;
- *Not properly using evidence-based investigation methods (e.g. root cause analysis)* - One of the most common issues is focusing too much on the early phases of an investigation (e.g. deciding whether to investigate and fact-gathering) and not enough on why an incident happened or what solutions might genuinely work.

The real challenge is how to resolve these problems in the context of a system under pressure from all sides and with finite resources.

One of the keys to this, NHSI suggests, may be to address the 'investigation fatigue' which arises from having to investigate large numbers of similar incidents again and again (often with 'weak' actions repeatedly coming out of these around reminding, reviewing, rewriting), leaving little time or energy to focus on real solutions.

Quality over quantity, it is being suggested, may be the answer. Careful consideration will however need to be given to how this squares with the statutory Duty of Candour where incidents reach the requisite harm threshold to trigger that duty.

What solutions are being suggested?

NHSI has put forward a number of possible options/approaches in relation to each of the problem areas identified and is inviting those completing the online survey to rate the likely effectiveness of each of these from 'very effective' to

'completely ineffective', as they see fit.

Possible approaches you can 'rate' as part of the survey include:

- Stating that incidents do not always have to be investigated if an ongoing improvement programme is delivering measurable improvement/reduction of risk, plus option of providing decision-aids to help determine which incidents should be fully investigated - e.g. based on risk/potential for improvement. (Again, a possible sticking point here may be the need to ensure compliance with the Duty of Candour);

- Requiring each provider to have a flexible, trained team of investigators comprising staff with other roles but with protected time for investigation duties or - alternatively - requiring each provider to have a dedicated team of trained investigators with no other duties in the organisation. (In practice, the dilemma Trusts face is that a dedicated investigation team would presumably add to the wage bill, plus there could be issues sourcing staff with the relevant skills/experience, but this needs to be weighed against the pressures on the current system which often involves people with little experience having to do investigations in their 'spare time', meaning they may not get to the root of the problem);

- Removing the 60 day timeframe; or keeping the 60 day timeframe but requiring organisations to rationalise their internal approval processes to allow more time for investigation; or recommending a 60 day timeframe but not managing performance against it. (On this point, it seems to us that some form of timeframe would still be needed to avoid investigations drifting);

- Introducing a mandated investigation report template and assurance checklist to help standardise evidence-based practice. (Whilst there are templates in use currently, our experience is that these often produce a lot of repetition, and a re-worked, national template might therefore be the way forward).

NHSI is also asking for views on a refreshed set of principles to underpin the framework - i.e. incident investigations should be: strategic (e.g. boards focusing on quality of output/learning, not numbers), *preventative* (i.e. acting on identified causal factors), *people-focused* (i.e. patients/families/staff are active participants), *expertly led* (by trained investigators with support of an appropriately resourced investigation team) and *collaborative* (e.g. enabling information sharing/action across systems). These principles are designed to tie-in with those of the Healthcare Safety Investigation Branch, which will also have a central role in helping to spread good investigation practice.

We may even be looking at a new name for the Serious Incident Framework, with NHSI also seeking views on whether a change of name is needed to reflect a fresh approach to incident investigation.

What next?

The online survey will be open until **12 June 2018**.

NHSI will then review the responses and work on revising the Serious Incident Framework over the summer, with a view to a new version of the framework being published by the end of 2018.

How we can help

Our national team of healthcare regulatory lawyers has extensive experience of supporting and advising health and social care providers on a wide range of matters relating to incident investigations, including:

- Reviewing draft serious incident investigation reports/actions plans;
- Advice on independent investigations - e.g. input on scope and draft findings;
- Clinical governance scrutiny to assess the effectiveness of incident investigations, as well as board leadership and culture on learning;
- Advice on Duty of Candour requirements;
- Liaison with external bodies - e.g. CQC, commissioners, coroners;
- Training for serious incident investigators and Duty of Candour workshops;
- Representation and support in relation to further investigations which may be linked to serious incidents, including inquests and HSE or police investigations.

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