Supporting Section 4 – joint investigation process

Where multiple organisations are involved in a single patient safety incident, a joint investigation in line with section 17 of the Regulations may be required. While a joint investigation should meet the same standards and requirements of any patient safety incident investigation as described in the Policy, there may be logistical differences in terms of how a joint investigation is conducted in practice.

This section, developed collaboratively by an All-Wales NHS Task & Finish Group, provides guidance and a structure for joint investigations involving multiple organisations although it is recognised that the process may need to be tailored to meet the needs of the patient or service user, organisations and/or depending on the complexity of the incident.

Joint incident management meetings

Joint incident management meetings are considered to be an essential element of the early process of starting to investigate a patient safety incident, to facilitate discussion and joint decision-making as soon as practicable after an incident has been identified.

Where possible, the format and membership of this meeting should be considered and understood ahead of time to enable meetings to be quickly established as required.

The below principles may help Health Boards and Trusts in establishing joint incident management meetings:

Relevant membership, which may include:

- Health Board/Trust representatives – while information from all relevant aspects of the patient's care should be captured (including emergency care, primary & community care, flow management etc.). Note: this may not necessarily require multiple Health Board/Trust representatives at the meeting, within the organisation there may need to be a process for information sharing and delegation to a single or small number of Health Board representatives in order to facilitate a timely meeting;
- Relevant social care/Local Authority engagement;
- Relevant independent/private providers;
- Other stakeholders engaged in commissioned services related to the incident.

Consideration should be given to:

- Whether meetings are established on a local or regional basis;
- The frequency of meetings, noting the expected timescales set out in the process below;
- Whether meetings are set up as routine (e.g. each fortnight) and/or in response to individual incidents.

Standard data set

As the purpose of the meeting is to have a rapid, informed discussion to support joint decision making, it is important that appropriate information is available to all members ahead of the meeting.

This could include:

- a list of incidents requiring joint discussion, and
- for each incident under discussion, a standard set of data including, where relevant and applicable:
    - Patient notes from the relevant episode(s) of care
    - Any relevant recent patient history including related to episodes of care, relevant discharges, outpatient appointments, primary and community care etc.
    - Operational position of relevant organisations
    - Any records of communication between relevant organisations
    - Mortality Review and Medical Examiner records
    - Information on any other concerns linked to the same patient

Investigation methodology

Consideration should be given to the use of the appropriate investigation methodology/ tools depending on the circumstances of the incident.

Although relevant for all incident investigations, the concept of systems thinking and taking systems-based approaches will be of particular importance to joint investigations, in order to study and understand the interfaces and interactions between different component parts of the healthcare system and community.

Regardless of the methodology used, the use of the Yorkshire Contributory Factors Framework is required as part of the investigation analysis, to facilitate local, regional and national collation and analysis of data.

Overview of joint investigation process:

1. The organisation who identifies that an incident has occurred is responsible for reporting the incident on their local Datix Cymru system in line with local requirements. This should be within one working day of identification of the incident.
2. In line with the organisation's local processes, the incident will be reviewed in a timely manner to assess the circumstances and determine next steps. It is expected that this review will take place within two working days of the report being made. A routine part of this review will be to consider if a joint incident management meeting is indicated.

Where a joint incident management meeting is indicated, the identifying organisation will initiate the joint review process with organisations relevant to the incident. This includes:

- identifying potential stakeholder organisations required for the joint incident management meeting;
- making stakeholder organisations aware of the circumstances of the incident, and of the indication for joint review and requesting relevant data to be collated ahead of the joint incident management meeting; and
- ensuring that the incident is discussed at a joint incident management meeting in a timely manner. This is expected to take place as soon as possible and usually within two weeks of identification of the incident, recognising that there may be occasions where this timescale is exceeded due to complexity.

3. To support discussions in relation to the incident, the data described in the standard dataset should be made available, where possible, to all parties involved in the joint incident management meeting. However, not having all the data should not prevent the discussion taking place.

4. The incident should be discussed at the joint incident management meeting to make a joint decision on whether it requires a joint investigation.

   - If the decision is that the incident <u>does not</u> require a joint investigation, then the rationale for this decision should be documented as part of the minutes for the joint incident management meeting. Consideration must be given to whether an individual organisation should carry out an investigation under PTR.
   - If the decision is that the incident <u>does</u> require a joint investigation, then the following points should be discussed and agreed (the below may be used as the template for an agenda, if helpful):
     - Clarity on what the incident is, as well as the outcome
     - Consideration of the level of harm arising from the incident (using the current knowledge available) as this will inform and influence actions under PTR
     - Scope and Terms of Reference for the joint investigation
     - Investigation methodology to be used and expected timescales for completion (30, 60, 90 or 120 days)
     - Roles and responsibilities of all organisations involved in joint investigation
     - Agreement of who will be the lead organisation, with responsibility for acting as the Single Point of Contact for the patient, service user or person acting on their behalf
     - Decision on any national reporting requirement (NRI)
     - Decision on any other external reporting that may be required
     - Plan to support staff who have been involved in the incident

- Governance and sign off arrangements for the final investigation report
- (if needed) plan for coordination with other concerns processes e.g. complaints, inquest
- Safeguarding considerations
- Media and communications considerations

5. Consideration of the lead organisation should be taken on a case by case basis. When deciding the lead organisation, consideration should be given to factors such as:

   - the patient must be put at the centre of the investigation so the primary consideration needs to be, which organisation will be best placed *for the benefit of the patient or service user and any person acting on their behalf* to undertake the lead role which will include acting as the single point of contact for the patient/family;

   - what the actual incident is and where it occurred, which may be different to where harm and/or the incident was identified.

6. All NHS Wales organisations involved in the joint investigation will raise an incident on their local Datix Cymru system, clearly coding this as a joint investigation with the relevant reference details for the other organisations for cross-matching purposes.

   Non-NHS Wales organisations should give consideration to their own local recording requirements.

7. Should the incident meet the threshold for national safety incident reporting, the lead NHS Wales organisation will undertake any national reporting requirement, taking into account the guidance provided in Section 15 of the Policy on incidents occurring in commissioned services.

8. The lead organisation will engage the patient, service user or person acting on their behalf in line with the requirements of PTR and the Duty of Candour. For incidents where moderate harm or above has resulted, this will include proactively making contact with the patient, service user of person acting on their behalf at the earliest appropriate opportunity, and engaging them in the investigation process, including understanding events from their perspective and ensuring any of their questions are taken into consideration as part of the investigation. Involvement of the patient, service user or person acting on their behalf should be undertaken throughout the investigation process.

9. Following the joint decision to undertake a joint investigation, a proportionate investigation will be jointly undertaken by the relevant stakeholders utilising the chosen methodology and within the stipulated timescale. Regardless of the methodology chosen, the joint investigation must include analysis in line with the Yorkshire Contributory Factors Framework (YCFF).

10. The end product of the joint investigation will be one investigation report which covers all parts of the patient's journey relevant to the incident, incorporating the YCFF analysis, along with identified areas for improvement.

    - It is essential that action is taken to address the identified areas for improvement, consideration should be given to whether this is best addressed through a stand-alone action plan or via a thematic action plan.

11. The joint investigation report will be submitted through the governance and quality assurance mechanisms for sign off as agreed at the strategy meeting.

12. Once the joint investigation report has been finalised, each NHS Wales stakeholder organisation will:

    - update their Datix Cymru record with the investigation outcomes and contributory factor analysis; and

    - share the outcomes and learning from the investigation within their organisation.

13. In addition to the above, the lead organisation will:

    - if the incident was nationally reported, complete any outcome requirements associated with the notification, including sharing the contributory factor analysis at a national level; and

    - complete any relevant PTR requirements in line with the organisation's governance processes, including engaging with the patient, service user or person acting on their behalf about the final investigation report.