POLICY CONTROL SHEET

(updated August 2011)

Policy Title and ID number:	**LfE5.9 Best Practice – National Confidential Enquiries/Inquiries**			
Sponsoring Director:	**Director of Quality and Performance**			
Implementation Lead:	Risk Manager			
Impact:	*(a) To patients*	**Yes**		
	(b) To Staff	**Yes**		
	(c) Financial	**Yes**		
	(d) Equality Impact Assessment (EIA)	Completed: **Yes**		
	(e) Counter Fraud assessed	Completed: **Yes / No**		
	(e) Other			
Training implications:	*To be incorporated into induction:* **No**			
Date of consultation:	***Approval Process***	**Date**	**Local Consultation**	**Date**
	Executive Team		*Joint Partnership Forum*	
	Board Committee:		*Local Negotiating Committee*	
	• *Clinical Governance*	*05/12/11*	*Infection Control Committee:*	
	• *Non Clinical Governance & Risk*		*Health & Safety Committee*	
	• *Audit Committee*		*Quality Safety Improvements & Effectiveness Board*	
	• *Finance Committee*			
	• *RATS*		*Investment Board*	
	Trust Board Approval / Ratification		*Patients Experience Board*	
	Other:		*Other:*	

Approval/Ratification at Trust Board:		Version Number:	5
Date on Policy Warehouse:		Team Brief Date:	
Circulation Date:		Date of next review:	Dec 2013

For completion by ET for *new* policies only:				
Additional Costs			Budget Code:	Revenue or Non Revenue
	(a) Training	£		
	(b) Implementation	£		
	(c) Capital	£		
	(d) Other	£		

Policy for managing Best Practice
National Confidential Enquiries/Inquiries

(POLICY ID: LfE 5.9)

Implemented 2007 updated February 2010 V4, and November 2011 V5

Sponsoring Director: Director Quality and Performance

CONTENTS

POLICY

SUPPORTING DOCUMENTS

ABBREVIATIONS AND ACRONYMS USED IN THIS POLICY

- NHSLA NHS Litigation Authority
- CEMACH The Confidential Enquiry into Maternal and Child Health
- NCEPOD The National Confidential Enquiry into Patient Outcome and Death
- HR Human Resources

Policy for Managing Best Practice
National Confidential Enquiries/Inquiries

(POLICY LfE 5.9)

1. STATEMENT OF INTENT

The intention of this policy is to ensure that Barnsley Hospital NHS Foundation Trust has robust systems in place so that all best practice recommendations and requirements arising from National Confidential Enquiries/Inquiries are considered by the appropriate clinical teams in relation to the planning and updating of clinical services. This will provide assurance to the patients and community of Barnsley that best practice and patient safety are major priorities at Barnsley Hospital.

2. INTRODUCTION

Whilst NHS Foundation Trusts (FTs) are exposed to less regulation and inspection than non FT status organisations, the trust Terms and Authorisation require it to consider all recommendations of best practice that come from any National Confidential Enquiries/Inquiries (collectively reported in this document as "best practice recommendations")

In April 2005, National Confidential Enquiries came under the umbrella of the National Patient Safety Agency (NPSA). The NPSA oversees three confidential enquiries that carry out research into the way patients are treated to identify ways of improving the quality of care. The confidential enquiries are:

- CEMACH – The confidential Enquiry into Maternal and Child Health
- NCEPOD – The review of medical clinical practice, including outcomes and deaths

3. IMPLEMENTATION

This policy will be implemented through the offices of the Director of Quality and Performance who will be responsible for ensuring information from best practice recommendations are sent to the appropriate nominated Clinical Divisions for consideration and implementation.

All relevant Clinical Divisions, under the auspices of the Divisional Director, will be expected to undertake a gap analysis and prepare action plans where gaps are identified. These will be added to the divisional risk register.

A report will be produced quarterly for the Clinical Governance Committee that reflects all best practice and recommendations received and the status in the consideration/implementation process across the Trust. An annual high level report is submitted to the Trust Board to provide assurance that the process is effective.

4. MANAGEMENT ARRANGEMENTS

Overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer for the Trust.

All Trust directors are responsible, collectively, for the Trust's systems of internal control and management. The Board of Directors is responsible and it needs to be satisfied that appropriate policies and procedures are in place and that systems are functioning effectively. In addition, the Board of Directors needs to be assured as to the Trust's compliance against the outcomes within the Care Quality Commission (CQC) regulatory framework.

The Board of Directors has delegated its accountability arrangements for managing the review of best practice recommendations to the **Director of Quality and Performance.**

The Director of Quality & Performance will:

- Ensure that all notifications and updates from best practice recommendations are distributed to the specified Divisional Directors/Clinicians for review and action as appropriate
- Ensure through the head of Clinical Effectiveness and Head of Midwifery that any requests for data are acted upon and documented.
- Ensure that where there are gaps in service standards these are appropriately identified on risk registers.
- Keep an updated set of all Action Plans received from divisions about actions being taken to implement best practice and recommendations.
- Update the Trust Risk Manager on areas of identified risk for the Trust within this work stream.
- If for any reason, there is a decision not to implement a recommendation from a National Confidential Enquiry/Inquiry, this will be discussed as part of both Clinical Governance and Executive Team meeting, with the Medical Director, Chief Nurse and Director of Quality and Performance present. All decisions will be fully minuted with the appropriate rationale given. This decision in turn will be presented at the next Trust Board meeting, in order to inform all Board members of the decision.
- Produce a quarterly report for the Clinical Governance Committee on progress.
- Produce a 6 monthly report for the Executive Team on progress.
- Produce an annual review for the Trust Board.

Director of HR will:

- Ensure that any required training (for Trust-wide changes in practice) is incorporated into the Corporate Core Curriculum

Divisional Directors will:

- Ensure timely review of all notifications and updates from National Confidential Enquiries/Inquiries in their divisions.
- Ensure that each division's Clinical Governance and business planning process take into account any information from relevant National Confidential Enquiries/Inquiries
- Copy any best practice recommendations that come to them direct, to the Director of Quality and Performance for further dissemination.
- Ensure that the relevant Implementation plan for their area is completed and returned to the Director of Quality and Performance by the date requested
- Ensure that action plans are acted upon and reviewed regularly at divisional meetings.
- Facilitate training or development as required by staff to deliver any changes in practice.

Assistant Directors of Nursing, Matrons and Assistant Divisional Directors will:

- Circulate any best practice recommendations that come direct to them to the Director of Quality and Performance for further dissemination.
- Work with the Divisional Director/specific Consultant in the development and delivery of Implementation plans as necessary

Risk Manager will

- Receive notification from the Director of Quality and Performance of any risks highlighted by Implementation plans and update the Corporate Risk Register accordingly

5. MONITORING AND EFFECTIVENESS

The Director of Quality and Performance will produce a quarterly report for the Clinical Governance committee detailing the best practice recommendations and the steps being taken, by whom and to what timescale to ensure that they are acted on. This will provide assurance that the recommendations are acted upon throughout the organisation. Where appropriate, particular recommendations will be managed as bi-monthly agenda items until the committee is assured that they have been effectively acted on.

The Director of Quality and Performance will produce a 6 monthly report for the Executive Team, detailing the best practice recommendations and the steps being taken to ensure that they are acted on. This report will also provide an evaluation of the effectiveness of the processes outlined in this policy and action plans to improve the processes where appropriate.

The Director of Quality and Performance will produce an annual report to the Trust Board providing high level details on best practice recommendations, the steps being taken to implement the recommendation, the process for ensuring that the recommendations are implemented throughout the organisation and the process for monitoring the effectiveness of the policies outlined in this document.

6. REVIEW DATE

The Clinical Governance Committee will review this policy 2 years after its approval or sooner if a change in national legislation or local procedures make it necessary.

7. APPENDICES

Appendix One National Confidential Enquiries/Inquiries and Responsible Director/Consultant

Appendix 1

National Confidential Enquiries/Inquiries and Responsible Director/Consultant

National Confidential Enquiries	**Accountable Director/ Consultant**
Confidential Enquiry into Maternal and Child Health (CEMACH)	Medical Director
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	

Appendix 2

LfE5.9 Best Practice – National Confidential Enquiries/Inquires Monitoring Matrix

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible person/group/ committee	Frequency of monitoring	Responsible person/group/ Committee for review of results	Responsible person/group/ Committee for development of action plan	Responsible person/group/ Committee for monitoring of action plan
a. duties	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET
a. process for ensuring that the organisation responds to requests for data	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET
b. process for identifying relevant documents	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET
c. process for disseminating relevant documents	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET
d. process for conducting an organisational gap analysis	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET
e. process for ensuring that recommendations are acted upon throughout the organisation	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET

f. process for documenting any decision not to implement National Confidential Enquiry/Inquiry recommendations	Report	Director of Quality & Performance	Quarterly CGC 6 monthly ET	CGC/ET	CGC/ET	CGC/ET

Equality Impact Assessment (EQIA)
Pro-Forma

The purpose of an Equality Impact Assessment (EQIA) is to ensure that the Trust does not unwittingly discriminate against groups belonging to any of the Protected characteristics (PC's) Age, Disability, Gender reassignment, Sexual Orientation, Race, Religion or Belief, sex, sexual orientation, marriage & civil partnership, pregnancy and maternity. An EqIA is a process which ensures we promote equality in the provision and take up of our services and employment practices at Barnsley NHS Foundation Trust.

Div/ Dept	Corporate
Policy/ Service	LfE5.9 Best Practice National Confidential Enquiries/Inquiries
Is this policy/ service New/Existing	Existing
Name of Assessor(s)	Sharon linter
Date of EqIA.	10 November 2011
Aims/Objectives/Purpose Of Policy/Service	To ensure that Barnsley Hospital NHS FT has robust systems in place so that all best practice recommendations and requirements arising from National Confidential Enquiries/Inquiries are considered by the appropriate clinical teams in relation to the planning and updating of clinical services.
Associated Objectives for this Service e.g. National frameworks, Equality Act.	Compliance with NCE recommendations
Who Does this policy/service Affect?	Staff
What outcomes do you want to achieve from this process?	Improved clinical services

What factors could contribute/detract from the effective delivery of this policy/service?	Contribute: Detract	Detract:
	Robust planning to bring into line with recommendations	Lack of funding/manpower to meet recommendations
Could this service/policy have a different impact on different groups protected characteristics (**PC's**)	**If Yes please circle which groups** Race Age Disability Gender reassignment Religion/belief Sexual Orientation Pregnancy maternity Marriage Civil partnership Sex	**N**
Explain any reasons/evidence to support the above question, relevant to this impact (e.g. language barriers, consultation, complaints, surveys, mystery shopper, evaluations)	NA	
If you have answered yes to the above, please describe any **planned actions**, (**SMART**), work streams which will help mitigate your EqIA and ensure your policy/service will: • **Eliminate discrimination** • **Promote equal opportunities** • **Foster good relations between others.**	NA	
Following the above actions, will there be a	• If yes please complete partial assessment.	**NA**

need for a further Equality Impact Assessment? (EqIA)	• If no this assessment needs to be completed, recorded and sent electronically to your **Equality & Diversity Advisor**	
How will your EQIA be communicated/shared?	• Emailed to Trust Equality and Diversity Advisor for agreement and sign off. • Communicated to your direct Line Manager. • Communicated to Div/Dept team brief.	. **Y** **Y** **Y**
When is the next review (Please note review should be immediate on any amendments to your policy etc.)	**1 year** **2 year** **3 year**	**2 Years**