To: **National Quality Board**

For meeting on: 1 March 2017

Report author: **NQB Secretariat**

Report for:

Decision	Discussion	Information
	X	X

Title: Coordination of serious incident investigations involving two or more providers

Summary: The purpose of this paper is to:

- set out how investigations into serious incidents involving two or more providers should be coordinated according to current guidance
- consider how effective these coordination arrangements are in practice
- outline potential actions to improve coordination

Recommendations / Action(s) requested:

The NQB is asked to:

a) Note/provide views on the content and conclusions of this paper.

ALB Involvement in development and sign-off of paper:

Care Quality Commission	NHS England	NHS Health Education England	NHS Improvement	NICE National Institute for Health and Care Excellence	Public Health England	DH Department of Health
X	X		X			

Coordination of serious incident investigations involving two or more providers

Purpose of this paper

1. The purpose of this paper is to set out how investigations into serious incidents involving two or more providers should be coordinated according to current guidance (Serious Incident Framework 2015). It also considers how effective these coordination arrangements are in practice and outlines potential actions to improve coordination.

Background

2. At the February 2017 meeting of the NQB, an action was taken by the Secretariat to draft a paper on the coordination of serious incident investigations involving two or more organisations. This followed the CQC's *Learning, Candour and Accountability* report (Dec 2016), which found that the majority of provider organisations reviewed were conducting investigations in isolation and that this impacted on identifying and sharing learning across care pathways spanning hospital and out-of-hospital care . The resultant Secretary of State announcement and DH coordinated *Learning from Deaths* programme seek to address this issue as well as the other recommendations in the CQC's report.

Current guidance on who should coordinate

3. The Serious Incident Framework (SIF) was published by the NHS England Patient Safety Team (now at NHS Improvement) in 2013 and updated in 2015. It outlines the serious incident management process for all NHS organisations to ensure that they are able to appropriately report, investigate and respond to serious incidents so that lessons are learned and future harm is prevented. It outlines the roles of providers, commissioners and regulators.

4. Section 2.2 describes the processes that should be followed to coordinate an investigation where there are two or more providers involved in a serious incident (Fig 1 below). The guidance is clear that a single investigation report should be developed but allows for local decision making on who should coordinate:

Serious Incident Framework (NHS England, 2015) **Fig. 1**

'All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate'.

'Commissioners should help to facilitate discussions as to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. Where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process'

'*Often in complex circumstances separate investigations are completed by the different provider organisations. Where this is the case organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues i.e. the gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent* recurrence. Those responsible for coordinating the investigation must ensure this takes place.

recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report'

CQCs Learning, Candour and Accountability findings and recommendations

5. The CQC's report drew conclusions on the coordination of serious incidents involving two or more providers across providers it reviewed (Fig 2 below)

Fig. 2

Learning, Candour & Accountability (CQC, Dec 2016)

A multi-agency approach to investigating is restricted by a lack of clarity on identifying the responsible organisation for leading investigations or expectations to look across pathways of care. Organisations work in isolation, only reviewing the care individual trusts have provided prior to death. This is a missed opportunity for identifying improvements in services and commissioning

Commissioners should be working collaboratively to agree how best to manage serious incidents for their services and make sure local protocols for reporting and escalating any complex or multi-agency issues exist.

Barriers to learning are most notable where care is provided outside of hospital settings and where multiple providers are involved

What is happening in practice?

6. Views from NHS England's regional teams, CCGs and Quality Surveillance Groups (QSGs) suggest that:

- There is an expectation that trusts look beyond their organisational boundaries and highlight investigations that may need to involve other providers to commissioners.
- Commissioners should be helping providers to do this, for example through supporting opportunities to build relationships and collaboration across organisational boundaries.
- In some complex scenarios, for example where it is difficult to ascertain which organisation should report/own the SI, separate investigations may be conducted /commissioned by each individual provider. The coordination role in these complex cases frequently falls to the commissioner of the services involved – CCG or NHS England. A joint approach may be taken if the services involved are commissioned by both (e.g. acute and primary care), but always with identification of a single lead commissioner responsible for the investigation.
- CCGs can and do request support from NHS England as required. This can include, for example, regular progress review meetings, advice on investigation format and methodology, support with the development of Terms of Reference etc. There is also evidence that Quality Surveillance Groups are being used to discuss complex serious incidents.

- The Secretariat has consulted with NHS England regional teams and some QSGs regarding the efficacy of current arrangements for coordinating serious incident investigations involving two or more providers and no concerns were raised about the ability of CCGs to fulfil the coordination role when required, requesting support from NHS England where required,
- Notwithstanding this, we need to be aware of the risk of commissioners not picking up or being alerted to serious incident investigations involving two or more providers. Consistent provider monitoring and development and robust commissioner oversight is required in order to ensure all cases are appropriately identified and managed. Commissioners could also be doing more to enable provider collaboration to support the building of local relationships across providers and other partners. Local relationships are key.

Prevalence

7. It is not possible to gain quantitative data on the numbers of serious incident investigations involving two or more providers that CCGs are coordinating. This is because there is no currently no data field on StEIS to capture this. At a local level, serious incidents involving two or more providers are monitored through direct dialogue with CCGs on individual cases (exception reporting from CCG to NHSE) and through NHS England's monitoring of StEIS incident descriptions.

Conclusion

8. As demonstrated by the CQC's report, there is clearly scope for significant improvement in the way that serious incident investigations involving two or more providers are coordinated. The current arrangements involve a number of decision points and junctures across multiple parties and commissioners may not be alerted to all cases by providers or pick them up through monitoring. In this context, inconsistencies and lapses in oversight are more probable, therefore a focussed effort is required to support good practice.

9. Going back to first principles of 'who should coordinate', we conclude that the current commissioner responsibilities on coordination of serious incidents are appropriate for reasons of capacity and leverage. NHS England regional teams could not feasibly coordinate all serious incidents involving two or more providers as it does not have the local/regional resources in place to take on this additional duty nor does NHS England hold the necessary authority to hold providers it does not commission to account on actions. The SI Framework stipulations on who coordinates serious incident investigations involving 2 or more providers should be upheld.

10. However, there are a number of ways in which we can drive improvement. These include:

NHS England

- National internal guidance for NHS England teams - the NHS England Quality Assurance Group (QAG), which reports to Executive Group Meeting (EGM) has recently approved the development of national internal guidance for NHS England teams on handling serious incidents and investigations. This will apply to NHS England's roles both as a direct commissioner and as a leader of CCG commissioners. The work is

being led by the NHS England Patient Safety Group (a working group of regional and national representatives) and will be completed by April 2017. The guidance will be based on the SIF, providing supplementary guidance on applying it in the context of NHS England's role and will reflect recent reports and best practice in this area. It will include guidance on coordination of serious incident investigations involving two or more providers. NHS England will also continue to work with colleagues to understand how it can better use its regional footprints to spread best practice beyond the guidance.

- *Better Births* recommended that serious incident investigations into perinatal mortality, neonatal mortality, maternal death and serious morbidity should be carried out under the auspices of the 12 regional Maternity Clinical Networks. Insight from the implementation of this will be used by NHS England to understand whether/how Clinical Networks can support serious incident investigations in future.
- NHS England's quality assurance processes at a local and regional level will be informed by and support the revised CQC inspection regime and the work of NHS Improvement with Trusts.

NHS Improvement

11. Providers have an important role to play in coordinating serious incident investigations which involve two or more providers and alerting commissioners to cases that may involve other providers. NHS Improvement will support implementation of best practice through direct engagement with Trusts and Foundation Trusts through its regional teams. It will also support the CQC's revised inspection regime. Regional teams will work with providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required.

HSIB

12. HSIB will lead on developing exemplar models for serious incident investigations. Any best practice emerging from the work of HSIB on coordination of serious incident investigations involving two or more providers will inform the work of Trusts, regulators and commissioners.

CQC

13. Following the CQC's report and the subsequent Learning from Deaths Programme, CQC's inspection regime will be revised to recognise providers' ability to identify, review, investigate and effectively respond to incidents as a key component of high quality care. This should include a focus on coordination of serious incident investigations involving two or more providers.

Next Steps and alignment with Sustainability and Transformation Plans (STPs)

14. Going forward, as STPs evolve and potentially become more involved in the oversight of health and care services, there could be the opportunity for them to support the coordination of investigations. At this early stage of STP development we recommend that that this is kept under review until more is known about how regulators and commissioners will operate to support STPs.

NQB Secretariat
February 2017