Northamptonshire Healthcare NHS

NHS Foundation Trust

Incident Investigation Policies and Procedures Review (IIPPR)

Final Report

Study set up at Request of Chair, *Aug 12*

Governor Team:

Dennis Holland: Air Accident Investigator
Gail Sutherland: Retired Nurse
Eileen Hales : Retired Psychiatric Nurse*
Wendy Steele: Service User*

**No longer a governor*

Difference Between Aviation and NHS Safety

Trust investigates itself

Advantage: intimate knowledge of problem

Dangers:

Blinkered thinking
Bullying
Politics
Personality clashes
Defensiveness
Cover-ups

Part 1 – Initial Documents Review (*2013 to 2014*)

Incident Policy - CRM002
Risk Management Strategy Document
Being Open Policy - CRM006
Complaints and Concerns Policy - CRM 003
Guidance of Staff Raising Issues of Concern - HR009
Supporting Staff - CRM 007
Investigation Policy - CRM 008

Part 1 - Documents Review Findings

Bad: inconsistencies between documents and no-longer-relevant job positions, untidy differences between the definitions parts of the documents.

Good: the elements outlining the procedures to be followed, are clear, consistent and readily understandable

Part 2 - Attendance at Serious Incident Review Committees

Investigators were encouraged to present a robust warts-and-all debrief

Has matured: covers the big picture – monitors outstanding actions - addresses improving the procedures

The Trust has a high standard of openness

Part 3 - Review of Completed Pressure Ulcer SI Review (*2014*)

Within the Trust:

SI report reviewed by team, comments made.

Met with SI author, who felt well-supported by the Trust, and that the Trust had a fair and open ethos.

Review of Completed Pressure Ulcer SI Review (*2014*)

Outwith the Trust:

DH attended a Pressure Ulcer Peer Review Group at Nottingham in ***Dec 14***. This SI report and others from East Midlands was peer-reviewed by Area Health reps

NHFT's Pressure Ulcer Champion Tracey Dodds also took part.

NHFT's reports were mildly criticized for being over-long

Our report format was a slightly-modified version of the NHS England Standard SI form; other trusts used abbreviated versions

We liked our report format, and it was legally-compliant

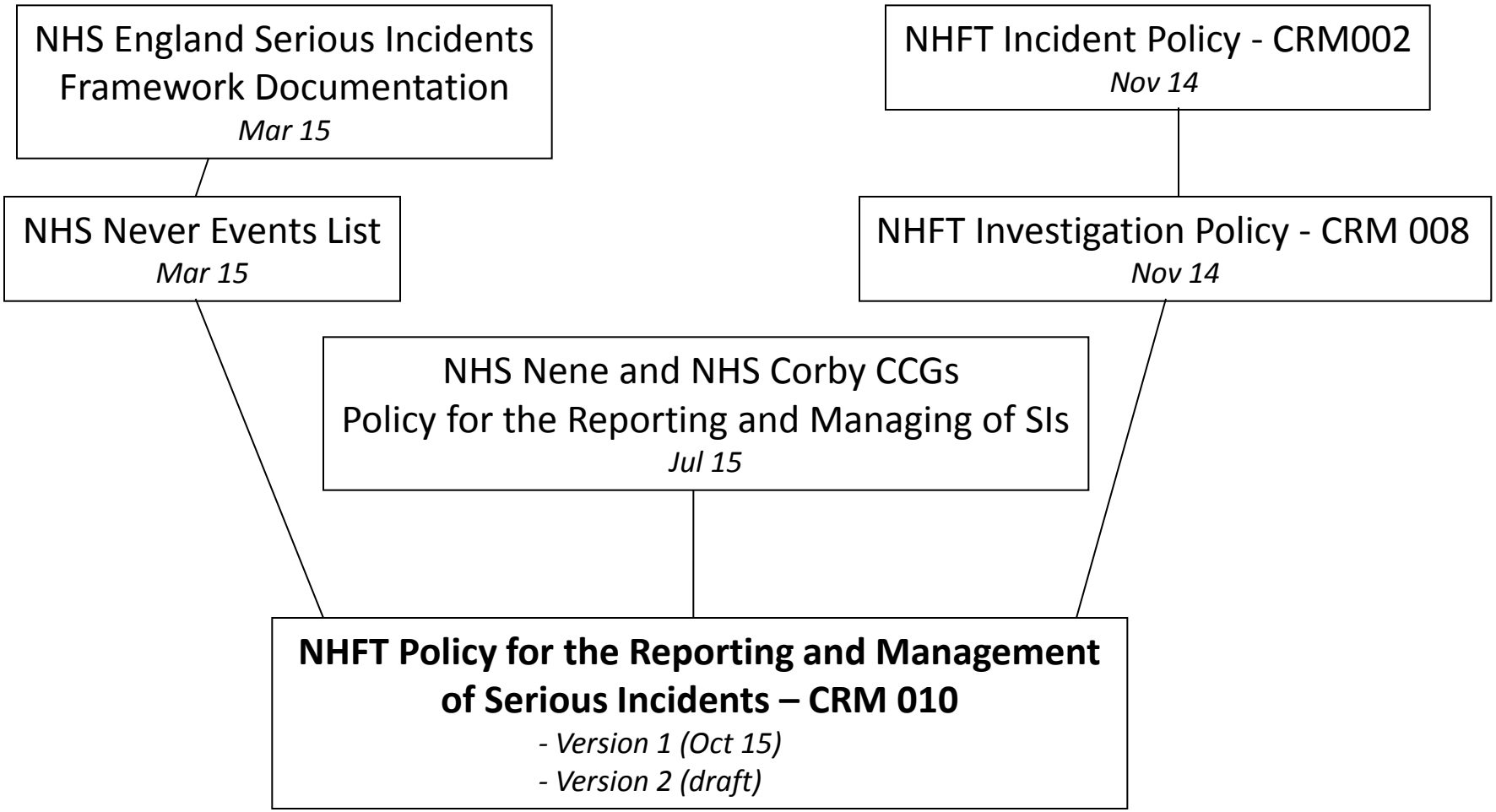
Aug 15:

Gail and I met with Tracey Dodds to go over the Nottingham meeting's findings

Informed of new NHS SI/never events documentation

Decided to conduct documentation review again

Part 4 – Second Documents Review (*Sep 15 to Oct 16*)



Part 4 - Documents Review Findings

Minor, inconsequential typos (reported back, NFA)

Documents are consistent
CRM 010 is clear, readily understandable and well written

IIPR Study Conclusions:

Documents Review

Overall, the Trust now has a consistent, well written and appropriate serviceable set of documents

Serious Incident Review Committee

The Trust has a high standard of openness

Review of Completed Pressure Ulcer SI Review

Comprehensive SI Report format; legally-compliant, and readily-understood

Summary

The Trust now has a gratifyingly-high standard of openness and fairness when investigating incidents, and consistent, robust and effective incident reporting and safety management procedures

LEARNING FROM MISTAKES LEAGUE

The rankings are as follows:

1 – **outstanding levels** of openness and transparency

2 – **good** levels of openness and transparency

3 – **significant concerns** about openness and transparency

4 – **poor reporting culture**

Wye Valley NHS Trust	✓	53
Dorset Healthcare University NHS Foundation Trust	✓	54
Sheffield Children's NHS Foundation Trust	✓	55
Northamptonshire Healthcare NHS Foundation Trust	✓	56
South London and Maudsley NHS Foundation Trust	✓	57
Cumbria Partnership NHS Foundation Trust	✓	58

Questions?