NHS Improvement: The future of NHS patient safety investigation

4. **How could the Serious Incident framework be revised to reduce defensiveness and increase openness so that patients, families, carers and staff are more effectively involved and supported? Please let us know your ideas.**

This can be a difficult balance. As the document states, the purpose of this is learning, which will lead to improved care. However, in highly charged emotional situations which can sometimes occur, there can be a swell of feeling to find someone to blame and to see action being taken against individuals. In this environment, any investigation that does not give the desired outcome could be viewed as defensive and protecting the professionals involved. Hence there needs to be clarity from the very outset about scope and purpose, and explanations to the families about how the various processes work with clear timeframes.

Contrary to this, staff can feel they are being blamed and so would also benefit from fully understanding the purpose and remit of the investigation.

5. **How effective do you think each of the following approaches would be in promoting open and supportive involvement of patients, families and carers?**

Providing patients/families/ carers with clear standardised information explaining how they can expect to be involved. This will mean they can more easily judge if an organisation is meeting these requirements and if it is not, raise this with the organisation (with support from their key point of contact that organisations are currently required to provide)

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring organisations to establish a process for gathering timely feedback from patients/families/ carers about the investigation process. Concerns can then be more easily addressed and reliance on the formal complaints process as a means of addressing potential problems reduced

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Asking patients/families/ carers to complete a standard feedback survey on receipt of the final draft investigation report that asks whether their expectations were met. This could help those responsible for overseeing investigations determine if a report can be signed off as complete

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

6. How effective do you think each of the following approaches would be in promoting more open and supportive involvement of staff?

Requiring organisations to have dedicated and trained support staff who listen to and advise staff on their worries and concerns following incidents

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring a formal assessment to be completed to determine whether an individual intended harm or neglect, acted with unmitigated recklessness or has performance, conduct or health issues before the employer takes any action against a staff member

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring those making judgements about the need for individual action to demonstrate up-to-date training and understanding of just accountability

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

7. **Please add any further comments or ideas below**

Training and consistency for investigators (and remaining up to date in such skills) is essential, as is dedicated time for this. The experience of College Fellows suggests that some investigations are carried out in too little time by those who have not been necessarily prepared for the role.

8. **How could the Serious Incident framework best support more effective use of investigation resources? Please tell us your ideas.**

The College has no specific comments on this question.

9. **How effective do you think each of the following approaches would be in promoting better use of existing investigative resources?**

Setting minimum resource requirements for an investigation team

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Setting a nationally agreed minimum number of investigations for each organisation (based on the size of the organisation) so that each organisation can plan how it achieves this number with the appropriate resources to deliver good quality outputs

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring organisations annually to develop an investigation strategy that identifies and incidents will be investigated and how their investigation will be resourced

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Stating that incidents do not always have to be investigated if an ongoing improvement programme is delivering measurable improvement/reduction of risk

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Providing decision aids and record-keeping incidents should be fully investigated

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

10. Please add any further comments or ideas below

The College has no further comments on this question.

11. What changes could be made to the assurance processes to better foster an environment for learning and improvement? Please tell us your ideas.

The College has no specific comments on this question.

12. How effective do you think each of the following approaches would be in developing an environment for learning and improvement?

Requiring a designated trained person in provider and commissioning organisations to oversee processes associated with Serious Incident management

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Setting minimum training requirements for board members and commissioners signing off investigation reports (covering behaviours as well as process to support learning and improvement)

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Introducing a standardised quality assurance tool to support investigation sign off and closure

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring increased involvement of patient and family representatives in the sign off process

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

13. Please add any further ideas or comments below

Training is essential and standardised tools will assist in this. The College would appreciate clarity regarding patient family involvement in sign off, as it seems unclear what would happen if there is nowhere further to progress the investigation, however the family feel unable to give their sign off.

14. What changes could be made to the framework to identify and facilitate cross-system investigations? Please tell us your ideas

Standardised tools may provide an opportunity to identify common themes across different investigations within different boards/Trusts.

15. How effective do you think each of the following approaches would be in helping organisations to identify and conduct cross-system investigations?

Requiring a cross-system investigation to be considered each time an investigation is initiated and, if it is not considered appropriate, the recording of why

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Having a designated trained lead in all sustainability and transformation partnerships who can work with all relevant organisations when a cross-system investigation is necessary

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Continuing to discourage the use of Serious Incident data for performance management

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Mandating through contracts/future regulation the need to contribute to cross-system investigations as required

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Rewarding those who initiate and/or engage in cross-system investigation

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

16. Please add any further comments or ideas below

The College is uncertain that contractually obliging / rewarding Trusts will be the correct approach, as there may be a view that this is only being done for reward rather than to actually benefit learning.

17. How could the Serious Incident framework best ensure that the necessary time and expertise are devoted to investigation? Please tell us your ideas

This is difficult and the most significant aspect, as senior clinicians / managers who may be asked to undertake such investigations tend to already be very stretched for time. There is no easy answer but we must ensure that time is provided for both training and conduction of investigations.

18. How effective do you think the following approaches would be in ensuring the necessary expertise is devoted to investigation?

Requiring each provider to have a flexible, trained team of investigators comprising staff employed by the organisation who combine investigation and management or clinical roles, but have dedicated and protected time for investigation duties. Additional clinical or managerial expertise should be sought as required on a case-by-case basis

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring each provider to have a dedicated team of trained lead investigators with no duties in that organisation other than investigation. Additional clinical or managerial expertise should be sought as required on a case-by-case basis Completely Don't know/ Very effective Somewhat effective Not very effective ineffective undecided

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring each provider to base the number of investigators it employs on its size and the number of investigations it expects to conduct each year, eg four whole time equivalent (WTE) lead investigators to conduct 20 investigations a year

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring each provider to have a trained head of investigation who selects, supports and oversees patient safety investigation management processes

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Requiring a trained head of investigation oversight for commissioning organisations

Completely/ **don't know**/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

19. How effective do you think each of the following approaches would be in ensuring the necessary time is devoted to investigation?

Removing the 60 working day timeframe and instead allowing the investigation team to set the timeframe for each investigation in consultation with the patient/family/carer (as is often the case in the complaints process)

Completely/ don't know/ Very effective/ somewhat effective/ Not very effective /ineffective /undecided

Keeping the set timeframe at 60 working days but reducing the number of investigations undertaken

Completely/ don't know/ Very effective/ somewhat effective/ **Not very effective** /ineffective /undecided

Keeping the set timeframe at 60 working days but requiring organisations to rationalise their internal approval processes to allow more time for investigation before external submission

Completely/ don't know/ Very effective/ somewhat effective/ **Not very effective** /ineffective /undecided

20. Please add any further ideas or comments below

Families are key stakeholders in deciding timeframes. They should help set the timeframe for individual investigations, which may vary depending upon complexity.

College Fellows suggest it is not appropriate to set targets for how many investigations should be carried out, they need to be completed upon merit and in a timeframe that gives reliable outcomes not rushed reactionary decisions. If however there is a reduction in the number of investigations, this needs to be publicly and clinically justifiable in order to maintain trust.

21. How could the Serious Incident framework support uptake of evidence-based investigation approaches? Please tell us your ideas.

The College has no specific comments on this question.

22. How strongly do you agree that a mandated investigation report template and assurance checklist could help to standardise and improve evidence-based practice across the NHS?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Other (please specify)

23. Please add further ideas or comments below

College Lay Advisors have suggested that the flow chart on page 8 is very wordy and perhaps a concise overview should be provided earlier in the document. Appendix 1 has the potential to be useful in regard but would need to be modified and made more user friendly.

24. A revised set of principles has been proposed below for your consideration:

Strategic

-Boards focus on quality of output, not quantity. -Resources are invested to support quality outputs. -Boards recognise the importance of findings. -There is a culture of learning and continuous improvement.

Preventative

-Investigations identify and act on deep-seated causal factors to prevent or measurably and sustainably reduce recurrence. -They do not seek to determine preventability, predictability, liability, blame or cause of death.

People focused

Patients, families, carers and staff are active and supported participants.

Expertly led

Investigations must be led by trained investigators with the support of an appropriately resourced investigation team to ensure they are:

· open, honest and transparent

· objective

· planned

· timely and responsive

· systematic and systems-based

· trustworthy, fair and just.

Collaborative

-Supports system-wide investigation (cross-pathway/boundary issues) -Enables information sharing and action across systems -Facilitates collaboration during multiple investigations

Do you think these principles could support the implementation of good practice?

Yes
No
Don't know/ undecided

Please explain your answer

25. Do you think these principles are clear and comprehensive?

Yes
No
Don't know/ undecided

Please explain your answer

26. Is there anything you would add or change in the drafted principles? Please give us your ideas

The College has no further amendments to the draft principals.

27. Do you think the name of the Serious Incident framework should be changed to reflect the step change in process and behaviour that may be required in some areas to embed good practice?

Yes
No
Don't know/ undecided

If yes, please include your suggestion(s):

- Learning Lessons on Patient Safety
- Improving Patient Safety Through Lessons Learned

28. If you have any further comments or ideas, please share these with us below

Overall, the document authors should consider carefully who the intended audience for this is, and the language used - would they understand terms like "systems approach"?

Thank you for taking part in this survey.

Once the engagement has closed we will analyse what people have told us and use this to inform the development of new systems and processes to improve the quality of patient safety investigation in the future. We will draft the revised Serious Incident framework over the summer and then continue to work with stakeholders to support its implementation

We hope to be able to publish the new Serious Incident Framework by the end of 2018. Before that, a summary of the responses to the questionnaire and feedback from other engagement events will be published on our website https://improvement.nhs.uk/resources/future-of-patient-safety-investigation