Serious Incident Action Plan 2019 for Mental Health & Learning Disability Delivery Unit

Intervention into Systems & Processes for the Management of Serious Incidents at Abertawe Bro Morgannwg University Local Health Board

Serious Incident Reporting

Objective	Action(s)	Target Date	Lead	Desired Outcome Outcome Measure	Progress
Improve Reporting Culture	Publicise a bulletin reinforcing the importance of Datix reporting including a quick reference guide on how and where to report Communication to be endorsed by Unit Nurse and Medical Director	End of April 2019	Quality & Safety Manager MH & LD Deputy Nurse Director MH & LD	Overall increase in the number of Datix reports Monitor improved reporting trend via Datix audit	Bulletin will be issued before end of April.
	Monitor for trends and themes of reporting across MH/LD services/localities MH/LD to report Datix trend analysis to Health Board Q&S forum	6 month on-going review	Quality & Safety Manager MH & LD	Overall increase in the number of Datix reports Monitor improved reporting trend via Datix audit	Monthly reports to Delivery Unit Management Board and Delivery Unit Quality & Safety Committee are in place.
Improve Timeliness of Reporting	Improve timeliness of initial Datix incident reviews, reaching an initial grading decision within 48	By 1st May 2019	Quality & Safety Manager MH & LD	Improved performance in keeping or exceeding set	A revised process has been introduced for managing Datix Incidents whereby 1st

	hours (working days)			timeframes. Monitor via Datix audit, reported to Quality Safety Committee and weekly high risk	line approval will be undertaken by a member of the Quality & Safety Team. This will allow 100% of incidents to be reviewed within 48 hours.
	Improve timings for submission of Welsh Government (WG) Serious Incident notifications to Corporate services	100% by 1st May 2019	Quality & Safety Manager MH & LD	Improved performance in keeping or exceeding set timeframes. Monitor via Datix audit, reported to Quality Safety Committee and weekly high risk	As above
Improved Assurance from Service Senior Management Team	Increased assurance of WG SI Forms before submission to Corporate services All SI forms to be assured by Unit Nurse or Medical Director or nominated deputies	By end of February 2019	Quality & Safety Manager MH & LD	All SI notifications are endorsed by Unit Nurse Director or nominated deputy Monitor via Serious Incident Team Concerns meeting and reporting	Complete All forms approved by Medical Director, Nurse Director or Deputy or Head of Operations.
Increased Reporting of MH/LD Deaths Occurring in Community	Develop SOP for collaborative approach with Primary and Community Services regarding MH/LD deaths occurring in Primary Care to ensure all deaths are identified and reported by the appropriate service	By end of May 2019		Agreed SOP	Head of Operations to discuss with Primary Care colleagues

Increased Corporate Assurance of Serious Incident Notifications	All Unit Nurse/Director agreed SI notifications to be reviewed by Assistant Director of Nursing or Medical Director for Quality & Safety and Patient Experience before executive sign off	By end of January 2019	Assistant Head of Concerns Assurance	Monitored via WG reporting and closure emails from Improving Patient Safety	Completed

Serious Incident Investigation

Learning	Action(s)	Target Date	Lead	Desired Outcome Outcome Measure	Progress
Clear Pathway for Review of all Deaths	Framework to determine the appropriate level of investigation/review i.e. RCA investigation, or local case note review etc.	By end of February 2019	Quality and Safety manager	Timely identification at initial strategy meetings to determine most appropriate method of investigation	Initial strategy meetings introduced in 2018. All SI Reports are received at SIG and the level of investigation agreed.
	Framework to determine standardised process for; • Reporting/identification of incident / death • Proportionate level of review • Escalation of review when higher level of review is required • Assurance process • Arrangements for learning	By end of February 2019	Quality and Safety manager		Framework agreed at February SIG meeting.
The Delivery unit needs additional resources to complete the RCA investigations in a timely manner	Member of Quality & Safety Team currently undergoing RCA buddy training with member of Corporate Team	By end of January 2019	Unit Nurse Director / Head of Operations	Serious Incident group to receive a monthly update on SI position and resources and consider remedial actions as available.	Buddy training ongoing and staff member has undertaken first review with Consultant as Clinical Adviser.

	Case for additional resources prepared, to be considered at Management Board 23rd January 2019.	By end of January 2019	Unit Nurse Director / Head of Operations	Serious Incident group to receive a monthly update on SI position and resources and consider remedial actions as available.	Case for additional resources supported. SI Investigator post advertised with interviews scheduled for 1st March 2019.
	Identification of additional members of Senior Team to undergo RCA buddy training who can then co-ordinate investigations.	By end of April 2019	Unit Nurse Director / Head of Operations	Serious Incident group to receive a monthly update on SI position and resources and consider remedial actions as available.	Agreed in principle. RCA buddy training to be arranged.
A recognised investigation methodology is not applied to all SIs – most cases are reviewed using a non-standardised clinical review approach	Investigations will use the HB's investigation report and be carried out using a RCA methodology	In progress	Quality and Safety manager	Reports will be presented to SIG where Assistant Head of Concerns Assurance for the HB will attend to provide external scrutiny	Corporate representation at SIG now re-established. The Delivery Unit has adopted the HB's SI template for investigation reports and is using a RCA methodology.
	Investigators will use the RCA methodology and receive clinical advice from consultants and other specialists. Investigations will be led by Quality & Safety Team with relevant clinician acting as clinical adviser.	By end of June 2019 once additional investigation capacity has been increased	Quality and Safety manager	Reports will be presented to SIG where the Assistant Head of Concerns Assurance for the HB will attend to provide external scrutiny	The Delivery Unit has started to use this approach and will do for all cases once the department is fully established with the additional resources.
	RCA mentoring will be provided to investigators via one to one support	In progress	Health Board SI team	Agreed in a cross HB meeting to discuss mentoring for serious incident investigations	
Improve	Human factors training	February 2019	Quality and	To be discussed at SIG	Members of the Quality &

Understanding of Human Factors and their Correlation with Serious Incidents			Safety Manager		Safety Team undertook Human Factors training on 20th February 2019. Consideration will now be given to extending this within the Delivery Unit.
Some issues require input from other services to develop solutions, for example, care of mental health patients presenting to the Emergency Department (ED). ED services were not present in the meeting nor had they been involved in the investigation.	All investigations will commence with the preparation of a timeline and the identification of all parties who need to be involved in the investigation.	In progress	Quality and Safety Manager	Reports will be presented to SIG where SI lead for the HB will attend to provide external scrutiny	This is now in place.
The Unit Nurse Director who has a lead role for quality and safety, was not present at the meeting neither was she included as a	The Nurse Director is a member and vice chair of the group	Complete since May 2018	Head of Operations	Nurse Director will attend all meeting as detailed in TOR	Completed

member of the group on the Terms of Reference					
The membership is drawn from with the MH & LD DU and lacks robust independent scrutiny and challenge that would reassure patients and families	TOR for Serious Incident group to be updated to include a senior member of the corporate ABMU Serious Incident team	Complete		Assistant Head of Concerns Assurance included on the TOR for MH & LD Serious Incident Group	Member of Corporate SI team now attends SIG.

Serious Incident Governance & Learning

Objective	Action(s)	Target Date	Lead	Desired Outcome Outcome Measure	Progress
Defined Assurance Process	Develop MH/LD service level assurance sign-off pathway for all levels of investigation/review Incidents managed under SIG process to be reviewed and assured prior to presentation at SIG	By end of April 2019	Quality and Safety manager		This is now in place.
	Defined and agreed escalation process from service to Corporate level for high-risk cases	By end of April 2019	Quality and Safety manager	Appropriate identification of incidents that require higher level (executive) oversight/support	Executive High Risk Lookback meetings are established. Assistant Head of Concerns Assurance reports to High Risk where appropriate
Increased Corporate Assurance of Serious incident Closure Forms	All Unit Nurse/Director agreed SI Closures to be reviewed by Assistant Director of Nursing for Quality & Safety and Patient Experience before sign off	By end of January 2019	Assistant Head of Concerns Assurance	Monitored via WG reporting and closure emails from Improving Patient Safety	
Corporate Assurance of SIG Process	Final terms of reference to be agreed by Health Board Nurse and Medical Director	By end of April 2019	Quality and Safety manager	Corporate sign off of SIG TOR	

	Paper to HB Q&S forum on 19 February 2019				
Defined Learning Pathway	Development of learning pathway, mapping lessons learned via forums and committees such as Quality and Safety Pathway to define communication pathway for learning into service areas	End of May 2019	Quality and Safety manager		MH/LD learning strategy in place Learning Matrix being enhanced (see below)
Improved Assurance on Actions and Recommendations	Further development of learning Matrix to ensure timely implementation of actions/recommendations	End of May 2019	Quality and Safety manager		
Membership & Attendance of National Collaborative for Serious Untoward Incidents	Frequent attendance at National Collaborative when relaunched in 2019	TBC	Quality and Safety manager		14 members of MH & LD senior staff attended the Collaborative Event on 13th February 2019. Director of Psychology & Therapies, Deputy Nurse Director and Quality & Safety Manager attend the quarterly meetings.
Improved Action Planning	Action plan training	End of May 2019	Head of Risk & Legal Services		

Updated 26.2.18 Janet Williams- Head of Operations MH&LD