

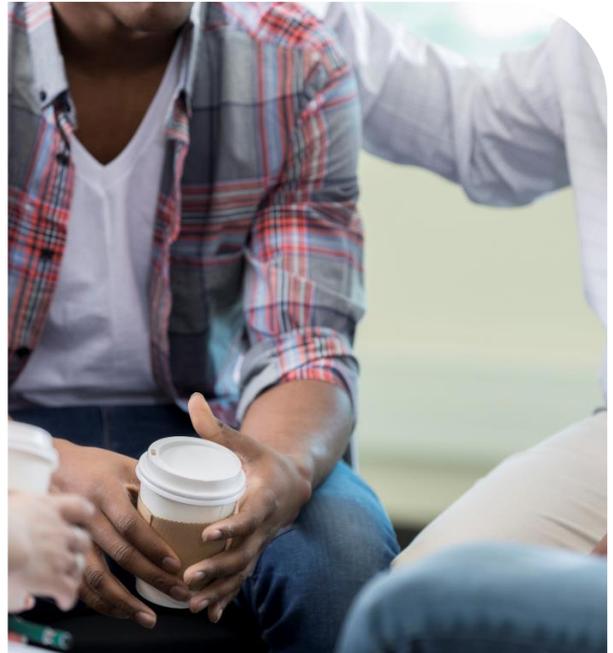
**Our *values-based* consultancy is a trusted advisor to our clients at the time of their greatest need for sensitivity and professionalism**

### About Niche investigations and reviews

The fundamental purpose of a patient safety investigation is to learn from the incident, and not to apportion blame. Examining incidents and events in a structured way allows the detail of events to be uncovered systematically, drawing out learning.

It is vital through a rigorous investigation to establish clear causes and contributory factors. This will ensure that the correct recommendations are made and the appropriate actions result in long-term sustainable change where future harm will be prevented. It is also imperative that healthcare services have robust mechanisms to ensure learning is implemented and embedded into practice; ensuring that *mindful learning* occurs.

Our team is comprised of experienced healthcare professionals who all have experience of carrying out complex investigations. We bring a wealth of quality assurance expertise, with a deep understanding of how to deliver robust investigations and to ensure that learning is operationalised and embedded. Most importantly, our expert team and investigative processes will help healthcare organisations be confident and assured that their services are safe.



### The principles of good quality investigations

Our investigation practice is modelled on the standards expected by the NHS England Serious Incident Framework, with additional measures of quality included based on our experience and other aspects of internationally recognised guidance. Our investigations are focussed on the discovery of any contributory factors that have influenced the untoward incident, and the analysis of events against best practice. Ultimately robust investigations should lead to practice and service changes that prevent recurrence. In our view good investigations require four key things:



1. **Transparency** – clarity on the purpose and scope of the investigation, with internal and external understanding and visibility. Key questions the commissioner of investigations should ask include: What is the investigation trying to achieve? What is the scope of the investigation? Have you consulted with the right people in setting the terms of reference and scope? Are the terms of reference realistic and achievable? What level of skill is required to carry out the investigation? Are there systems to ensure people know what to expect and when? All of these need a different focus and a different skill set.



2. **A just culture** – an intention to focus on systems learning, without a blame approach. Leaders should ensure there is a culture based on openness, with an understanding of the human and other contributory factors that can impact on untoward incidents. The investigation must be conducted with independence and without bias. This therefore means ensuring there is an open and compassionate environment for staff to share information, and that they feel able to speak up without impunity.



3. **Stakeholder engagement** – involvement of senior, operational and clinical staff, as well as engagement with families and other interested parties. The involvement of teams who have been under scrutiny because of an incident is crucial to foster openness and ensure there is a safe environment in which to examine events. Families must be involved at all stages of the investigation, with clear supportive communication.



4. **Clear outcomes** – specific outcome-focussed recommendations that are intended to influence or change practice. The development of an outcome-focussed action plan is an essential output, and should follow from clear action orientated recommendations. These action plans should lead to positive changes in practice that can be evidenced to demonstrate learning, and be directly linked to the recommendation.

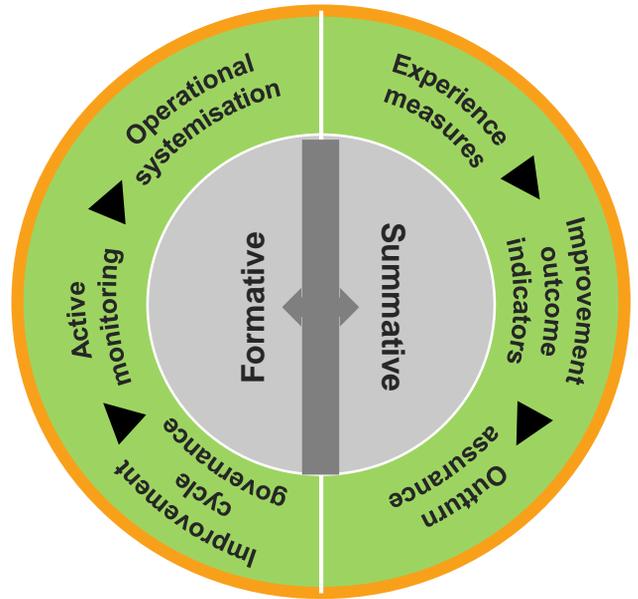
## Better support for organisations

### The Niche Assurance and Review Framework (NARF)

The Niche Assurance and Review Framework (NARF) is our bespoke assurance framework. This can be used to test out the level of embeddedness of your actions for change, and provide evidence based assurance that the intended actions have been completed, the outcomes achieved, and that practice change is occurring.

We know that for lessons to be truly learned and practice to change following incidents, the investigation process needs to be robust from start to finish. The completion of the investigation report is not the end of the process, but just the end of the beginning. The end of the investigation process only occurs when there is real assurance that 'lessons have been learned' and that changes to practice and process are now truly embedded.

Our investigations present an in-depth, evidence based analysis of issues, and we make outcome focussed recommendations for system changes. Ideally we would work with you to develop a robust action plan, and can support you to determine what kind of evidence you will need to provide for internal and external assurance in line with our Niche Assurance and Review Framework.



#### The main types of investigation services we offer:

1.	<b>Independent Mental Health Homicide</b> <i>Where there has been a death related to a mental health service user and Article 2 of the Human Rights Act is engaged.</i>
2.	<b>Complex or independent Level 2 or Level 3 investigations</b> <i>Where there is concern that internal resources are insufficient or, in the case of an adverse event where an external view would be helpful.</i>
3.	<b>Never Events</b> (single or multiple) <i>When you require assistance to understand underlying issues.</i>
4.	<b>Death in Custody clinical review</b> <i>Where a death has occurred in custody and a review of healthcare provided is required.</i>
5.	<b>Domestic Homicide Reviews/Individual Management Reviews</b> <i>At the request of a Safeguarding Board or Community Safety Partnership.</i>
6.	<b>Safeguarding Adult/Child Reviews</b> <i>Where there is concern that a vulnerable adult or child has been harmed and there has been mental health service involvement.</i>
7.	<b>Assurance review of implementation of actions</b> <i>Where there are concerns about recurring themes, or where robust assurance is sought to show that lessons have been learned.</i>

#### About Niche

Niche is proud to be a values driven consultancy and we have over 26 years' experience in the field of analytics, investigations, evaluation and governance. We are proud to be one of the leading suppliers of independent investigations on the NHS England Investigations Framework.

**No other consultancy has more experience at delivering professional, sensitive and value adding investigations.**

We have developed our investigative method to an extremely high standard and through our work we support trusts and other clients to improve their own investigative method that is now also being used by trusts to help them with their internal investigations. Our work is rigorous and we work with some of the most experienced investigators in the country. We are one of very few investigation services who are ISO accredited for our quality and information governance processes and we believe this gives us the credibility and assurance you need at this vital time. And all of our practitioners are security cleared to either BPSS standards or DBS checked, and many of our practitioners are clinically trained.

Our investigations and reviews are robust, proportionate, evidence-based and supported by the most up to date examples of good practice. We offer an analytical service too, helping identify correlations and themes between incidents; we develop practical plans to resolve contributory factors, taking a proactive approach to patient safety and aiming to prevent the recurrence of incidents.



#### Nick Moor- Partner, Investigations & Reviews

With nearly 20 years experience as a consultant and a further 20 years experience as a Mental Health Nurse, Nick has led and developed our investigations practice for the last ten years. Over that time he has focussed on delivering high quality robust investigations and helping organisations learn from incidents and embed changes in clinical and board assurance processes.

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