Serious incidents & Never Events investigating process

Within 2 working days

- Confirm as serious incident
- Report internally and externally
- Appoint a Lead Investigator (RCA trained) and support team
- Convene a scoping meeting for investigation; define terms of reference
- Ensure initial Duty of Candour initiated
- Obtain clinical records
- Organise date for debriefing meeting

Within 3 working days

- Complete 72 hour brief and inform CCG and NHSI
- Request statements, where appropriate
- Identify and communicate to staff who are required to be interviewed
- Contact patient/family/carer with offer of interview/involvement in investigation process
- Diarise all meetings for investigation team

Within 25 working days

- Interview patient/family/carer (if accepted)
- Interview all staff identified at scoping meeting
- Review all statements
- Obtain all relevant policies, guidelines and pathway documentation
- Timeline of events
- Populate appropriate RCA tools
- Mid point review meeting between Investigation lead, Patient Safety Manager and Lead from Directorate/Specialty
- Contact experts as required
- Further interviews or statements identified and obtained/carried out

Within 35 working days

- Investigation team to meet and discuss findings
- Final draft of investigation report prepared by the Investigation Lead (incident details, family concerns, RCA, contributory factors, recommendations and actions, monitoring)
- Appendices of draft report finalised by the Patient Safety Team
- Full debriefing meeting for those staff involved
- Define actions necessary to prevent recurrence (SMART)
- Identify how lessons/changes in practice will be achieved, shared and monitored

Within 50 working days

- Final draft of investigation report reviewed for challenge and 'sign-off' by Medical Director / Chief Nurse (for Never Events additional approval from CEO and NED required)
- Final approved draft sent to CCG
- Provide feedback to the patient / family as agreed (Duty of Candour)
- Investigation closed

On-going

- Implement the recommendation and learning from the investigation
- Organisation-wide communication of the lessons learned
- Follow-up progress on action plan delivery and non-compliance escalation to the Patient Safety Committee

Within 50 working days

Support and involve those affected (including patients, victims and their families and staff

Opportunities for feedback and learning identified and information shared