SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRI) POLICY
(Including Mortality review process)

Please be aware that this printed version of the Policy may NOT be the latest version.
Staff are reminded that they should always refer to the Intranet for the latest version.

Purpose of Agreement	To detail the reporting and management of Serious Incidents Requiring Investigation (SIRI)
Document Type	Policy
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Document Manager (Job Title)	Head of Patient Safety
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This version includes minor amendments on section 4.4.7 from the version ratified on June 2016. Chairs action were taken in May 2017 but operational date and review date are kept the same.

Expiry date extended to September 2019, requested by author.

Review Log

Include details of when the document was last reviewed:

Version Number	Review Date	Name of reviewer	Ratification Process	Reason for amendments
V2	06/08/2013	Janey Harbord	SIRI Panel	Minor changes to process, Never Events criteria updated, National Policy updated, Staff titles and organisational structure, TOR , Strategy Meeting Template, Action plan and internal Solent requirements
V3	12/14	Tom Williams	Clinical Risk Manager sign off	Changed terminology of roles etc. and updated the policy owner.
	04/15	Tom Williams/ Teresa Power	Policy Steering Group	Revised SIRI Framework published. Policy amended to reflect this.
	05/15	Teresa Power	Policy Steering Group	Embedded documents, amended as full documents in the appendices.
V4	23/16	Tracy Beck		Update the policy owner Change review date front page and Para 8.1 Para 6.1 removed Appendix 4 Revised SIRI template implemented Appendix 5 Divisional Clinical Governance Leads terminology standardised

Table of Contents

Appendices

Serious Incidents Requiring Investigation (SIRI) Policy

1. Introduction and Purpose

1.1. The systems-improvement approach to safety acknowledges that causes of incidents cannot simply be linked to the actions of individual people. The framework therefore uses a system- wide perspective for notification, management and learning from serious incidents. It supports openness, trust and continuous learning and service improvement. Where relevant, it highlights where engagement with relevant bodies for full investigation and identification of learning from a serious incident is needed.

1.2. The Purpose of this policy is to:

- Provide a consistent definition of a serious incident that requires investigation; Clarify roles and responsibilities;
- Provide information on requirements and timescales;
- Draw together legal and regulatory requirements associated with the management of serious incidents and which form the basis of this framework;
- Provide an overarching framework developed from good practice, along with signposting tools and resources that support good practice;
- Provide guidelines to ensure that all incidents are reported to the relevant bodies to ensure full investigation (including independent investigations) and learning from the event.

1.3. This policy supports openness, trust, continuous learning and service improvement from serious incidents.

2. Scope

2.1. When a serious incident occurs it can have a devastating and far reaching effect. It may have an impact on those directly involved, patients, relatives, staff or visitors, and also on the reputation of the healthcare organisation, the service or the profession within which the incident occurred, and the wider NHS.

2.2. This policy applies to all directly and indirectly employed staff and other persons working within Solent NHS Trust.

2.3. Solent NHS Trust is committed to the principles of equality and diversity and will work to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and equal opportunities for users of services, carers, the wider community and Solent staff.

3. Definition of a Serious incident requiring investigation (SIRI) and 'Never Events'

3.1. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Acts or omissions in care that result in; unexpected or avoidable death.
- Unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse.
- Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.
  - Wrong-site surgery
  - Wrong implant/prosthesis
  - Retained foreign in a patient after a surgical/invasive procedure
  - Mis-selection of a strong potassium containing solution
  - Wrong route administration of medication
  - Overdose of Insulin due to abbreviations or incorrect device
  - Overdose of methotrexate for non-cancer treatment
  - Mis-selection of high strength midazolam during conscious sedation
  - Failure to install functional collapsible shower or curtain rails (Mental Health Settings)
  - Falls from poorly restricted windows
  - Chest or neck entrapment in bed rail
  - Transfusion or transplantation of ABO-incompatible blood components or organs
  - Misplaced naso- or oro-gastric tubes
  - Scalding of patients.

All Adult & Child Serious Case Reviews are Serious Incidents. – Some will also be serious incidents requiring investigation and healthcare providers will be expected to contribute to the Serious Case Review's.

3.2. Supplementary Terms

- **Incident** – an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public

- **NHS-funded services and care** – healthcare that is partially or fully funded by the NHS, regardless of the location.

- **Unexpected death** – Where natural causes are not suspected. Local organisations should investigate these to determine if the incident contributed to the unexpected death.

- **Permanent harm** – Permanent lessening of bodily functions, including sensory, motor, physiological or intellectual.

- **Severe harm** – a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

- **Major surgery** – a surgical operation within or upon the contents of the abdominal or pelvic, cranial or thoracic cavities or a procedure which, given the locality, condition of patient, level of difficulty, or length of time to perform, constitutes a hazard to life or function of an organ, or tissue (if an extensive orthopaedic procedure is involved, the surgery is considered 'major').

- **Abuse** – A violation of an individual's human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation, of the person subjected to it.

- **Duty of Candour** – a statutory requirement has been introduced to ensure health care providers operate in a more open and transparent way. The regulation for Duty of Candour applied to health service bodies from 27 November 2014. It will be extended to all other providers from 1 April 2015, subject to Parliamentary process and approval.

- **Patient Safety Incident -** Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS-funded healthcare.

3.3. Please Refer to:

- NHS England (March 2015) Serious Incident Framework.

3.4. When an Information Governance SIRI (or suspected SIRI) occurs Risk Management staff will notify the Information Governance Team immediately who will follow the Department of Health (June 2013) Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents guidance.

3.5. If there is any doubt as to whether or not an incident should be classed as a SIRI, the Risk Management Team/Information Governance Team/Chief Nurse or Medical Director will contact the Lead Commissioner or Commissioner Support Unit for advice.

4. Process / Requirements

4.1. Process for Communicating SIRI

4.1.1 All Solent NHS Trust staff members are expected to follow the Reporting of Adverse Incidents Policy which interlinks with this policy.

4.1.2 Solent NHS Trust expects any Independent Contractors to have in place robust procedures for informing the organisation, via the Executive Team, Heads of Service or designated link with the Contracting team.

4.1.3 As with all incidents, the main priority is to ensure the safety of those involved and those who may be affected as a result of the incident.

4.1.4 As soon as the SIRI has occurred, without delay and within 24 hours, the service manager (or person in-charge at the time) must be informed.

4.1.5 As soon as Solent NHS Trust managers are aware that a SIRI has occurred, based upon the nature of this incident, they should report it to:

- Clinical Risk Manager
- Clinical Director for the service
- Information Governance Manager
- Information Asset Owner
- Clinical Governance & Quality Lead for the Service
- Operations Director
- Chief Nurse/Medical officer
- Chief Operating Officer(s)
- Caldicott Guardian
- If out-of-hours or if any of the above are unavailable, the On-call Director.

4.1.6 Depending on the circumstances of the SIRI the Chief Executive Officer will be directly informed. Where the SIRI involves a controlled drug, the incident must also be reported to the organisation's Controlled Drug Accountable Officer.

4.1.7 The report of a SIRI may be from a Department, Service or Care Group Division or from another source such as the Complaints Team, Safeguarding Team or Information Governance Team. The SIRI may also be identified by trend analysis or by recommendation by the Commissioning body.

4.1.8 The Risk Management Team (or the on-call Director) once informed of the SIRI will immediately (or as soon as practicable) undertake the following process:

- Ensure that immediate steps have been taken to ensure patient safety and to protect the site of the incident where appropriate.

- If the incident is considered to be a SIRI, the Clinical Risk Manager or designate will inform the relevant Commissioning body of the incident by completing the relevant form on the Strategic Executive Information System (STEIS).

- The Commissioning body will be notified that a new SIRI has been submitted to STEIS within 2 working days of the incident occurring.

- All SIRI involving patients must be reported to the National Patient Safety Agency. Depending on the source of the incident, this report might have been completed by another organisation, in which case, it does not need to be re-reported.

- Ensure the recording and update of all serious incidents on the local risk management system (LRMS).

4.2. Management / Investigation of a SIRI

4.2.1 The circumstances surrounding each incident will vary in terms of levels of harm and impact based on complexity and the involvement of other agencies. Therefore, the response to each incident should be proportionate to the scale, scope and complexity of each incident. As with any approach from the media, members of staff must direct all enquiries to the Communications Team.

4.3. Identification and Response

4.3.1 In all instances, the first priority is to ensure those individuals affected by the incident are supported including any remedial or clinical action taken to mitigate that impact:

- A safe environment should be re-established, all equipment or medication retained and isolated, and relevant documentation copied and secured to preserve evidence and facilitate investigation and learning. If there is a suggestion that a criminal offence has been committed, Solent NHS Trust must contact the police.

- For Information Governance incidents an immediate review of the breach or suspected breach should be undertaken, identifying all involved and the data affected, so that potential further breaches can be avoided.

- Early consideration must be given to the provision of information and support to patients, relatives and carers and staff involved in the incident, including information regarding support systems which are available to patients, relatives, visitors or contractors following guidance provided in the Solent NHS Trust 'Being Open' policy.

- The needs and involvement of staff in the incident should also be considered and support provided.

- If the incident is potentially a child safeguarding concern, the Safeguarding Children Policy must be followed. Children's Social Care and the Police are the statutory leads.

- If the incident is potentially an Adult safeguarding concern, a safeguarding alert must be raised in line with Safeguarding Policy. It is also important to identify where other agencies need to be brought into the management of a serious incident when required (see the appropriate Safeguarding Policy for guidance).

- Identify an appropriate specialist/clinician to conduct an initial incident review to confirm whether a serious incident has occurred and if applicable, the level of investigation required and to outline immediate action taken (including where other organisations/partners have been informed) (See Appendix 1)

4.4. Strategy Meeting

4.4.1 On receipt of notification of a SIRI the Clinical Risk Manager/Service lead will make arrangements to convene a Strategy Meeting. This will take place no later than 4 working days/72 hours following the incident. In exceptional circumstances and with the agreement of the Chief Nurse/Chief Medical Officer or relevant Care Group Chief Operating Officer, the strategy meeting may be 'virtual'.

4.4.2 Attendees at the Strategy Meeting will include or representation for:

- Chief Nurse and/or the Chief Medical Officer
- Head of Patient Safety
- Senior Service line representative
- Clinical Governance & Quality Lead for the Service
- Service representative with knowledge of the incident
- Clinical Risk Manager
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4.4.3 Depending on the type of incident and how it was reported, other attendees may also be invited as follows: Information Governance, Human Resources, Safeguarding and PALs and Complaints Team.

4.4.4 The Strategy Meeting's purpose is to consider the patient and staff safety elements of the incident – what has already been done and what needs to be done. Prior to the meeting the Head of Service/Clinical Director/ Operations Director will have arranged for a IMR review and the answering of any specific questions. This information will be submitted for discussion at the strategy meeting.

4.4.5 A standard template will be used to record the discussion and decisions from the Strategy Meeting (Appendix 2).This template includes all information about the incident, the date it was reported, the date reported on STEIS and the STEIS reference. (It also identifies the agreed Commissioning Manager, Investigating Officer, scope and timescales etc. as well as the commissioning brief for the investigation).

4.4.6 Using, previously referenced, guidance, the meeting will agree whether the incident is:

- A SIRI requiring investigation and delivery of a report within 60 working days
-
- A high risk incident requiring investigation and management
- An incident requiring local investigation and management
- Should be passed to another agency/organisation.
- **Should be a joint investigation with another organisation(s)**

4.4.7 The meeting will identify the Investigating officer and give a commissioning brief for the investigation detailing any specific questions that need to be answered. Serious Incident Requiring Investigation investigators are to engage with all key stakeholders (which may include family members)/services that were/are involved in a person's care and offer them input into the investigation process. The meeting will also determine any additions to the core circulation list for the SIRI Alert and will determine the date for receipt of the draft report and the date for the submission to the SIRI Panel.

4.4.8 If the SIRI Panel dates will not allow for a high quality report to be produced within the timeframe, the Strategy Meeting will acknowledge this and require that the Commissioners be contacted by the Risk Manager to agree a more appropriate submission date.

4.4.9 If the incident is decided by the Strategy Meeting to be a high risk incident requiring investigation but does not fulfil the SIRI criteria is will be deescalated in conjunction with Commissioner agreement. The Risk Manager will liaise with the appropriate Service lead to ensure this decision is fed back and that the investigation is programmed.

4.4.10 The SIRI Alert email will be sent, following the meeting, to all Solent NHS Trust Directors, Associate Directors, Communications Team and others on the agreed circulation list to keep them informed. (Appendix 3).

4.5. Draft Report

4.5.1 The draft Root Cause Analysis Investigation Report (SIRI Report) will be delivered by the mid - point of the investigation period. The Clinical Risk Manager will maintain contact with the Investigation Officer during the investigation. Any appointed investigator, internal or external, will have appropriate skills to investigate the incident fully. The draft report will take a standard format as agreed with Commissioners. The report format is attached at Appendix 4.

4.5.2 The draft SIRI Report will be submitted to the Commissioning Manager which is usually the Clinical Director. In discussion with the Investigating Officer the draft report will be examined against the Commissioning Brief to ensure that all key questions have been answered. Relevant specialists will also be invited to comment at this time. The recommendations of the report will be considered and the Clinical Director will draw up an action plan to address and implement improvements in response to the recommendations.

4.5.3 The Clinical Director is responsible for ensuring that the SIRI report and action plan has been submitted as agreed to the Clinical Risk team for the forthcoming SIRI Panel meeting (Within 60 working days). It is expected that all SIRI and HRI reports are discussed through service line/Care Group governance meetings prior to submission to SIRI & Mortality Review Panel.

4.6. SIRI Panel

4.6.1 The SIRI Panel will have standard membership (including a Non-Executive Director) and will meet on a monthly basis. Terms of Reference and membership of the Panel is attached at Appendix 5. The Panel will consider the final SIRI Report, the recommendations and the actions to address these. They will also consider and advise on monitoring arrangements to ensure firstly that actions are completed and secondly, that actions will have the desired effect changing practice and processes to prevent future reoccurrence of the incident without introducing new and potentially unmitigated risk issues.

4.6.2 The SIRI Panel is able to comment where they believe further investigation is needed whether this results in an amendment to the SIRI Report or an additional piece of risk management work outside the remit of the report.

4.6.3 The SIRI Panel will formally sign-off the SIRI Report for the organisation and agree to submit the report to Commissioners within target closure date. In exceptional cases ;(as decided by the Chief Medical Officer/ Chief Nurse) two members of the following; Chief Nurse/Chief Medical Officer or Chief Operating Officer may sign-off the report for the organisation. The sign-off will be documented in the SIRI Panel Minutes.

4.6.4 An overview of the report and the decision made will still need to be presented to the SIRI Panel at the next available meeting. Once the report has been signed off by the organisation and submitted to Commissioners the 'clock' will stop. (Stopping the clock relates to the Commissioners referring the SIRI to NHS England) The Commissioners will close the SIRI on STEIS once the report has been accepted and a closure confirmation alert will be issued by the Clinical Risk Manager.

4.6.5 The SIRI Panel will, on a monthly basis receive a list of all new SIRI and a status report on all SIRI. This will include details of submissions and responses from Commissioners and closure on STEIS. With this overview, the SIRI Panel will be able to comment on the overall performance of the process and any trends in SIRI and will be able to report to Service Line Governance Groups and to Board.

4.7. SIRI Closure-Submission of Final Report

4.7.1 Serious incident reports and action plans must be submitted to the relevant commissioner within 60 working days of the incident being reported to the relevant commissioner, unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced. (See appendix 6 for checklist)

4.8. Mortality Review Process

Please refer to the interim Mortality Review Policy.

4

4.9. Administration and Learning

4.9.1 The revised SIRI 2015 Framework takes account of the changes and acknowledges the increasing importance of taking a whole-system approach to quality, where cooperation, partnership working, thorough investigation and analytical thinking are used to understand where weaknesses/ problems in service and/or care delivery exist, in order to draw learning that minimises the risk of future harm.

5. Roles and Responsibilities

5.1. The **Chief Executive** has ultimate responsibility for all aspects of risk management, including the management of incidents and SIRI. This involves ensuring services are adequately resourced to comply fully with this policy.

5.2. The **Executive Directors** have a responsibility to:

- Ensure compliance with this policy
- Ensure that all investigations are dealt with effectively and appropriately
- Ensure that action plans are appropriate and are implemented within their services
- Provide evidence that lessons have been learnt.

5.3. The **Clinical Director** have a responsibility to:

- Be aware of, and comply with this policy
- Provide support to all staff and patients involved in reporting of SIRI or potential SIRI (actual and near miss)
- Ensure that all investigations are dealt with effectively and appropriately
- Ensure that action plans are appropriate and are implemented within their services
- Provide evidence that lessons have been learnt

- Monitor the quality and effectiveness of reporting and subsequent investigations by receiving and commenting on trend analysis and investigation reports.

5.4. The **Risk Management Team** has a responsibility to:

- Be aware of, and comply with this policy
- Identify SIRI reported via incident forms and safeguarding alerts, as SIRI and upload them onto STEIS.
- Play a key role in ensuring that as an organisation that Solent meets the performance requirements of the commissioning organisation.
- Produce SIRI reports showing trends.
- Support the review of root causes and learning from these incidents at the Service Line Governance Groups.
- Highlight any particular concerns / changes to practice, and the lessons learned, to relevant staff.

5.5. The **Information Governance Team** has Responsibilities for:

- Ensuring all IG SIRI are reported to the appropriate bodies including the Information Commissioner.
- Contributing to, as Specialist Officer, or investigating all IG SIRI Producing an IG SIRI report showing trends.
- Discussing root causes and learning from these incidents at the Information Governance Steering Committee.
- Reporting annually all IG SIRI in the annual report and the Statement of Internal Control (SIC)

5.6. The **Caldicott Guardian** and **Senior Information Risk Officer** (SIRO) has responsibility for:

- Reflecting patients' interests regarding the use of patient identifiable information.
- Ensuring patient identifiable information is shared in an appropriate and secure manner.
- Fostering a culture for protecting and using data.
- Providing a focal point for managing information risks and incidents.
- Receiving updates from the Information Governance Team regards all Information Governance SIRI.

5.7. Service Leads /Departmental Managers have a responsibility to:

- Be aware of, and comply with, this policy.
- Investigate all reported SIRIs and inform the Risk Management Team of the outcome.
- Be aware of all SIRIs reported in their team/department.
- Raise any concerns regarding SIRI with the relevant Service Manager.
- Ensure that all incident reports are completed with all relevant details and without delay and within 48 hours of incident occurring: in accordance with the Solent NHS Trust Reporting of Adverse Incidents Policy.
- Review the relevant risk assessments following a SIRI.
- Inform the Risk Management Team if the SIRI results in staff absence from work (even if this does not happen immediately after the incident) or any changes to staff duties.
- Inform the Risk Management Team of any changes to action plans
- Consider and, where appropriate, implement the Solent NHS Trust *Being Open Policy* when reporting SIRI.
- With the relevant departments, provide support to all staff and patients involved in an incident.

5.8. Employees have a responsibility to:

- Report incidents within timeframe.
- Be aware of, and comply with, this policy.
- Consider and, when appropriate, implement the Solent NHS Trust 'Being Open' Policy.
- Give details of actions on the incident reporting form.
- Report any risks that could warrant further investigation.
- Be fully open and co-operative with the SIRI reporting and investigation process as detailed within this policy but also the Solent NHS Trust HR Investigation Policy.

6. Training

6.1. Those members of staff who are required to undertake Investigations of SIRI, High Risk incidents or incidents that fall under the safeguarding umbrella will receive specific training for this role, as above. This will include support from the Corporate Safeguarding team as detailed in the *Safeguarding Vulnerable Adults* policy. Root Cause Analysis Training will be made available to support investigators provided by the risk team or external agency as required and training provided by the Human Resources team in investigating potential poor practice and the disciplinary procedure.

7. Equality & Diversity and Mental Capacity Act

7.1. An Equality Impact Assessment form relating to this policy has been completed and was submitted with the policy during the ratification process, please see Appendix 8.

8. Review

8.1. The policy will be reviewed after 3 years unless operational arrangements or legislation prompt an earlier review

9. References and links to other documents

NHS England (March 2015) **Serious Incident Framework**, NHS England.

NHS South Central (May 2010) **South Central Strategic Health Authority Guidance For Serious Incident Process,** NHS South Central.

NHS South of England (March 2012) **Process for reporting and learning from serious incidents requiring investigation,** NHS South of England.

Department of Health (June 2013) Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents guidance. Department of Health.

Department of Health (October 2012) **The never events policy framework -*An update to the never events policy.*** Department of Health*.*

Other Solent NHS Trust Policies:

Incident, Complaints/Concerns investigation, analysis and Organisational Learning Policy
Adverse incident reporting Policy
Risk Management Strategy Information Governance Policies

Health & Safety Policy
Being Open Policy
Complaints Policy
Safeguarding Adults Policy
Safeguarding Children Policy
HR Investigation Policy
Information Risk Policy

Initial Management Report

To be completed and forwarded to:

Responsible Associate Director/Head of Service/Head of Risk /Clinical Risk Manager

Person Details: *(please complete as applicable)*

Gender:			
Age:			
NHS Number:			
GP Practice Post code:		GP practice Locality:	
Commissioning organisation:			
Date of admission or commencement of NHS Services (relevant to this incident):			
Date of Death *(if applicable)*			

Incident Details: *(please complete as applicable)*

STEIS ref:			
Incident No:			
Claim ref:			
Complaint ref:			
Inquest ref:			
Date of Incident:			
Division:		Department:	
SIRI criteria identified: *(why is this incident a SIRI?)*			

Brief Incident details: *(including events leading up to the incident)*	
Immediate actions taken: *(from date of incident to present)*	

Brief Chronology: *(all pertinent and related events/actions)*

Date/Time	Event	Issues identified/Actions Taken

Assurance statement (*to be completed by Medical and Non-Medical Clinical Governance Leads*)

Please include the current conclusions reached regarding issues related to: Human Resources/Clinical Management (both Medical and Nursing)/Patient Safety/Dignity & Respect/Being Open

Date:		Medical Clinical Governance Lead	
Date:		Non -Medical Clinical Governance Lead	

Summary of Management plan undertaken:

Action *(please complete with details of actions)*	**Evidence**	**Date for completion**	**By Whom**
Staff Support -			
Patient/Client support – (ref to Being Open)			
Patient Safety issues addressed -			
Strategy Meeting held -			
Agreed Comms approach -			

Media Strategy: *(to be completed by the Communications Team - as required)*

(Embed MIA)

External notification undertaken or to be undertaken: *(as applicable)*

External Agency	**Date informed**	**By whom**	**Comment**

Please ensure that all supporting documentation is submitted with this IMR

Completed by:		**Date:**	
Received by Risk Management Team:		**Date:**	
Agreed by: (Ass Dir)		**Date:**	
Agreed by: (DoN/MD)		**Date:**	

Appendix 2: Strategy Meeting Template

Strategy meeting – SIRI no:

Incident / HRI No:

Date:

Location:

Phone – 08009171950

User pin – 72466944

Chair code - 17727424

The contents of this meeting are to be treated as confidential and not shared with anyone outside of this forum unless on a need to know basis

Agreement to adhere to confidentiality statement indicated by all attendees

– Chair's Signature:

The purpose of this meeting is to examine the collated evidence so far and make shared decisions relating to the process of management of this incident and:

- Agree the investigation approach required, based on the grading of the incident and the information provided to date
- Commission the investigation into this SIRI, which will include:
- Ensuring that any immediate or significant safety issues are addressed
- Identifying the scope and remit of the investigation
- Identifying roles and responsibilities regarding the investigation and production of the Root Cause Analysis Report
- Ensure that timelines for submission to commissioners are clear
- Identify individuals to be interviewed as part of the investigative process
- Agree the Commissioning Brief and the Lead investigator and Specialist
- Consider any further internal or external reporting requirements

Attendees:

Required		**Consider** *(please refer to the guidance at the end of this template)*	
Name	**Title**	**Name**	**Title**
	Clinical Risk Manager		Chief Medical Officer
	Chief Nurse		Chief Operating Officer
	Head of Patient Safety		HR Representative
	Service representative with knowledge of the incident		Head of Patient Insight & Professional Leadership
	Clinical Governance & Quality Lead		Head of Safeguarding
	SIRI Co-Ordinator		Person most able to give an account of the incident

Apologies:

Name	**Title**	**Name**	**Title**

Pre-meeting preparation – to table	
Action	By whom
Incident report to be completed by service	Person most able to give an account of the incident
Operations/Clinical Director to be briefed by Head of Service	Head of Service
IMR to be undertaken by-	Person most able to give an account of the incident
Clinical lead to identify all Medical staff and brief/ support	Clinical Lead
Head of Service to identify all nursing /AHP staff and brief/ support	Head of Service
Chronology to be prepared by service	Person most able to give an account of the incident

Information re: previous related incidents (individual/service/Type)	Risk Management Team
Information re: previous related complaints (individual/service/Type)	PALs & Complaints Team
SIRI alert email is circulated appropriately	Risk Management Team
Verbal or face to face meeting with family/carers has taken place within 10 days (copy of minutes/record of meeting or entry into Medical Records to be forwarded to Risk Management Department as a priority)	Clinical Director/ Operations Director/ Clinical Governance & Quality Lead/ Head of Service

Patient/Staff Safety Issues – Summary *(Amend to reflect incident)*	
Issue	Action

Family /Carer/ Staff/External involvement & support: Please ref: *Duty of Candour*	Please detail:

Is there known or likely involvement of Coroner in	Yes/No	Is it known or likely that there is to be an inquest in connection with this incident?	Yes/No	If the answer is **yes** to either question - refer to and follow the 'Protocol for Managing Inquests' (Appx within SIRI Policy)

Further Information Required

All information to be forwarded to the Lead Investigator

Action	Date for completion	Update	By Whom

Action to be taken

Does this incident meet	Yes/No	Grading of incident	**1**	Level of investigation required	**2**	SIRI Category	

If this incident does not meet the SIRI criteria and is to be raised by Solent Healthcare, why is it not a SIRI and what action is to	

Commissioning Brief - for inclusion within RCA

Executive Lead –

Commissioning Manager –

Investigating Officer:

NB: Ensure all Patient Identifiable Data is removed from the draft report before it is circulated to the list below.

Lead Investigator/RCA Author: is requested to carry out an investigation and deliver a Root Cause Analysis report (as per Solent NHS Trust template – embedded below) to the point of recommendations (Action plan to be developed, agreed and added to report in consultation with the Commissioning Manager)

With particular consideration to issues relating, but not limited to:

Name	Email	Tel
Tracy Beck		
Mandy Rayani	**Mandy.rayani@solent.nhs.uk**	**02380 608820**
Dan Meron	**Daniel.Meron@solent.nhs.uk**	

Date of Panel Meeting:

Closure Date:

Appendix 3: SIRI Alert Email

SIRI (Serious Incident Requiring Investigation) Alert – For your information

SIRI ref Number	Type/ Category	SIRI Grade	Level of Investigation	Date Notified - STEIS	Investigating Officer	Specialist	Service Line	Service	Executive Lead	25 Day Investigation Period ending:	Final closure deadline

Incident report No:		Date of incident:		Date incident reported:	
Brief details of incident at the time of reporting :					

- RCA report to be reviewed at ******* SIRI Panel (Papers to be submitted – ********)
- If you have any queries or require further information please do not hesitate to contact the Clinical Risk Manager.
- **Please note** - All communication regarding this SIRI will identified by the SIRI reference number.
- Please note - the milestone and the **final closure** deadline if you are the Investigating Officer or the Executive Lead

Everything contained within this email is to be treated as confidential and not shared to anyone unless on a need to know basis

Appendix 4: Root Cause Analysis Template

Root Cause Analysis Investigation Report

Solent NHS Trust SIRI Summary Sheet	
SIRI Number	
Solent Incident Number	
Solent Service	
Category	
Level of investigation	
Criteria	
When was this SIRI discussed at the service line governance group?	
Has this been formally signed off by the Commissioning Manager?	
Has this report been agreed for closure by the Solent SIRI Panel?	
Has Duty of Candour been met with regard to this incident?	
Action Plan completion date	
Has this report been checked for Patient Identifiable Data?	
Staff present at the SIRI Panel:	

Main Report

Incident Description and Consequence (concise incident description and outcome for patient, staff, service or organisation)	
Incident Date:	
Incident Type:	
Directorate (Service):	
Actual effect on patient:	
Actual severity of the incident:	

Risk Assessment		
A **Potential Severity** **(1-5)**	**B** **Likelihood of recurrence** **at that severity (1-5)**	**C** **Risk Rating** **(C = A x B)**

Background and Context (brief description and any contextual issues that may have an impact on the outcome)

Terms of Reference

Aim
The aim of the investigation is to establish the facts of the case. This will include *what* happened (which will be documented using a tabular time line), to *whom, when* and *where.* Once the facts have been established the aim of the investigating team will be to establish the reasons *why* this incident occurred, including contributory factors and root causes.

Objectives
To establish whether failings occurred in care and/or treatment.
To identify learning points and improvements rather than apportion blame.
To establish how a recurrence may be effectively reduced or eliminated.
To formulate realistic recommendation which address the root causes and learning points; to improve systems and services.

Outcome
To present the key findings in a report, as a record of the investigative process.
To prepare an action plan for implementation of recommendations made.
To provide a consistent means of sharing learning locally and nationally as appropriate.
To ensure that provision is made for monitoring the action plans developed.

Strategy panel membership
(Names will be removed when report is submitted to the CCG/SHA)

Name	Title

Investigation Team
(Names will be removed when report is submitted to the CCG/SHA)

Name	Title

SIRI panel membership
(Names will be removed when report is submitted to the CCG/SHA)

Name	Title

Scope and Level of Investigation (Describe briefly what the investigation covered)

Investigation type, methods used (eg Root Cause analysis, medical records, staff interviews incident decision tree)

Involvement and support of patient and relatives (Duty of Candour, correspondence or meetings to discuss incident) (*Apology given* *Given information and offered opportunity to complain* *Informed of the investigation* *Arranged a meeting to discuss the report and its findings*)

Chronology (timeline) of events (A list of key events)	

Detection of the incident (How and/or when the incident came to light)

Conclusion (A discussion as to the outcome of the investigation and why the incident occurred. It must be evidentially linked to information in the report)

Care and Service Delivery problems (Care Delivery: relates to direct provision of care arising during the process of care – usually actions or omissions by members of staff. E.g. (1) care which deviated beyond safe practice (2) the deviation had at least potential direct or indirect effect on the adverse outcome for the patient, member of staff or 'general public'. Service Delivery: failures identified, which are associated with the way a service is delivered and the decisions, procedures and systems that are part of the whole process of service delivery.)	
Care Delivery problems	
Service Delivery problems	

Contributory Factors (Factors which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of Care or Service Delivery problems occurring. Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. Generally speaking, the removal of the influence may not always prevent or significantly reduce the chances of recurrence.)

Root Cause(s) (The prime reason(s) why the incident occurred; fundamental factors, removal of which will either prevent or reduce, the chances of a similar type of incident occurring in similar circumstances in the future. Root causes should be meaningful – not sound bites such as communication failure – and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient)

Lessons Learnt (Key safety and practice issues identified, which may not have contributed to this incident but from which others can learn)

Recommendations (Courses of action that are recommended to address the problems identified and analysed during the investigation. They must be directly linked to the root causes and lessons learnt and should be clear but not detailed – detail belongs in the action plan.)

Arrangements for Shared Learning (How lessons learned/changes in practice have been/will be shared locally/Trust-wide/with other organisations: by who and when by)

Author		
Name	**Title**	**Date**

Action Plan

Organization Name:		**Individual Completing Action Plan:**	
Service Line:		**Phone:** **Email Address:**	
Action Plan Title:	*(inc SIRI/HRI/Complaint ref)*		
Start Date:		**Finish Date**:	
The aim of this Action Plan is to:			
Evidence Base / Rationale for undertaking this Action:			
Audit requirements/links identified as: ***(ref to 'evidence of completion' column)***			

(G = in progress/completed; A = not yet started; R= Delay against timescale)

Issue 1	Action Required	Start Date	Finish Date	RAG	Action Owner	Outcome / Target	Evidence of Completion

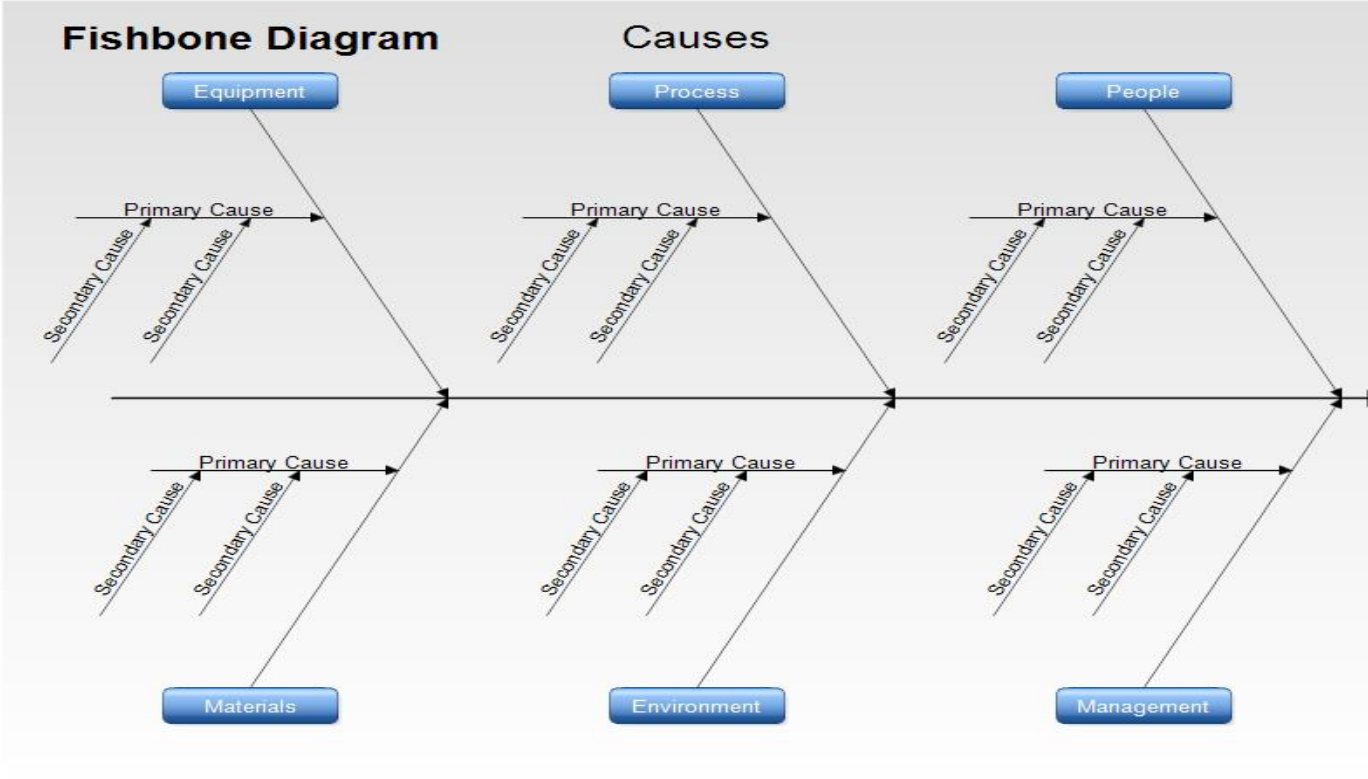
Issue 2	Action Required	Start Date	Finish Date	RAG	Action	Outcome / Target	Evidence of Completion

					Owner		

Issue 3	Action Required	Start Date	Finish Date	RAG	Action Owner	Outcome / Target	Evidence of Completion

Group signed off:	
Sustainability for this Action Plan:	
Action Plan completed:	

Example Fishbone Diagram



A cause and effect diagram, also known as an Ishikawa or "fishbone" diagram is a graphic tool used to explore and display the possible causes of a certain effect. In a typical Fishbone diagram, the effect is usually a problem needs to be resolved, and is placed at the "fish head". The causes of the effect are then laid out along the "bones", and classified into different types along the branches. Further causes can be laid out alongside further side branches.

A cause and effect diagram has a variety of benefits:

- It helps teams understand that there are many causes that contribute to an effect.
- It graphically displays the relationship of the causes to the effect and to each other.
- It helps to identify areas for improvement.

The main goal of the Fishbone diagram is to illustrate in a graphical way the relationship between a given outcome and all the factors that influence this outcome.

Appendix 5 – SIRI Panel Terms of Reference

1. Purpose

The SIRI panel is responsible for ensuring that when a SIRI occurs it is properly investigated in line with the Trust and relevant National Policy. Each completed SIRI investigation must adequately reflect the rigour and requirements from the SIRI Strategy meeting with a supporting action plan with time specific actions to be completed by service leads.

The panel will ensure that, following review of the report it is either accepted in full, or accepted with further amendments to be undertaken or rejected. If accepted it will be used to advise and seek assurances from the care groups or service line if applicable Divisional Clinical Governance Leads' Clinical Governance Subcommittee. The Subcommittees are responsible for ensuring that all recommendations are implemented and clearly noted at their governance meetings. The care groups or service linel Clinical Governance Leads' Clinical Governance Subcommittee is accountable to the Quality Improvement and Risk Group and the Clinical Directors are required to provide the Assurance Committee with suitable assurances on the status of all action plans. The Quality and Risk team are required to maintain a database of action plans and ensure that actions are completed and the plan updated.

The Panel will receive from service lines standardised template reviews of all inpatient expected deaths.

The SIRI Panel's main functions are:

- To receive a list of all new SIRI and a status update report on all SIRI. (This will include details of SIRIs submitted to Solent's Commissioners for a confirmation of final closure) Specifically the Panel will review all inpatient unexpected deaths as SIRIs and inpatient expected deaths as part of the Trust Mortality Review process ;
- To receive SIRI investigation reports in the agreed Trust NPSA adapted format, and with an accompanying action plan;
- To receive themes from complaints, staff and patient feedback, incident reports and triangulate with mortality reviews
- Ensure that the report reflects the commissioning brief and has determined contributory factors, root causes, and lessons learnt;
- Assess the level of quality of the investigation, ensuring that the report is written to an appropriate standard and is a formal record of the investigation process with clear findings and recommendations. Investigation reports are then submitted to external stakeholders, namely the Commissioners and NHS England;
- To ensure reports are completed within the timeframe appropriate for the level of investigation, which will allow one week for review of the report and a further week for distribution before panel and that these timeframes are explicit in the commissioning brief;
- Comment where the panel believes further investigation is needed either recommending amendments to the report or further specific risk management work outside the initial remit of the report;
- To formally recommend submission in order to request Commissioner Sign off following panel agreement that the investigation is complete and can be closed to NHS Solent;

- To confirm closure on STEIS as a completed provider investigation
- Determine on the basis of individual SIRI received whether trend investigation or aggregated review is required;
- Exception reporting and learning will be shared at the QI&R Group and then reported through to Assurance Committee and Board
- To provide assurance to Commissioners on the Quality Contract on a monthly basis
- To provide assurance to the Board on a monthly basis;
- Ensure that all Being Open and Duty of Candour requirements have been met;
- Employment cases of note, Employment Tribunals and any Whistle Blowing cases will be reviewed at the SIRI panel each month
- To receive information regarding inquests.

2. Aims

The aim of SIRI Panel is to ensure that when a serious incident or unexpected death arises, a consistent and robust investigation process takes place to enable root causes to be established and understood and lessons learnt. There is also an expectation that expected inpatient deaths are discussed and reviewed using the agreed template to enable lessons learnt to be actioned and disseminated.

3. Responsibilities & Scope of Authority

The investigation process will ensure that the panel can:

- Demonstrate the safeguarding of patients, property, the service's resources and its reputation;
- Understand why the event occurred;
- Ensure that steps are taken to reduce the likelihood of a similar event happening again;
- Share the learning for both our directly provided services and commissioning services.

- The responsibilities and tasks of the SIRI panel include **Chief Nurse** (Chairperson)**:**
  - Ensuring consistent rigour is applied to the review of all SIRI received by the panel.
- **Chief Medical Officer** (Vice Chair)**:**
  - Core member responsibility and specific decision responsibility to support quoracy provision outlined under section 5. The Medical Director will chair reviews of mortality. The Chief Nurse may stand in for MD, in his absence.
- **Service Line Clinical Governance Leads :**
  - Ensuring that all SIRI identified in their care delivery units are dealt with effectively and in line with the SIRI Policy providing staff with support to provide the report within the required time frames;
  - Ensuring that commissioning briefs are provided in standard format (appendix A)
  - Ensuring that mortality reviews are provided in standard format (appendix C)
  - Ensure that all reports are delivered in standard format as per policy
  - Ensuring they monitor the quality and effectiveness of the investigations;
  - Assisting with trend analysis;
  - Reviewing the RCA prior to submission to the panel and prepare the associated action plan.
  - To ensure the SIRI action plan ensure all actions are completed.
  - Will be responsible for presenting reviews of expected in-patient deaths

- **Director of HR** (or deputy)**:**
  - Responsible as part of the core decision making part of the panel.

- Specific investigation involvement pertaining to overlapping HR investigations and or aspects of staff performance.

- **Non Executive Director:**
  - Providing an independent perspective to the investigation report and outcomes;
  - Further demonstrating the organisation's commitment to patient safety and improvement.
- **Clinical Risk Manager:**
  - Supporting the quoracy provision outlined under section 5;
  - Sharing responsible for and supported by the Clinical Risk Manager for checking that any minor alterations have been made to reports and action plans following panel prior to submission to the commissioners.
  - Ensuring authors of reports are notified of the panel dates and agree times for presentation at the panel;
  - Submitting the completed SIRI report with action plan to commissioners following panel agreement to close;
  - Ensuring the entry on STEIS is completed and the incident closed as a provider investigation following panel agreement to close;
  - Preparing the agenda for Panel supported by the SIRI Facilitator.
- **Associate Director of Quality & Safety:**
  - Receives the action plan for follow through in the Divisional Clinical Governance Leads' Groups and reports to the Quality Improvement and Risk group when the last action has been completed;
  - Maintaining a record of action plans and liaises with service leads to ensure the agreed time frames are met;
  - Reporting any failure to comply with actions recorded from SIRI investigations through the Quality Improvement and Risk group
  - Ensuring that lessons learned from investigations are submitted to QI+R group

4. Membership:

The SIRI Panel will have standard membership (including a Non-Executive Director) and will meet on a monthly basis.

- Chief Nurse (Chairperson)
- Director of Human Resources & Organisational Development
- Chief Operating Officer
- Chief Medical Officer
- Non Executive Director
- Associate Director Quality & Safety
- l Clinical Governance Leads'
- Head of Patient Safety and Clinical Risk Manager

Associate Membership

- PALS, Complaints and Legal Services Manager
- Named Nurse for Safeguarding Children
- Chief Pharmacist
- Information Governance Manager
- Head of Safeguarding
- LSMS
- Medical Trainees

In attendance:

- SIRI Facilitator
- Service Line Clinical Governance Leads', Operations Director, Clinical Director and the individual investigating officer of the service for which a SIRI is being presented.

5. Quorum

No business shall be transacted at the meeting unless the following are present:

- Chief Nurse (Chairperson)
  OR
- Chief Medical Officer (Vice Chair)

With a minimum of three of the following with additional membership from the core members that reflect the type of SIRIs received:

- Non Executive Director/Chief Operating Officer
- Clinical Risk Manager
- One Service Line Clinical Governance Leads'

6. Extraordinary Panel Meetings:

In order to ensure timely sign off of RCA investigations extraordinary meetings may be organised outside of the monthly SIRI panel for this purpose;

- The Chief Nurse and/or Chief Medical Officer and one other (Chief Operating Officer, Clinical Risk Manager, Non-Executive Director) may together sign-off the report for the organisation outside of SIRI panel. Any reports managed in this way will be presented to the SIRI Panel at the next available meeting for noting.

7. Administration and Format of Meetings

7.1 Meetings will be held monthly. Minutes will be recorded by the SIRI Facilitator, reviewed by the chair and circulated within 5 working days of the panel to ensure any follow up actions can be undertaken within the required reporting framework. Extraordinary meetings are arranged as required.

7.2 Agenda setting will be determined by the Lead for Patient Safety & Quality with the Clinical Risk Manager. Administration will be provided by the SIRI Facilitator. (Appendix B – Template Agenda and action Tracker)

8. Reporting

In the event of Solent NHS Trust receiving a National Enquiry Summary Report with implications for the organisation, the SIRI Panel will agree the actions that need to be undertaken.

8.1 Panel minutes to be presented to the Quality Improvement and Risk group

Appendix 6- Closure Checklist

Closure Checklist

Phase of investigation	Element	Answer (yes/no)	If no, was there a robust rationale and that prevents this affecting the quality of the investigation?
Set up/ preparation	Is the Lead Investigator appropriately trained?		
	Was there a pre-incident risk assessment?		
	Did the core investigation team consist of more than one person?		
	Were national, standard NHS investigation guidance and process used?		
Gathering and mapping	Was the appropriate evidence used (where it was available) i.e. patients notes/records, written account?		
	Were interviews conducted?		
	Is there evidence that those with an interest were involved (*making use of briefings, de-briefings, draft reports etc*.)?		
	Is there evidence that those affected (*including patients/staff/ victims/ perpetrators and their families*) were involved and supported appropriately?		
	Is a timeline of events produced?		
	Are good practice guidance and protocols referenced to determine what should have happened?		
	Are care and service delivery problems identified? *(This includes what happened that shouldn't have, and what didn't happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems)*		
	Is it clear that the individuals have not been unfairly blamed? (*Disciplinary action is only appropriate for acts of wilful harm or wilful neglect*)		
Analysing information	Is there evidence that the contributory factors for each problem have been explored?		
	Is there evidence that the most fundamental issues/ or root causes have been considered?		
Generating solutions	Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed? Are actions assigned appropriately? Are the appropriate members i.e. those with budgetary responsibility involved in action plan development? Has an options appraisal been undertaken before final recommendation made?		

Throughout	Is there evidence that those affected have been appropriately involved and supported?		
Next steps	Is there a clear plan to support implementation of change and improvement and method for monitoring?		
Overall assessment and feedback			

Appendix 7 – Individual Mortality Review Mortality Review: complete this form for each death.

Age of patient	Sex:	Hospital Number:
Admission Date:	Date of Death:	Ward/ Place of death:
Reason For Admission:		
Primary diagnosis at admission:		
Responsible Clinician at time of death:	Other Consultant/s involved in episode:	
Summary of clinical details relating to the mortality (light touch):		
Cause of Death as put on death certificate		
1a:		
1b:		
1c:		
2:		
Case referred to Coroner? (circle/delete as appropriate) YES / NO		
Post mortem performed? (circle /delete as appropriate)		
	Yes – coroner's PM	No
Categories	**Explanation ?why – justify choice as you see fit/ appropriate**	
Expected Unexpected		
Was the patient admitted to the appropriate ward?	*Include information about why the patient was admitted to this ward and if another ward/care home etc would have been more appropriate*	
Was the patient on the end of life pathway?	*Was the pathway clear and did staff follow the pathway?*	

What were the palliative care needs of the patient?	*Were these needs documented/discussed and were they met?*
Could anything have been done differently to improve outcome and care quality?	*In your opinion could anything have been done differently to improve the experience for the patient? Was the patient regularly reviewed etc?*
Did the patient suffer harm from a condition unrelated to their presenting complaint?	*(E.g. fall, pressure ulcer, CVA, complication of procedure, MI, hypoglycaemia, drug related problem, haemorrhage, health care associated infection, VTE, Acute Kidney Injury)?* *If yes, specify here:*
Recognition and response issues (timeliness and appropriateness)	*Was any deterioration recognised and what actions were taken?*
Escalation & DNAR decisions **(were there any concerns)**	*Was there a documented DNAR and were staff aware and were there any concerns?*
End of Life issues **(was it a good death experience for all?)**	*Did the patient die in a place of their choice? Were they alone or with their chosen relatives/friends/carers. Were they comfortable?*
Were the patients spiritual needs identified and met?	
What could be improved **(clinical or system issues)**	
Should this death be considered in more detail at next month's mortality meeting?	

UNEXPECTED DEATHS **IF UNEXPECTED THEN COMPLETE BELOW AS IS RIGHT FOR CASE.**

Learning points and actions to take forward – clinical

Learning points and actions to take forward – systems and processes
Actions to improve care quality - by who and by when to improve outcome

Signed: _____

Role: _____

Date: _____ / _____ / _____

Appendix 8 – Service Line Mortality

[Service line Mortality Review]

Report Written by:	
Contact Details:	
Report Completion Date:	
Service	

Report Outline

Action Taken:

Methodology:

The Trust's standard Mortality Review proforma was adapted and used for data collection, which assesses the clinical information, identifies areas of good practice and where improvements can be made. A copy of the data collection tool is appended.

Reviewing team:

Patient Selection:
Example: Number of patients etc

Results
Example:
Patient age ranged from 50yrs to 95yrs. Average age of patient was 78yrs.

Review of the notes revealed the following:

Of 31 patients, 22 were admitted directly from their home and 8 were admitted from either a care, nursing or residential home. One patient was admitted as a transfer from SWICC (Swindon Intermediate Care Centre).

Of 31 patients, 13 were diagnosed with Pneumonia or Pneumonia related conditions upon admission. Remaining diagnoses on admission include sepsis, cellulitis, acute renal failure, DVT, atrial fibrillation, infection exacerbation of COPD, breast cancer, acute pulmonary oedema, left pleural effusion and general deterioration in health.

Of all the admissions, 16 patients were admitted out of hours.

All patients had multiple co-morbidities.

Fourteen patients had an End of Life Care Pathway in place, and of the remaining 17 patients, it was felt that a further 4 patients should have had an end of life care pathway in place.

Twenty-five patients did not express any end of life wishes. A relative of 1 patient had confirmed there were end of life wishes, but was unable to provide details.
The family of 1 patient expressed wishes for a transfer to a residential nursing home. Unfortunately the nursing home did not respond to the transfer request.
Of the remaining 4 patients it was not known if the patient had expressed end of life wishes.

Conclusions

CLINICAL REVIEW: Example:

- Standards of record keeping remain inadequate particularly in terms of patient identifiers on each sheet
- Some patients with advanced diseases such as dementia and are clearly dying would be better cared for in the nursing home where they live – better advance care planning for these patients is needed.

Recommendations

- ***List recommendations***

Report presentation / dissemination

It is intended this report to be presented to:

- Solent SIRI and mortality review panel
- Service line Governance Meeting

Acknowledgements

- Name/s of Clinician/s
- Name of Clinical Audit Facilitator

Appendices

- Clinical Audit Action Plan
- Data collection proforma (where used)

Summary of case reviews and key learning

Appendix (a): Clinical Audit Action Plan

KEY Status – (1) Recommendation agreed but not yet actioned, (**2)** Action in progress, (**3)** Recommendation fully implemented, **(4)** Recommendation never actioned (please state reasons) and (**5)** Other (please provide supporting information)

Project Title:			
Action plan lead:	**Name:**	**Title:**	**Contact:**

Ensure that the recommendations detailed in the action plan mirror those recorded in the "Recommendations" section of the report.
The "Actions required" should specifically state what needs to be done to achieve the recommendation.
All updates to the action plan should be included in the "Comments" section.

Recommendation	Actions required	Action by date	Person responsible	Comments/ Action status (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)	Change stage (see key)

Appendix (b): Data Collection Form *(Please attach)*

Appendix (c): **Summary of case reviews**

Case No.	Case Summary	Learning points / Comments
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Appendix 9 – Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	Ans
1. What are the main aims and objectives of the Document?	To detail the reporting and management of Serious Incidents Requiring Investigation (SIRI)
2. Who will be affected by it?	All staff who might be involved with or be informed of an incident
3. What are the existing performance Indicators/measures for this? What are the outcomes you want to achieve?	N / A
4. What information do you already have on the Equality impact of this document?	N o
5. Are there demographic changes or trends locally To be considered?	N /
6. What other information do you need?	N /

Step 2 - Assessing the Impact; consider the data and research	Yes	No	Answer
1. Could the document unlawfully discriminate Against any group?		x	
2. Can any group benefit or be excluded?		x	Applies to all staff groups
3. Can any group be denied fair & equal access To or treatment as a result of this document?		x	N/A
4. Can this actively promote good relations with And between different groups?		x	N/A
5. Have you carried out any consultation Internally/externally with relevant individual groups?	x		NHSLA & Policy Steering Group members SIRI Panel members Associate Directors & relevant Senior
6. Have you used a variety of different methods of consultation/involvement	x		Via email and face to face meetings
Mental Capacity Act implications			
7. Will this document require a decision to be Made by or about a service user? (Refer to the Mental Capacity Act document for further information)		x	Does not apply to patients

If there is no negative impact – end the Impact Assessment here.

Solent NHS
NHS Trust

Appendix 10 – SIRI Flow Chart

	Reported (usually via the Incident or Complaints Reporting System)	
	Assessed and formally declared as a SIRI, by an Executive Director where possible	
1 DAY	Service requested to provide assurances of initial safety and summary review of the incident. Engagement with patients or others must be in-line with the Being Open Policy.	Quality & Risk Team
	All Directors, Clinical Lead and Communication Team are notified of core details of SIRI (via standard e-mail template). Other leads as required e.g. Safeguarding. The CEO will alert the Chair where necessary.	
2 DAYS	Reported to Commissioners using STIES, citing applicable information and where applicable, others such as CQC, HSE, Police (ideally this would be after the strategy meeting; however it must be reported to commissioners in 2 days). The Head of Risk & Quality Assurance will be responsible for the content of this update.	Quality & Risk Team
3/4 DAYS	Internal Strategy Meeting is arranged (within 2 working days)	Quality & Risk Team
	Formal 72 hour update will be submitted to Commissioners by the Quality & Risk Team from information made available. The Head of Risk & Quality Assurance will be responsible for the content of this update.	Quality & Risk Team
	Strategy Meeting is convened – responsible for establishing the key ToR and ensuring a suitable investigator is or has been identified and to ensure any other significant implications are addressed e.g. Safeguarding and HR.	Operations Director
	Investigator and Executive Lead is appointed and informed that the investigation and report must be completed within 25 days (from the time reported to Commissioners) and presented to the applicable Service Line Operational Director. *May need extraordinary meeting.	
20 DAYS	The Quality and Risk Team to seek update from the investigator and Operational Director.	Quality & Risk Team
25-31 DAYS	The report will be issued to the Operations Director who will assess the level of any further involvement of the Clinical Director.	Operations Director
	The investigation report must be signed-off by the Service Line.	
	The investigation report must be submitted to the Quality and Risk Team within 31 days. The report will be reviewed.	Quality & Risk Team
31-45 DAYS	The Quality and Risk Team will ensure the report is submitted to SIRI Panel agenda 7 days before the meeting.	Quality & Risk Team
	SIRI Panel will convene and approve or reject the report, including accepting recommendations. Where the report is accepted, subject to some changes, the panel will formally request that these changes are made before submission to commissioners with the 45 day timeframe.	SIRI Panel
	The Operational Director will be formally informed to ensure that any action plan is locally and formally monitored to conclusion, ensuring that the Service Line Clinical Governance Groups are fully assured.	Operations Director
	The Operational Director / Clinical Lead will be required to well versed, proved a level of assurance to the Assurance Committee.	Operations Director & Clinical Lead