AGENDA ITEM
3.2.14

QUALITY & SAFETY COMMITTEE

INCIDENT MANAGEMENT FRAMEWORK: LISTENING, LEARNING & IMPROVING SAFETY

Date of meeting	(19/07/2022)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lydia Thomas, Head of Quality & Safety Louise Mann, Assistant Director of Quality, Safety & Safeguarding
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
QA	Quality Assurance

1. SITUATION/BACKGROUND

1.1 Following the publication of the National Quality & Safety framework by the Welsh Government in June 2021, the Health Board formulated an incident management toolkit to standardise the investigation processes and documentation throughout the Health Board. The Health Board framework was launched on the 8th June 2022 across

all communication channels. Drop in sessions following the launch were also offered to provide staff with the opportunity to raise any questions or comments they had regarding the publication of the framework.

The framework will be revised in July/ August 2022 following the Health Board's organisational change to reflect the governance arrangements within the care groups.

1.2 Refreshed Root Cause Analysis training is currently in development with 3 launch sessions planned across the three Integrated Locality sites in July & August 2022. Following the release of training dates via the Health Board communication channels, within a 24 hour period over 30 staff had requested to attend one of these sessions. At the end of June 2022 the number of requests had risen to 72. The plan for the sessions is for them to be interactive, with a number of speakers in attendance. Future plans are for the training to become available as a module on ESR to allow training to be more accessible.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The framework is designed to guide staff in their decision-making, with a clear emphasis on investigations not being intended to apportion blame, but to focus on essential learning that can be taken forward by not only local teams and departments but Health Board wide.

The development of the framework involved the ILG governance teams highlighting areas of the investigation process they required further clarity and guidance on along with feedback from the Integrated Locality Nurse Directors.

2.2 The Framework is set out with process maps and useful tools to walk managers through the investigation process. It also has useful links and contacts for managers to utilise within the investigation process for both family liaison and staff. Alongside the incident management framework, a small information booklet for staff who are not directly undertaking investigations has been developed outlining what to expect after they have reported an incident.

2.3 There is clear guidance on the Nationally Reportable Incident (NRI) & Locally Reportable Incident (LRI) process and how as a Health Board we ensure these are reviewed timely and effectively with prompt reporting to the Delivery Unit for those which are NRI's or Never Events.

2.4 Additional topics such as psychological safety, human factors and safety II approach has been covered as we continue to embed a culture of sharing learning from incidents in a positive way to allow staff to be more engaging in improvements within their departments.

The framework enhances knowledge on the following areas:

- Human Factors & psychological safety
- Putting Things Right (PTR) process & Duty of Candour
- Principles of Breach of Duty & Qualifying liability
- Standardising letters sent to families across the Health Board
- Learning from Events Reports (LFER's) being focus at the start of the investigation

2.5 There is a clear focus on the importance of LFER's being considered at the start of the investigation, with evidence being saved throughout on Datix. The importance of the Datix system being updated regularly and action modules used to allow managers to oversee and manage more effectively actions within their services.

The chapter covering Redress, Breach of Duty and Qualifying Liability has been welcomed within the ILG teams due to there not being a definitive documented process from when healthcare professionals identify a breach and the process of involvement with our redress and claims teams.

2.6 There are a number of recommendations to be considered for further refinement of the framework and RCA training:

- Mortality Review process
- Investigations which are outsourced
- Multi-agency safeguarding investigations
- RCA training to become ESR module
- Interface with the Listening & Learning Framework

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 No key matters or escalation required to Board/ committee.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Enables standardisation of Investigations across Health Board
	Governance, Leadership and Accountability

Related Health and Care standard(s)	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

5.1 **NOTE** the content of the report