Action Plan for: Mortality and SIRI Improvement

Southern Health NHS Foundation Trust

Version No: 10 ***Date:*** 31/03/2016

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. The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level.	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	31.03.16 37% of Serious Incident Investigation reports adhere to national timescales due to the backlog of historical incident which are more than 100 days overdue. Technical issues aligning Ulysses and Tableau has created a delay on combined reports	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), Communications 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 TEG minutes	1.2 Completed	1.2 Completed				
			1.3 Serious Incident Investigation Training to include the National timescale requirement.	1.3 Investigators in post and in date for training and competency requirements to undertake their role	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 workforce metrics to include- 'in post' and 'vacancy' position (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 Slippage - trajectories not being met, predicted backlog closure 30.04.16				
			1.6 All incident trackers to form part of the Ulysses Safeguard system rather than stand-alone spreadsheets.	1.6 All investigations will be on 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. Evidence - ERCA report.	1.6 31.03.16	1.4 Completed				
			1.7 Implement the new death reporting process.	1.7 Compliance monitoring of Divisions at each stage of the new reporting process evidenced within the Flash report.	1.7 31.01.16	1.7 Overdue Combined Tableau reports with Spine and Ulysses data not available until 04.16 due to technical issue with N3 security agreements and data extractions from the Ulysses system				
			1.8 Increase compliance to 48hr panel process.	1.8 Monitor compliance to 48 hr panels through the TEG Flash Report aiming to achieve set improvement criteria of 75% by January 2016 and to 95% by February 2016.	1.8 30.06.16	Overdue 21.03.16 87% compliance achieved - monitored on a rolling 4 week basis				
			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 completed	1.9 Completed in Ulysses				

			1.10 All Trust staff must be informed of changes to policy and the new procedures linked to improved incident investigation and the oversight of mortality. All new policies to be published on the intranet and highlighted in the staff bulletin. Executive level announcements to the made about the changes to process and why incident investigation is so important.	1.10 Policy publication, staff bulletin features and team level meeting minutes.	1.10 30.04.16	1.10 On track			
2	Ensure that Serious Incident investigation reports are of the required quality, identify a clear root cause and investigations have been undertaken by a trained professional.	high	2.1 All corporate panels to be chaired by an Executive director.	2.1 Corporate panel minutes and Terms of Reference	2.1 Completed	2.1 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.	31.03.16 67% Serious Incidents achieving panel approval on first submission and progressing to minor amendments panel. 87% Serious Incident reports now contain 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
			2.2 Recruit centralised Serious Incident Investigator team to be known as the Divisional Lead Investigation Officers.	2.2 Demonstration that these individuals are in post, competent and are working to a defined job description	2.2 Completed	2.2 Completed				
			2.3 Provide Investigator Training to Divisional Lead Investigation Officers and those staff who undertake Investigating Officer roles. The course will be advertised and booked through the LEaD training system. This training will include: All related SHFT policies NPSA guidance tools on report writing in training Root cause analysis tools and how to use these to extract a root cause National Serious Incident Framework guidance inclusive of timescales Requirement for reporting deaths in detention Duty of Candour (cross reference to section 4 DoC) Human Factors Complaints management Ulysses system training Legal and inquest overview	2.3 Course schedule and attendance logs	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 and an example of an SI produced in the electronic format.	2.4 Completed . Electronic template went live on 1st January 2016	2.4 Completed				
			2.5 Senior clinician in a senior leadership role to lead Divisional Serious Incident report reviews prior to presentation at corporate panel.	2.5 Standardised Terms of reference for the Divisional Panels - which include a scheme of delegation	2.5 Review of Terms of Reference to include a scheme of delegation	2.5 In review but on track				
			2.6 Create a register of Trust-wide Investigating Officers to ensure all have been trained and competency assessed by undertaking a minimum requirement of one investigation per annum	2.6 Register of Investigating Officers to include annual number of investigations undertaken and supported by each individual	2.6 30.04.16	2.6 On track				
			2.7 Develop a Divisional Lead Investigating Officers supervision session for case study learning from IMAs and Corporate Panels and updates to National guidance.	2.7 Minutes of the Divisional Lead Investigating Officers supervision session	2.7 Completed	2.7 Completed				
			2.8 To ensure improvement is demonstrable through the monitoring of first time sign off of SI Investigation reports at commissioner sign off panels and by the coroner	2.8 Monitoring evidence of % achievement against aim of 100% first time sign off at both corporate panel and by commissioner panel and coroner	2.8 30.04.16	2.8 On track				
3	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	3.1 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).	3.1. The corporate panels schedule and the minutes and Terms of Reference of the panel	3.1. Completed	3.1. 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.	31.03.16 This target cannot yet be accurately monitored due to the backlog of historical incidents 2013, 2014 and 2015 which have not been closed. There is an exercise taking place with commissioners to clear this backlog.	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
			3.2 Minor amendment review panels to be held every other week with Associate Director Chair to ensure timely final version reports uploaded onto STEIS.	3.2 The minor amendment review panel schedule and the minutes and Terms of Reference of the panel	3.2 Completed	3.2 Completed				
			3.3 Serious Incident panel process to be clearly and simply described in the SHFT policy.	3.3 Up to date policy.	3.3 Completed	3.3 Completed				
			3.4 Minutes of corporate panels to be recorded and held by the Serious Incident and Incident Team.	3.4 Process in place for the taking of, storage and Chair sign off of serious incident panel minutes. This can be evidenced by SOP.	3.4 Completed	3.4 Completed				
			3.5 The learning from Serious Incident investigations to be extracted and shared within 'Hot-Spots'.	3.5 'Hot-Spots' organisational learning tools to be disseminated on a monthly basis with Corporate Panel learning points.	3.5 Completed	3.5 Completed				
			3.6 A scoring mechanism to be added to the corporate panel minutes, scoring the quality of the reports submitted to track improvement.	3.6 Evidence of the scoring mechanism and ability to track improvement. Improved quality scores in all Divisions	3.6 Completed	3.6 Completed				
4	Ensure that Duty of Candour requirements	medium	4.1 Duty of Candour training to be delivered as part of the investigators course.	4.1 Investigators course programme supported by evidence in SIRI reports.	4.1 Completed	4.1 Completed				

	are always met.		4.2 Leaflet to be created which explains the Duty of Candour requirements to service users / patients / staff / next of kin.	4.2 Leaflet created approved by the Patient Engagement workstream prior to launch, evidence provided in minutes.	4.2 31.03.16	4.2 Slippage - not approved by the work stream requires direction within the policy	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.	31.03.16 100% compliance to DoC but manual process to validate at the present time.	Briony Cooper, Head of Quality Contracts and Quality Performance	Dr Lesley Stevens, Medical Director - Executive sponsor of the Patient Engagement workstream
			4.3 Ulysses Safeguard screens to be further developed to map the Duty of Candour requirement and to record full compliance with each stage. Audit of data capture will be used as an evidence base for assuring family involvement or reviewing cases where it has not been appropriate to facilitate involvement.	4.3 Ulysses capture screens - screen shots - audit	4.3 30.04.16 - for audit tool and first audit	4.3 On Track				
			4.4 Data from Ulysses Safeguard to be used to report the Duty of Candour compliance to Commissioners via CQRM process.	4.4 Informatics report and validation process. Serious Incident panel minutes will capture that the Duty of Candour has been met for all Serious Incidents.	4.4 Completed	4.4 Completed				
			4.5 Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families.	4.5 Role description.	4.5 Completed	4.5 Completed				
			4.6 Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations.	4.6 Up to date policy.	4.6 31.03.16	4.6 Slippage - document in ratification process				
			4.7 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)	4.7 Evidence of family involvement in investigations to be shown by; SIRI report Family feedback to be capture in commissioned report Corporate panel review templates	4.7 31.01.16	4.7 Overdue - report has been commissioned to seek information regarding family involvement				
			4.8 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).	4.8 Copy of the investigation template extracted from Ulysses	4.8 31.03.16	4.8 Completed				
			4.9 The Trust will seek to engage lay people, families and service users to oversee the development of documents in relation to Duty of Candour and the investigation processes	4.9 Evidence of oversight and input from lay people, families and service users to be found in mortality related minutes and within the ratification groups for new policies or procedures or patient facing literature	4.9 30.04.16	4.9 On Track				
5	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	5.1 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.	5.1 Copy of the Procedure for the Reporting and Investigation of Deaths and evidence of sign off by the Mortality Working Group.	5.1 Completed	5.1 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.	31.01.16 Audit tool developed and piloted, 1st result 82%	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
			5.2 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.	5.2 Screen shot of death reporting form and audit evidence that these have been completed correctly.	5.2 Completed	5.2 Completed				
			5.3 Provide Trust wide communication of the new process ahead of 'go live' using bulletin and intranet communications.	5.3 Evidence of Trust communication team circulating the new process ahead of the 'go-live' date.	5.3 Completed	5.3 Completed				
			5.4 Monitoring of compliance with this process to be undertaken by the Mortality Working Group under Executive leadership.	5.4 Minutes of the Mortality Working Group and Ulysses extraction to provide assurance of reporting.	5.4 Completed	5.4 Completed				
6	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	6.1 Divisions to introduce regular Mortality Meetings (minimum of once a quarter).	6.1 Schedule of Mortality Meetings.	6.1 31.03.16	6.1 Completed	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.	31.03.16 Evidence base within SharePoint site not 100% complete	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
			6.2 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.	6.2 Terms of Reference and standardised agenda documents.	6.2 Completed	6.2 Completed				
			6.3 Divisional Mortality Meetings to report into the Trust Mortality Review Group under Executive leadership (quarterly).	6.3 Minutes of the Mortality Review Group.	6.3 31.03.16	6.3 On Track				
			6.4 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.	6.4 Minutes of the Mortality Meetings.	6.4 31.03.16	6.4 Slippage - evidence within SharePoint site not complete being chased				
			6.5 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.	6.5 Evidence of the use of 'Hot-Spots' in the Division which contain Serious Incident learning.	6.5 31.03.16	6.5 Slippage - evidence not yet provided from all Divisions				

No.	Issue	Risk	Action	Evidence	Date	Status	Outcome	Progress	Lead	Executive Lead
			6.6 Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly).	6.6 Examples of the standardised reports provided.	6.6 Completed only for Spine reports in Tableau	6.6 Overdue. Combined Tableau reports with Spine and Ulysses data not available until 04.16 due to technical difficulties				
			6.7 Organise and deliver bi-annual Serious Incident workshop / conference to discuss improvement progress and changes to national frameworks.	6.7 Programmes for the workshops and attendance lists	6.7 Completed	6.7 Completed				
			6.8 Provide improvement report to the SOG on a quarterly basis.	6.8 Report to be provided.	6.8 Completed	6.8 Completed - standard agenda item				
7	Ensure robust systematic Mortality Reporting to Trust Board and Board Sub-Committees which review mortality.	med	7.1 Develop standardised Board report templates through Mortality Task and Finish Group to include numbers, national benchmarks, case studies, themes and organisational learning.	7.1 Standardised Board and sub-committee reporting of mortality and the associated themes. Evidence will be the papers.	7.1 31.03.16	7.1 Slippage - standardised mortality report not yet created due to delay of integration of Ulysses and Tableau. Manual based reporting is in place.	Complete and effective Board oversight and assurance. External confidence in the annual report.	31.03.16 Report not yet standardised	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
			7.2 The Mortality Review Groups and Mortality Meetings must identify any Mortality themes and link themes to clear risks on the risk register.	7.2 Mortality Review Group and Mortality Meeting minutes.	7.2 31.03.16	7.2 Completed				
			7.3 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.	7.3 Content of the Annual Report.	7.3 31.03.16	7.3 Completed - section submitted				
8	Improve thematic review across the Trust and share this process externally with the stakeholders (CCGs) for assurance.	low	8.1 Produce a thematic review template in line with best practice guidance to include lessons learnt.	8.1 Standardised template	8.1 29.02.16	8.1 Overdue but in development - pilot template used in OPMH	Improved oversight and assurance of thematic review process.	31.03.16 template in development, thematic review paper to be discussed at SOG 11.04.16	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
			8.2 Share thematic review approach, template and schedule with CCGs.	8.2 Minutes of SOG.	8.2 31.03.16	8.2 Agenda item for SOG on Monday 11 April				
			8.3 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.	8.3 Evidence of thematic reviews.	8.3 30.06.16	8.3 On Track				
			8.4 Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	8.4 Supply thematic review papers for discussion.	8.4 30.06.16	8.4 On Track				
9	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	9.1 Re-write SHFT incident policy to ensure alignment to the national framework to acknowledge process developments made during the last year.	9.1 Up to date policy.	9.1 Completed	9.1 Completed	Accurate national reporting aligned to the published national frameworks. Evidence that the NRLS criteria are being applied correctly.	31.03.16 Completed	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
			9.2 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.	9.2 Minutes of a meeting and SHFT process for uplift to NRLS	9.2 31.03.16	9.2 Completed				
10	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	10.1 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.	10.1 Programme for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	10.1 Completed	10.1 Completed	SHFT to be fully engaged in multi-agency Serious Incident investigations and thematic review.	31.03.16 - Commissioners are taking responsibility for action 10.3, there a further meeting organised and SHFT will receive feedback	Helen Ludford, Associate Director of Quality Governance	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			10.2 Engage all stakeholders in a workshop to discuss the process of commissioning and managing multi-agency Serious Incident investigations.	10.2 Content of the agenda for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	10.2 Completed	10.2 Completed				
			10.3 As part of a wider stakeholder group create a process framework for undertaking multi-agency Serious Incident investigations.	10.3 Process framework for undertaking multi-agency investigations agreed by all stakeholders.	10.3 31.03.16	10.3 This piece of work is being led by WHCCG DoN&Q, there is a multi-commissioner organised for April with no provider input. Consider extending the deadline for this action as not SHFT led. Interim processes are in place for discussions with CCGs on a case by case basis if multi-agencies are involved in the care and treatment.				

11	Ensure that the physical health needs of patients in mental health and learning disability services are met.	med	11.1 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.	11.1 Course content and learning outcomes which will be reviewed. Attendance data per service.	11.1 31.03.16	11.1 Slippage - evidence being obtained	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 physical health care plans in place.	31.03.16 Physical health audit planned fro June 2016	Sara Courtney, Acting Director of Nursing and Allied Health Professionals and all Associate Directors of Nursing Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors	Dr Lesley Stevens, Medical Director Sara Courtney, Acting Director of Nursing and AHP's
			11.2 As part of service redesign, ensure that integrated teams contain physical expertise as part of the staffing component.	11.2 Staffing models following service redesign.	11.2 31.03.16	11.2 Slippage - evidence being obtained				
			11.3 A clinical audit to be undertaken within Q1 of 2016/17 to evidence that physical health needs of mental health and learning disability patients are being met.	11.3 Clinical audit results achieve above 90% compliance to physical health care plans being in place and up to date.	11.3 30.06.16	11.3 On Track				