

Information for staff

2021-22

Welcome to Niche...

You have been provided with this information because Niche may have been asked to undertake an independent investigation into the care and treatment someone has received and you may have been involved at some stage of their care journey.

Niche has been undertaking independent investigations for many years, mostly in relation to healthcare, with all manners of organisations, with many different subjects and we have worked with many different organisations and staff. Most of our teams have previously worked in healthcare delivery and so we are deeply cognisant of some of the daily challenges that you face.

We recognise that 'being investigated' can seem like a very stressful prospect. This document will provide you with the main information that you might need through this process and we hope to reassure you of our approaches, although you can always talk to your investigation team if you would like more information or assistance.

Why do an investigation?

The purpose of an investigation is to gain an understanding of the full facts of the case which led to the outcome, whatever that might be. When investigations are conducted properly they can take quite some time to complete. This is because we use a broad range of investigative approaches and techniques (otherwise known as fieldwork), these include:

- **Interviews** – in some investigations we can interview hundreds of people. These include members of staff who have left, newer members of staff, senior leaders and other stakeholders.
- **Family engagement** – we spend time taking in your views on how care has been handled, we provide you with updates and we spend time talking to you about the findings when they are ready.
- **Document review** – we spend a significant proportion of the investigation reviewing documents, sometimes we will read and critique thousands of documents, including the care record and this can take considerable time.
- **Forming a care chronology** – the first stage is that we form a very detailed timeline of events, this can sometimes take a few months to complete. This becomes the framework for our investigation and enables us to ask questions based upon any gaps or issues.
- **Draft reporting** – taking all of the above together we start to put together a draft report which we then refer for validation from key stakeholders.
- **Validation** – we ask the family and organisations to confirm the accuracy of our evidence only and not of the views we form.

Healthcare quality will not improve if investigations into serious incidents are not robust and organisations cannot demonstrate that improvement has happened. We undertake investigations across the country from primary care to complex acute health care, and from community services to mental health, both in the NHS and the independent sector. We are also one of only a few organisations on the NHS England Framework to undertake independent investigations following a mental health homicide.

We are frequently asked to scrutinise and review internal investigations, providing assurance to both the board and commissioners. We have amassed a wealth of significant experience in this field; however, despite the 2015 Serious Incident Framework from NHS England, we often still see:

- investigations that have been poorly conducted;
- families not involved;
- reports that have been badly written;
- action plans that have not been properly completed; and
- a lack of oversight assurance and governance.

We know that in order for lessons to be truly learned and for practice to change following incidents or complaints, the investigation process needs to be robust from start to finish. The process doesn't end once the investigation is completed. In fact, the completion of the investigation report is not the end of the process, but just the end of the beginning. The real end of the investigation process occurs when there is tangible assurance that 'lessons have been learnt' and that changes to practice and processes are now truly embedded.

In our view good investigations and reviews require four key things:

1. **Transparency** – clarity on the purpose and scope of the investigation, with internal and external understanding and visibility. 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, dare say it, a different skill set.
2. **A just culture** – an intention to focus on systems learning, without a blame approach. Leaders should ensure that there is a culture which is based on openness, and an understanding of the human and other contributory factors that impact on untoward incidents. This means that there is an open and compassionate environment for staff, but most of all that they are proud to work for an organisation which empowers them to be curious and to learn.
3. **Stakeholder engagement** - involvement of senior, operational and clinical staff, and engagement with families, individuals and other interested parties. The involvement of teams who have been under scrutiny because of an incident is crucial in order to foster openness and ensure there is a safe environment in which to examine events. Families, carers and individual service-users must be involved at all stages of the investigation, with clear supportive communication.
4. **Clear outcomes** – specific outcome-focused recommendations that are intended to influence or change practice. An outcomes focus is crucial to ensuring action orientation and the planning of measures to guide changes. The development of an outcome focused action plan is an essential output, and should follow from clear action orientated recommendations. We can help organisations to design an action plan which is appropriate and robust, and our assurance framework can be readily employed to check whether changes are operational and embedded.