Action Plan for: Mortality and SIRI Improvement

Southern Health NHS Foundation Trust

Version No: 4 ***Date:*** 14.01.16

Issue No.	What is the issue to be addressed?	Current Risk/ Priority Low, Med, High	Action/s to be taken	Evidence of the completion of each action	Action Timescale	Action Progress Blue=Complete Green=Begun & On Track Amber= Risk of slippage Red=Overdue	Evidence of the achievement of the required improvement	Progress with achieving required improvement It should be noted that whilst individual actions may be completed, a number of these will need a few months 'bedding in time' before the required improvement is seen. This column provides progress updates on achieving the actual improvements rather than completion of individual actions Red = improvement overdue or at risk of being overdue Amber = improvement partially achieved or not yet achieved but on track Green = improvement achieved Blue = improved position maintained consistently over 3 month period	Who is responsible for completing the action Name & Job Title	Who is accountable for ensuring the action is completed? Name & Job Title
			Number							
1	Ensure that Serious Incident investigation reports adhere to national timescales.	high	1.1 Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation - this will be embedded into the Trust BI System.	1.1 Weekly Flash produced in new format.	1.1 Completed	1.1 Completed	60% of all Serious Incident Investigation reports to adhere to national timescales by 31.03.16. 90% of all Serious Incident Investigation reports to adhere to national timescales by 30.06.16	05.01.16 42% of Serious Incident Investigation reports adhere to national timescales	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments) Sarah Pearson, Head of Legal & Insurance Services (for SIRI management team) Mayura Deshpande, Associate Medical Director (Quality), Patient Safety and Divisional Clinical Directors	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			1.2 Executive team to review the governance 'flash' report every week.	1.2 Weekly Flash is reviewed by TEG every week	1.2 Completed	1.2 Completed				
			1.3 Serious Incident Investigation Training to include the National timescale requirement.	1.3 Investigators training includes reporting timescales.	1.3 Completed	1.3 Completed				
			1.4 Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and an initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report.	1.4 Centralised lead investigation team in post (register of names / divisions to be supplied) and role specification.	1.4 Completed	1.4 Completed				
			1.5 Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. If improvement trajectories are not being met a divisional review of capacity will take place.	1.5 Monitoring of the percentage improvements in the ability to complete quality investigations within 60 days.	1.5 30.03.16	1.5 On track				
			1.6 All incident trackers to form part of the Ulysses Safeguard system rather than stand-alone spreadsheets.	1.6 All investigations to be input on to the Ulysses system as of the 1st January 2016, a dual process will be in place until 1st April 2016 when the trackers will be closed down. This will be monitored by the Ulysses System Analyst.	1.6 31.03.16	1.6 On track				
			1.7 Implement the new death reporting process.	1.7 Death / mortality reporting process implemented and compliance to use in practice. These will audited against the Tableau mortality reports.	1.7 31.01.16	1.7 Risk of Slippage Combined Tableau reports with Spine and Ulysses data not available until 03.16				
			1.8 Increase compliance to 48hr panel process.	1.8 Monitor compliance to 48 hr panels on a monthly basis aiming to achieve set improvement criteria of 75% by January 2016 and to 95% by February 2016.	1.8 30.06.16	1.8 Compliance being monitored - current trajectory shows risk of slippage				
			1.9 All deaths of patients detained under the Mental Health Act to be reported via the Death reporting process and have system 'flag' to ensure that all are investigated as Serious Incidents.	1.9 System generated mortality report and Serious Incident tracking report.	1.9 31.01.16	1.9 Combined Tableau reports with Spine and Ulysses data not available until 03.16				
2	Ensure that Serious Incident investigation reports are of the required quality and always identify a clear root cause.	high	2.1 All corporate panels to be chaired by an Executive director.	2.1 There is an Executive chair to each serious incident panel to provide scrutiny and oversight evidenced by minutes.	2.1 Completed	2.1 Completed				
			2.2 Recruit and train Serious Incident Investigator team.	2.2 Recruitment process / assessment centre notes for Lead Investigation team and training course documentation.	2.2 Completed	2.2 Completed				
			2.3 Include NPSA guidance tools on report writing in training.	2.3 Included in the investigators training packs and training course materials.	2.3 Completed	2.3 Completed				

			2.4 Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation.	2.4 Template for electronic RCA developed in the Ulysses system.	2.4 Completed	2.4 Completed	60% of all Serious Incident Investigation reports will achieve panel approval on first submission by 31.03.16 (some minor amendments acceptable). 80% of all Serious Incident Investigation reports will achieve panel approval on first submission by 30.06.16 (some minor amendments acceptable). 95% of Serious Incident Investigations to include a root cause.	05.01.16 Monitoring process for approval at panel on first submission not yet in place. 05.01.16 87% include a root cause.	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments) Sarah Pearson, Head of Legal & Insurance Services (for SIRI management team)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			2.5 Provide investigation training to Divisional staff undertaking Investigating Officer roles.	2.5 Investigator training offered via LEaD bi-annually. Evidence of course content.	2.5 Completed	2.5 Completed				
			2.6 Senior clinician in a senior leadership role to lead Divisional Serious Incident report reviews prior to presentation at corporate panel.	2.6 Evidenced through death reporting process and 48hr panel compliance.	2.6 Completed - process in place	2.6 Completed				
			2.7 Ensure the Investigation training provides a definition of root causes and the investigative tools approach as to how to extract them as part of an investigation.	2.7 Included within the investigators training.	2.7 Completed	2.7 Completed				
3	Ensure that Serious Incident Investigators are adequately trained.	medium	3.1 Create and deliver a 2 day investigators course to all staff undertaking an Investigating Officer role. Ensure the course encompasses all elements of the historical NPSA course linked to SHFT policies, processes and risk management system.	3.1 Investigators course programme.	3.1 Completed	3.1 Completed	Register of active and trained Investigating Officers within each Division to ensure that outcomes for issues 1 and 2 are met.	05.01.16 Supervision session not yet developed but on track.	Helen Ludford, Associate Director of Quality Governance	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			3.2 Create Lead Investigators roles in all Divisions to provide ongoing expert and competency assessment.	3.2 Central Lead Investigators recruitment (register of names / divisions to be supplied) objectives for the role will be assessed during appraisal.	3.2 Completed	3.2 Completed				
			3.3 Develop an investigator supervision session to be held quarterly for case study learning and updates to National guidance.	3.3 Central investigation team clinical supervision session in place but a quarterly wider meeting is still to be developed. Agendas provide evidence.	3.3 31.03.16	3.3 On Track				
4	Ensure that Corporate review panels are effective in the sign off of high quality investigation reports and that they are used to capture organisational learning.	high	4.1 Corporate panels to be held every other week with Executive Director Chair and all Serious Incident Investigation Reports to be presented and signed off through this panel (excluding pressure ulcers).	4.1. The corporate panels schedule and the minutes of the panels.	4.1. Completed	4.1. Completed	60% of reports signed off by external CCG panel on first submission by 31.03.16. 90% of reports signed off by external CCG panel on first submission by 30.06.16.	05.01.16 Monitoring data collection tool in development.	Helen Ludford, Associate Director of Quality Governance Sarah Pearson, Head of Legal & Insurance Services (for SIRI processes)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			4.2 Minor amendment review panels to be held every other week with Associate Director Chair to ensure timely final version reports uploaded onto STEIS.	4.2 The review panel schedule and the minutes of the panels.	4.2 Completed	4.2 Completed				
			4.3 Serious Incident panel process to be clearly and simply described in the SHFT policy.	4.3 Up to date policy.	4.3 31.01.16	4.3 On Track				
			4.4 Minutes of corporate panels to be recorded and held by the Serious Incident and Incident Team.	4.4 Process in place for the taking of, storage and Chair sign off of serious incident panel minutes. This can be evidenced by SOP.	4.4 Completed	4.4 Completed				
			4.5 The learning from Serious Incident investigations to be extracted and shared within 'Hot-Spots'.	4.5 'Hot-Spots' organisational learning tools to be shared.	4.5 Completed	4.5 Completed				
			4.6 A scoring mechanism to be added to the corporate panel minutes, scoring the quality of the reports submitted to track improvement.	4.6 Evidence of the scoring mechanism and ability to track improvement	4.6 31.01.16	4.6 On Track				
5	Ensure that Duty of Candour requirements are always met.	medium	5.1 Duty of Candour training to be delivered as part of the investigators course.	5.1 Investigators course programme.	5.1 Completed	5.1 Completed	100% compliance to the commissioned requirements for Duty of Candour compliance. 100% compliance that families or next of kin, where possible, have been involved in Serious Incident Investigations by 31.03.16 100% compliance with new procedure for writing to families where death was not a SIRI by 30.06.15.	05.01.16 Monitoring of commissioned compliance achieving 100%. Monitoring data collection tool of family involvement in Serious Incident Investigations in development.	Briony Cooper, Head of Quality Contracts and Quality Performance	Dr Lesley Stevens, Medical Director - Executive sponsor of the Patient Engagement workstream
			5.2 Leaflet to be created which explains the Duty of Candour requirements to service users / patients / staff / next of kin.	5.2 Leaflet created approved by the Patient Engagement workstream prior to launch, evidence provided in minutes.	5.2 31.03.16	5.2 On Track				
			5.3 Ulysses Safeguard screens to be further developed to map the Duty of Candour requirement and to record full compliance with each stage.	5.3 Ulysses capture screens - screen shots.	5.3 Completed	5.3 Completed				
			5.4 Data from Ulysses Safeguard to be used to report the Duty of Candour compliance to Commissioners via CQRM process.	5.4 Informatics report and validation process. Serious Incident panel minutes will capture that the Duty of Candour has been met for all Serious Incidents.	5.4 Completed	5.4 Completed				
			5.5 Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families.	5.5 Role description.	5.5 Completed	5.5 Completed				
			5.6 Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations.	5.6 Up to date policy.	5.6 31.03.16	5.6 On Track				

			5.7 Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation)	5.7 Process to be defined and guidance letter templates developed. Reference to these to be included in first review of new Procedure for Reporting and Investigating Deaths.	5.7 31.01.16	5.7 On track				
			5.8 Root Cause Analysis investigation template to be amended in order that the section which outlines what involvement/contact there has been with the families is more structured and requires specific details (currently a free text box).	5.8 Corporate panel meetings to review on ongoing basis	5.8 31.03.16	5.8 on track				
6	Ensure that there is evidence of the rationale of the decision making process of whether to conduct an investigation into a death and that it is clearly recorded.	high	6.1 Provide a clear definition of the decision making process surrounding what constitutes a serious incident. Incorporate this process in Serious Incident training and document it within the new Procedure for the Reporting and Investigation of Deaths.	6.1 Copy of the Procedure for the Reporting and Investigation of Deaths and evidence of sign off by the Mortality Working Group.	6.1 Completed	6.1 Completed	There will be a robust audit trial of the decisions to investigate a death which is 60% correct without need for central moderation by 31.03.16 and 95% correct by 30.06.16.	05.01.16 Audit in development, to be added to the Internal Audit timetable.	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			6.2 Develop and launch a Ulysses death reporting form. This will commence a process with a senior clinical sign off as to whether a death should be investigated and what level of investigation would be required. This will all be tracked and monitored within the system.	6.2 Screen shot of death reporting form.	6.2 Completed	6.2 Completed				
			6.3 Provide Trust wide communication of the new process ahead of 'go live' using bulletin and intranet communications.	6.3 Evidence of Trust communication team circulating the new process ahead of the 'go-live' date.	6.3 Completed	6.3 Completed				
			6.4 Monitoring of compliance with this process to be undertaken by the Mortality Working Group under Executive leadership.	6.4 Minutes of the Mortality Working Group and Ulysses extraction to provide assurance of reporting.	6.4 31.01.16	6.4 On Track				
7	Ensure a systematic approach to cross organisational learning from deaths through formal Mortality review processes at Divisional and Trust level through Mortality Meetings and themes and trends are clearly identified and acted on.	high	7.1 Divisions to introduce regular Mortality Meetings (minimum of once a quarter).	7.1 Schedule of Mortality Meetings.	7.1 31.03.16	7.1 On Track	That themes from Serious Incident Investigations will be discussed at Division level and shared with the wider clinical group. Improvements to care delivery / patient pathways can be linked to thematic evidence.	05.01.16 Thematic review and reporting to be developed by the Organisational Learning workstream of the Quality Improvement Programme - meeting scheduled 14.01.16.	Helen Ludford, Associate Director of Quality Governance Tracey McKenzie, Head of Compliance Mayura Deshpande, Associate Medical Director (Quality), Patient Safety and Divisional Clinical Directors	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			7.2 Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	7.2 Terms of Reference and standardised agenda documents.	7.2 Completed	7.2 For final approval at Mortality Working Group - 12.01.16				
			7.3 Divisional Mortality Meetings to report into the Trust Mortality Review Group under Executive leadership (quarterly).	7.3 Minutes of the Mortality Review Group.	7.3 31.03.16	7.3 On Track				
			7.4 Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role and the data presented by the Lead Investigator for the Division.	7.4 Minutes of the Mortality Meetings.	7.4 31.03.16	7.4 On Track				
			7.5 All Divisions to use 'Hot Spots' and 'Could it happen here?' templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	7.5 Evidence of the use of 'Hot-Spots' in the Division which contain Serious Incident learning.	7.5 31.03.16	7.5 On Track				
			7.6 Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly).	7.6 Examples of the standardised reports provided.	7.6 Completed only for Spine reports in Tableau	7.6 Risk of Slippage. Combined Tableau reports with Spine and Ulysses data not available until 03.16				
			7.7 Organise and deliver bi-annual Serious Incident workshop / conference to discuss improvement progress and changes to national frameworks.	7.7 Programmes for the workshops.	7.7 Completed	7.7 Completed				
			7.8 Provide improvement report to the SOG on a quarterly basis.	7.8 Report to be provided.	7.8 Completed	7.8 Completed - 1st report submitted Nov 2015				
8	Ensure robust systematic Mortality Reporting to Trust Board and Board Sub-Committees which review mortality.	med	8.1 Develop standardised Board report templates through Mortality Task and Finish Group to include numbers, national benchmarks, case studies, themes and organisational learning.	8.1 Standardised Board and sub-committee reporting of mortality and the associated themes. Evidence will be the papers.	8.1 31.03.16	8.1 On Track	Complete and effective Board oversight and assurance. External confidence in the annual report.	05.01.16 Planning commenced for 2015/2016 report.	Sarah Pearson, Head of Legal & Insurance Services (for SIRI data) Amanda Owen, Corporate Governance Manager Briony Cooper, Head of Quality Performance and Quality Contracts	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			8.2 The Mortality Review Groups and Mortality Meetings must identify any Mortality themes and link themes to clear risks on the risk register.	8.2 Mortality Review Group and Mortality Meeting minutes.	8.2 31.03.16	8.2 On Track				
			8.3 2015/16 Annual Report to include detail of new mortality reporting process and any early identification of themes from specialities. This will not be a complete data set which will be in place for the 2016/17 Annual Report. First draft to be shared in February 2016.	8.3 Content of the Annual Report.	8.3 31.03.16	8.3 On Track				

9	Improve thematic review across the Trust and share this process externally with the stakeholders (CCGs) for assurance.	low	9.1 Produce a thematic review template in line with best practice guidance to include lessons learnt.	9.1 Standardised template	9.1 31.01.16	9.1 On Track	Improved oversight and assurance of thematic review process.	05.01.16 in development and on track.	Tracey McKenzie, Head of Compliance Briony Cooper, Head of Quality Performance and Quality Contracts	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer, Dr Lesley Stevens, Medical Director
			9.2 Share thematic review approach, template and schedule with CCGs.	9.2 Minutes of SOG.	9.2 31.03.16	9.2 On Track				
			9.3 Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report to Quality and Safety Committee.	9.3 Evidence of thematic reviews.	9.3 30.06.16	9.3 On Track				
			9.4 Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	9.4 Supply thematic review papers to discussion.	9.4 30.06.16	9.4 On Track				
10	Ensure that SHFT incident reporting and management policy is aligned to the national framework and submission of data to the National Reporting and Learning Service is evidenced as correct to guidance.	med	10.1 Re-write SHFT incident policy to ensure alignment to the national framework to acknowledge process developments made during the last year.	10.1 Up to date policy.	10.1 31.01.16	10.1 On Track	Accurate national reporting aligned to the published national frameworks. Evidence that the NRLS criteria are being applied correctly.	05.01.16 Policy out for consultation and NRLS meeting being organised.	Fiona Richey, Head of Risk and Business Continuity Sarah Pearson, Head of Legal & Insurance Services	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			10.2 Governance team to meet with the NRLS centralised team to ensure that the Southern Health impact grading and uplift processes are occurring within the required criteria.	10.2 Minutes of a meeting.	10.2 31.03.16	10.2 On Track				
11	Ensure that the requirement for multi-agency retrospective and forward planned thematic reviews and Serious Incident investigations are discussed with partner organisations, CCG's and the Local Authorities to agree process.	med	11.1 Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	11.1 Programme for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	11.1 01.02.16	11.1 On Track	SHFT to be fully engaged in multi-agency Serious Incident investigations and thematic review.	05.01.16 Workshop scheduled for February 2016.	Helen Ludford, Associate Director of Quality Governance	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			11.2 Engage all stakeholders in a workshop to discuss the process of commissioning and managing multi-agency Serious Incident investigations.	11.2 Content of the agenda for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	11.2 01.02.16	11.2 On Track				
			11.3 As part of a wider stakeholder group create a process framework for undertaking multi-agency Serious Incident investigations.	11.3 Process framework for undertaking multi-agency investigations agreed by all stakeholders.	11.3 31.03.16	11.3 On Track				
12	Ensure that the physical health needs of patients in mental health and learning disability services are met.	med	12.1 Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service.	12.1 Course content and learning outcomes which will be reviewed. Attendance data per service.	12.1 31.03.16	12.1 On Track	Compliance rates for the 5 day course will meet those stipulated for each area. Audit results of physical health care plans in MH/LD services will show 95% or above as having appropriate		Sara Courtney, Acting Director of Nursing and Allied Health Professionals and all Associate Directors of Nursing Mavura Deshpande, Associate	Dr Lesley Stevens, Medical Director Sara Courtney, Acting Director of