Memorandum of Understanding for Multi-Agency Serious Incidents Requiring Investigations

1 Introduction

1.1 In March 2015, NHS England published the Serious Incident Framework explaining the responsibilities and actions for dealing with Serious Incidents and the tools available. It outlines the process and procedures to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. This memorandum details how multi-agency incidents should be reported, investigated and monitored. CCGs Incident Reporting Policies should be read in conjunction with this document.

1.2 The benefits of a robust multi-agency investigation, (in the absence of any other appropriate process), have been demonstrated. It is recognised that identification of the root causes of an incident and then, importantly, specifying and sharing the learning are a vital part of any investigation. Investigating complex and serious cases within one agency can be challenging, but when more than one agency needs to be involved, the challenges are much greater. It is recognised that there is a need for an agreed multi- agency process to support such investigations. In response, and as an adjunct to safeguarding procedures and serious case reviews, where appropriate this memorandum seeks to establish a governance process through which multi-agency investigations can be commissioned and completed.

1.3 The purpose of the document is to provide a framework through which the organisations within the NHS England South footprint may commission a multi-agency RCA investigation (MARCAI) where no other process exists. The document is designed to ensure that an agreed process is followed when a MARCAI is deemed appropriate and that proper governance arrangements are in place to facilitate the investigation. It must not replace any safeguarding or other single agency process but provides an adjunct to existing processes to be used where appropriate. For investigations that cross Independent Sector and Voluntary Sector organisations the Memorandum may be issued for agreement with those organisations at the time.

2 Multi-Agency Incident Reporting and Monitoring

2.1 The NHS has put patient safety and patient experience at the centre of the delivery of high-quality care. It is important that where care traverses organisational boundaries and when errors occur, the organisations within the health and social care system can demonstrate that a thorough investigation has taken place and that learning from the incident has been identified and shared.

2.2 All incidents should be investigated at the appropriate level and it should be demonstrated that learning has been gained from the investigation. Where serious or catastrophic incidents have occurred, Root Cause Analysis (RCA) methodology or another suitable investigation process should be employed and the root causes of the incident identified. Where an incident occurs and a multi-agency approach is needed, the commissioners should expect to be involved, and the organisations within the health and social care system should work willingly together to investigate and to learn. Incident trends across the system should be analysed and action plans put in place to address issues arising.

2.3 This memorandum cannot and must not replace any criminal, statutory or non-statutory safeguarding process rather it is intended to provide an opportunity for a multi-agency investigation to be undertaken where either safeguarding thresholds for investigation are not met, there is no other obvious mandated process for the investigation or this is specifically agreed as a complimentary process by the relevant Safeguarding Board

2.4 The consent necessary to investigate an incident should always be obtained at the outset in order to maintain continuity between agencies, enable effective information sharing, and to minimise anxiety for people and their families or carers. Whilst explicit consent is not always necessary in order to carry out an investigation using client records, “best practice” is to gain written consent that enables all agencies involved to produce and share their records for the purposes of the investigation. The agency that starts the investigation should gain consent on behalf of all agencies that are likely to subsequently be involved in the investigation. Due to the confidential nature of the professional to client relationship, written consent from the individual provides written proof that the person is willing for all records to be shared with the investigation team.

2.5 Information Sharing Agreements must be signed by the relevant agencies to enable the effective sharing of relevant client information so that multi-agency investigations can take place without delay. The "Overarching Information Sharing Protocol for Health and Social Care Organisations in Devon" has been signed by the main health organisations and local authorities in order to share client information in specific circumstances, and this agreement enables the sharing of patient information in line with the following justifiable purposes, Acts and Guidelines:

- Assuring and improving the quality of health, treatment and services
- Section 22 of the NHS Act 1977: the duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of people.
- Data Protection Act 1998
- Common Law Duty of Confidence
- Caldicott Principles

2.6 Where the lead organisation can be clearly identified this should be confirmed as early as possible to NHS England South, the commissioners and the other agencies involved. Where there is no clear organisational lead it would be expected that an Executive level discussion to agree leadership for the investigation process should take place as soon as feasible upon notification of the incident to the commissioner. Leadership should be determined by the level of independence required, the complexity and seriousness of the issue, capacity of the organisation to lead the investigation and level of accountability for the care pathway. It may be an option for the investigative team to be made up of personnel drawn from the agencies involved.

2.7 The investigation will then be commissioned by a Director or Chief Executive from the lead organisation as agreed by the Chief Officers or their designate. Terms of reference for the investigation will be set out by the lead organisation in agreement with the participating organisations and should make clear the purpose of the investigation and the desired outcome. The investigation will involve representatives from all appropriate stakeholders e.g. social care, independent or voluntary sector, the ambulance service, primary or acute care with agreement.

2.8 The investigation will follow the lead organisation's approved internal policy and procedures, using the NPSA Root Cause Analysis methodology or other recognised investigation process in agreement with the Executive lead of each organisation. NHS England South recommends organisations adopt the structure of the Root Cause Analysis Report Writing tools available on the National Patient Safety Agency website.

2.9 The NHS England South Area Team will facilitate investigations and lead those where an independent view is required or where the incident is deemed to be extremely complex. The decision as to whether the CCG will lead an investigation will be discussed with the NHS England South Director of Nursing or another Executive Director in their absence in agreement with the relevant responsible executives within the participating organisation.

2.10 The process for reporting and monitoring will be as recommended in the National Reporting Serious Incidents guidance. The nominated lead organisation will report the incident to STEIS ensuring that other organisations involved have sufficient opportunity to comment on factual accuracy prior to completion.

2.11 All agencies involved will ensure that the investigation is reported through their local internal governance processes, following the previous point.

2.12 The learning and recommendations from the investigation will be shared widely within the Health and Social care community. NHS England South will take overall responsibility for ensuring wider dissemination of learning. Organisations involved with the investigation will take responsibility for the completion of actions identified for their organisation; the commissioner will take responsibility for ensuring that appropriate assurance on actions is in place across the system.

2.13 All signatories to this agreement agree to work closely with partner agencies when investigating an incident and will be open, honest and transparent. The 'no blame' philosophy of the RCA methodology will be the overriding philosophy of the MARCAI.

2.14 The following common governance principles will apply:

2.14.1 All organisations will work in an open and transparent manner with each other when a serious incident has occurred

2.14.2 They will ensure that a board director or equivalent is formally designated to lead on and be responsible for patient safety and the management of serious incidents, and the specific incident in question

2.14.3 They will have systems in place to receive regular briefings on the detail of the investigation

2.14.4 They will ensure that the patient/families or carers and staff a relevant front line staff are kept informed about the progress of the investigation, in line with the 'Being Open' guidance and the Duty of Candour.

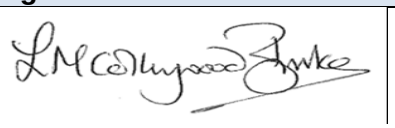
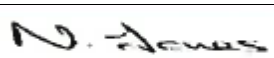
2.14.5 They will manage any staff related issues identified during the course of a MARCAI within the principles of an 'open and just culture'

2.14.6 Ensure that incidents are reported to the appropriate regulatory and healthcare bodies, including CQC, NTDA, Monitor and NRLS, as necessary

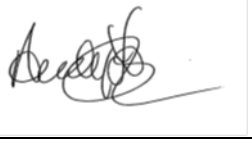
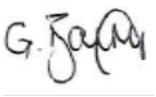
2.14.7 They will ensure that human factors principles are applied during the investigation.

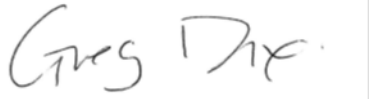
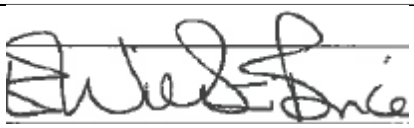
3. Signatories

Signed on behalf of Northern, Eastern and Western Devon Clinical Commissioning Group, South Devon and Torbay Clinical Commissioning Group, Kernow Clinical Commissioning Group and NHS England South.

Signature:	Title:	Date:
	Chief Nursing Officer	2nd December 2015
	Programme Director for Clinical Quality	19th November 2015
	Nursing Director NHSE South	19 November 2015
	Director of Quality Assurance and Improvement **South Devon and Torbay Clinical Commissioning Group**	Thursday, 19 November 2015

Signed on behalf of: (provider organisation)

Organisation:	Signature:	Title:	Date:
Devon Doctors Ltd		Director of Quality and Performance	19th November 2015
Devon Partnerships NHS Trust		Director of Nursing and Practice	3.12.15
Northern Devon Healthcare NHS Trust		Director of Strategy and Transformation	23.11.15
NSL Care Services		Account Director	08/12/2015
Plymouth Community Healthcare CIC		Director of Professional Practice, Safety and Quality	19-11-2015

Plymouth Hospitals NHS Trust		Director of Nursing	17/11/15
Royal Devon and Exeter NHS Foundation Trust		Deputy CEO/ Chief Nurse	26/11/15
South Western Ambulance NHS Foundation Trust		Chief Executive	01/12/2015
Virgin Care		Regional Director of Operations	26th November 2015

Susan Bracefield
Deputy Chief Nurse: NEW Devon CCG
October 2015

4. Principles

A number of principles to support good investigation practice and transparent outcomes have been agreed. These can be summarised as:

1. Reporting should be actively encouraged
2. There should be absolute clarity for all stakeholders of the purpose, content and outcomes for an investigation
3. People (including staff) and the public should be supported and kept informed throughout the process
4. That, where appropriate, expert investigators should be employed to ensure speed, consistency and learning
5. Fact, not assumption, should be an absolute characteristic
6. Openness, transparency and honesty should be a feature in line with 'A Duty of Candour'
7. Good practice should be described and followed
8. Fair and tempered responses are required where there are individual, organisational or system failures
9. Learning must be made widely available across the whole system including voluntary services
10. Independent evaluation should follow large scale investigations
11. Courtesy and common sense must prevail
12. Outcomes and learning are critical to prevent re-occurrence

These principles are not a list of 'must do's', however they do set a number of ways in which the quality of relationships and investigations can be improved