North East Hampshire and Farnham Clinical Commissioning Group
Surrey and Borders Partnership NHS Foundation Trust

Updated 24 June 2014

Review of Serious Incidents Requiring Investigation: Improvement Plan

Progress to be monitored monthly through Clinical Quality Review Group meeting

No	Recommendation	Actions Required	By Whom?	By When?	RAG Rating	Update/Outcome
A	SABP and NEHFCCG agree reporting arrangements for suicides for those 'in receipt' of service (to include a definition of "in receipt")	To review and develop proposal for reporting arrangements Present for agreement to CQRM	Director of Risk & Safety (SABP) Quality Manager (NEHF CCG)	01/12/2013 updated to September 2014		This has now been completed . There has been agreed process which was presented to the CQRM with a clear trajectory for investigation completion timescales. In receipt refers to all SI of people who were using mental health services at the time of their death . All other reporting arrangements are in line with the reporting framework for SI requiring investigation (work to make process robust underway)
B	SABP CRS to make links with Karen Lascelles, project lead Suicide Prevention Networking Project, in order to inform a National debate on STEIS criteria	Renew contact with Karen Lacelles.	Director of Risk & Safety (SABP)	01/11/2013. Updated May 2014		SABP has renewed Contact and expressed interest in being involved. Further contact from Karen Lacelles to take place. We have however attended the SI learning event and we are signed up to the standardising of reporting approach. Awaiting guidance
C	2013 Review of Incident Review policy to be undertaken in collaboration with key stakeholders	Identification of key stakeholders Coordination by SABP	Director of Risk & Safety (SABP)	01/01/2014 Updated June 2014		Policy currently in date and is undergoing review at present.
D	As a priority SABP to provide a strategy for staff development on Suicide and Risk Management	To undertake targeted staff development through learning workshops, involvement and sharing of good practice through Suicide Prevention Action Group process	Director of Risk and Safety (SABP)	Jan-14		The Trust has a suicide prevention action plan which outlines our activities to ensure suicide risks are adequately assessed and managed- SABP Suicide Prevention Action group workshops are part of this process-We have initiated a safety & Experience Improvement Hub which focuses on improvement in a number of areas including self harming and AWOLS inline with the patient safety collaborative approach of using the PDSA cycle
E	SABP to collaborate with HE Thames Valley in enhancing the knowledge and skill of professionals in assessing and addressing suicide risk	Put in place steps to ensure that the is a clear process to enhance the knowledge and skill of our clinicians in assessing suicide risk (this may be done with the support or in collaboartion with universities where required)	Director of Risk & Safety (SABP)	01/12/2014 Updated June 14		The Trust risk assessment training programe meets this requirement and was upodated last year. Training is 3 yearly and a process of making a training programme availabel yearly is currently underway. Further work to engage other agencies as needed will continue to be considered

F	Consider widening the scope of information collected in order to inform thematic analysis	Modify the investigation template & Datix to capture themes in order to aid more robust analysis and learning	Director of Risk & Safety (SABP)	Jan-14		In progress- SABP Datix form has been amended to capture more information & support the linking of cases and themes . SABP RCA template has also been amended to sufficient capture key contributory factors using the fishbone technique. Our annual report to the Quality Committee highlights the themes and our agreed approach to managing these.
G	SABP to initiate a meeting with Coroner's office and develop jointly a MoU	Meet with Coroner to discuss learning and working relationship / sharing of learning	Director of Risk & Safety (SABP)	Jan-14		Met in January 2014. Coroner has written outlining new rules which clearly outline expectations from Trusts - good working relationship with Coroner through SABP legal services manager. Coroner has also agreed to attend our Suicide Prevention Action Workshop in August 2014 to help share learning
H	SABP to work in partnership with Public health and other stakeholders in formulating a Surrey Suicide Prevention Strategy that features attention to those who use Mental Health Services	SABP to be part of the Surry wide Suicide Prevention Group & help in formulating a strategy	Director of Risk & Safety (SABP)	01/11/2013 Achieved		SABP has done and continue to work closely with public health- shared our suicide prevention action plan. SABP attend the surrey suicide meeting and share wider learning on suicide prevention
I	All Investigating Managers and Medical Reviewers to be updated in RCA methodology including the use of tools	Ensure all staff undertaing an SI investigation have recieved sufficient guaidance and training in the RCA process	Director of Risk & Safety (SABP)	01/03/2014 Achieved		Investigation of SI's is now undertaken in-house by the Clinical Risk & Safety Team who had a recent update on the core principles of the RCA process further to the review of the investigation template to include fishbone and 5 whys guidance . SABP will undertake ongoing update and we are exploring receiving further training through the Area team
J	Develop a process to ensure that Terms of Reference are developed for each case	Develop Terms of Reference for each SI	Director of Risk & Safety (SABP)	01/12/2014 Achieved		New template has clear terms of reference which outline the focus for the investigation
K	CRS team to use the findings of 6.6 of this report to inform: - (a) The development of a revised reporting format (b) staff development	Amend reporting format in line with recoomendations	Director of Risk & Safety / Head of Clinical Risk & Safety (SABP)	Jan-14		SABP has reviewed their reporting format and we are now focusing on developing our investigators further for them to be able to change and provide sufficient scrutiny to identify a root cause.
L	(a) Reports to include concise timescale of key activity and RiO records to be excluded from circulation post SABP scrutiny (b) Working Age Adults Division (WAA) to pilot scrutiny of Reports both with and without appended RiO record	Ensure investigation have clear timeline of events leading to the incident in order to sufficiently identify where gaps may have occurred as contributory to aid better targeted learning.	Head of Clinical Risk & Safety (SABP)	Jan-14		SABP investigations have a clear timeline which now includes two columns which identify the source of the information and a significance column to help us focus on ensuring that no issues about care are missed when contributory factors are being listed. An analysis of every interaction as part of the investigation will help SABP get to a true root cause
M	Incorporate a periodic audit of investigation reports into revised policy	Review the incident management policy to include adhoc review of historical reports to identify any quality assurance issues	Head of Clinical Risk & Safety (SABP)	01/01/2014 Updated June 14		work currently underway as part of SABP policy review

N	Consider the potential for creating a new clinical post for DATIX coding and process monitoring	Appoint to Datix lead post	Director of Risk & Safety(SABP) (NEHF CCG)	01/12/2014 Achieved		Clinical Risk & Safety Manager responsible for managing Datix/ SI process and supporting teams in post
O	NEHFCCG and SABP to agree action against the backlog of cases not yet reported upon	Action and trajectories to be defined aiming for SIRIs reported in 2013/14 to be managed within contract timescales	Director of Risk & Safety (SABP) Quality Manager (NEHF CCG)	Nov-13		Extra SI closure panels held. Progress made in reducing the backlog and completing investigation within the timescales for recently reported Sis. Further work required to reduce the backlog further.- Further work ongoing to close the SI's with the CCG
P	SABP work in collaboration with NEHFCCG in developing a revised policy aimed at promoting rigorous investigation wherever possible within timeframes and addressing the tension that must arise from meeting a timeframe and ensuring a rigorous investigation approach.	Links with Recommendation C	(NEHF)	Jan-14		Policy currently in date and is undergoing review at present.
Q	NEHFCCG to nominate two Commissioners to lead on Scrutiny and Sign off of SIRIs	To be reviewed following presentation of proposed SIRI closure process to Surrey Collaborative	Director of Risk & Safety(SABP) (NEHF CCG)	Nov-13		NEHF CCG leading and managing the SI closure and review panel from January 2014 as sub committee to Surrey Scrutiny panel and from April 2014 as subcommittee to CCG QCG Committee. Membership refreshed and strengthened to include Local Authority and Safeguarding. Now forms Part A of monthly CQRM.
R	NEHFCCG and SABP together to formulate a flow chart of expectation from each party in terms of reporting, monitoring and closure	To be developed with recommendations C & P	Head of Clinical Risk & Safety (SABP)	01/01/2014 Updated July 2014		Process is now much clearer with the introduction of the action plan log and adhoc catch-up meetings to ensure both organisations are clear about the status of each investigation.
S	CRS Team to reinvigorate a programme of educational sessions aimed at sharing lessons learnt	CRS Team to reinvigorate a programme of educational sessions aimed at sharing lessons learnt	Director of Risk & Safety(SABP) (NEHF CCG)	Jan-14		This has now resumed

RAG Rating	
Completed	
In progress (returns to Red if Amber for 3 months)	
Not started/limited progress	