Barnsley Hospital NHS
NHS Foundation Trust

NCG12/02/9.1

POLICY CONTROL SHEET

(updated August 2011)

Policy Title and ID number:	**Policy For Investigation, Analysis and Improvement** LfE 5.5, 5.6 & 5.7			
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**		
	(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:	*23.02.12*	*Local Negotiating Committee*	
	• *Clinical Governance*		*Infection Control Committee:*	
	• *Non Clinical Governance & Risk*	*09/02/12*	*Health & Safety Committee*	
	• *Audit Committee*		*Quality Safety Improvements & Effectiveness Board*	
	• *Finance Committee*			
	• *RATS*		*Investment Board*	
	Trust Board Approval / Ratification	*23.02.12*	*Patients Experience Board*	
	Other:		*Other:*	

Approval/Ratification at Trust Board:	February 2012	Version Number:	1
Date on Policy Warehouse:	February 2012	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 INVESTIGATION, ANALYSIS AND IMPROVEMENT
DOCUMENT ID: LfE 5.5, 5.6 & 5.7

NOVEMBER 2011
(AMALGAMATED:
LEARNING FROM EXPERIENCE 5.5
LEARNING FROM EXPERIENCE 5.6
LEARNING FROM EXPERIENCE 5.7)

SPONSORING DIRECTOR: DIRECTOR OF QUALITY AND PERFORMANCE

POLICY FOR INVESTIGATION, ANALYSIS AND IMPROVEMENT

CONTENTS

ABBREVIATIONS AND ACRONYMS

- The Trust — Barnsley Hospital NHS Foundation Trust
- SI — Serious Incident
- CQC — Care Quality Commission
- NHSLA — NHS Litigation Authority
- MHRA/MDA — Medicines and Healthcare products Regulatory Agency
- NPSA — National Patient Safety Agency
- CAS — Central Alerting System
- EFA — Estates and Facilities Alerts
- SHA — Strategic Health Authority
- PCT — Primary Care Trust
- HSE — Health and Safety Executive
- ET — Executive Team
- RCA — Root Cause Analysis
- DH — Department of Health
- CGC — Clinical Governance Committee
- NCG&RC — Non-clinical Governance and Risk Committee
- QSIEB — Quality & Standards Improvement and Effectiveness Board

POLICY FOR INVESTIGATION, ANALYSIS AND IMPROVEMENT

STATEMENT OF INTENT

Barnsley Hospital NHS Foundation Trust recognises that, at times, things go wrong within the hospital through human, process or mechanical error. This document alongside the associated procedures outlines the Trust's systematic approach to investigating and analysing all internally and externally reportable incidents, complaints, claims, inquests, and other related risk management information, and then translating these findings into learning and improvement across the Trust to minimise risk to the patients and staff.

INTRODUCTION

The Trust requires that every adverse incident, near miss, complaint, claim or unexpected death is investigated and management action taken to prevent harm or minimise risks to their lowest possible level of impact or likelihood. Investigations will be commenced in line with the three levels of RCA investigation as detailed in NPSA Guidance 2008 (see Appendix 1), this may include the use of root cause analysis where appropriate, as detailed in the Procedure For The Use Of Root Cause Analysis (see Appendix 2). Reported information is stored on risk management databases; systematic analysis of the databases provides reports to support learning and improvement at all levels of the Trust as detailed in Appendix 3.

The Trust recognises the importance of translating learning from incidents into practical long-term solutions for change and ensuring these are embedded into its routine culture and practices. Identifying key learning points is an important requirement of any investigation and as such they will be shared within the Trust, externally with its stakeholders and also with those affected by an incident. A full debriefing should be given to all relevant Trust staff within as short a time as possible including any initial actions. Locally this could be through ward or departmental meetings, divisional governance committees or via line managers to individual members of staff. Across the organisation this could be through trust wide staff briefings, escalation through the Clinical Governance Committee, Non-Clinical Governance &Risk Committee or the Quality Safety Improvement and Effectiveness Board.

The Trust works closely with external agencies principally NHS Barnsley, South West Yorkshire Foundation Trust, Barnsley Social Services, Sheffield Teaching Hospitals, Rotherham Hospital NHS Foundation Trust and South Yorkshire Ambulance Service as necessary when investigating incidents. There is also working relationships with the NHS Litigation Authority, National Patient Safety Agency, Heath & Safety Executive and trust Solicitors and there are networking groups to ensure lessons learned are disseminated across the wider NHS community.

In order to achieve high levels of investigation, analysis and improvement the Trust will provide systems of staff training in conjunction with the Learning and Development Department through induction, the corporate curriculum and individually identified training needs.

IMPLEMENTATION

This Policy will be implemented through the Director of Quality and Performance in conjunction with the Head of Governance, the risk management department, health and safety department and divisional management teams.

MANAGEMENT ARRANGEMENTS

Chief Executive

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

Trust Board

All Trust Directors are responsible, collectively, for the Trust's systems of internal control and management. The Board needs to be satisfied that appropriate policies and procedures are in place and that systems are functioning effectively.

Chief Nurse

The Chief Nurse is the director with responsibility for patient safety and risk management, including the impact of claims in the context of overall patient experience. The Chief Nurse is the designated member of the Board of Directors with responsibility for ensuring compliance with related policy and procedures.

Director of Quality and Performance

The Director of Quality & Strategy is the Director with responsibility for the Risk Management Department and claims function within the Trust. This post also Chairs the QSUIE Board and Strategic Risk Group where claims are primarily reported and monitored.

Head of Corporate Governance

The Head of Corporate Governance is line manager for the Risk Manager and has responsibility for ensuring governance of relevant policy implementation within that function.

Risk Manager

The Risk Manager has the overview of a range of systems and procedures that identify risks and in liaison with Divisions and Directorate to coordinate processes for investigation, analysis, learning and improvement. The Risk Manager is responsible for ensuring dissemination of the reports as detailed in Appendix 3.

Clinical Risk Advisor

The Clinical Risk Advisor is responsible for disseminating all alerts received through the CAS (NPSA patient safety alerts, MDA and EFA alerts) to relevant staff and departments within the Trust, and monitoring and reporting progress to QSIEB.

Specialist Advisors

Specialist Advisors are officers within the Trust who have a substantial responsibility for defined areas of risk management, patient and staff safety. This includes Risk Management, Health & Safety, Infection Control, Resuscitation, Child and Adult Protection, Blood Transfusion, Moving & Handling, and Security. The Specialist Advisors are required to advise the Chief Nurse with regard to legal and best practice requirements in line with this policy.

Chief Operating Officer

The Chief Operating Officer is the lead Director for many of the Divisional functions, performance management systems, National Service Frameworks and other high level enquiries and national service standards. This requires assessing the need for improvements to services, identifying actions and implementing change.

Medical Director

The Medical Director is responsible for the Trust's system of reviewing and implementing NICE Guidelines and Caldicott Guardian issues. This requires assessing the need for improvements to services, identifying actions and implementing change.

Executive Team

All Directors have a responsibility to participate in relevant hospital committees and where appropriate local heath community networks to identify solutions and implement change to improve safety and practice.

Divisional and Directorate Arrangements

Directors, Divisional Directors and managers have responsibility for the implementation of this policy at a local level. Each Division (including sub-specialties) has a responsibility to have in place local Risk Management and Governance arrangements whose role it is to undertake prospective risk assessment and reflective review of risk management data and information. They also have a responsibility to escalate identified high risks to the Executive Team to ensure appropriate improvement actions are recorded and monitored through the governance processes. Such escalation should also be coordinated through the Risk Manager onto local and corporate risk registers. There is also the expectation that all learning and improvement should be highlighted and disseminated to all relevant staff.

Quality Assurance and Governance Officer

This post has a pivotal role in coordinating, monitoring and reporting the progress of high level action plans identified through SIs, incident trends, complaints, inquests and risks arising from clinical audits. If any clinical audit work is required, as detailed in or as a result of the actions, it is the responsibility of the Quality Assurance and Governance Officer to facilitate the audit in line with Clinical Audit Policy and Procedures.

All Staff

All members of staff have a responsibility to highlight any risk issues which could warrant further investigation. Staff should be fully open and cooperative with any investigation process.

COMMITTEE ARRANGEMENTS FOR GOVERNANCE

The outcome to the investigation and improvement processes occurs at Committees at various levels throughout the organisation.

The Risk Management and Health & Safety Departments are responsible for providing summary reports on a monthly, quarterly or annual basis as outlined in the schedule below. These reports provide data/information at departmental, divisional or corporate level. The output of these reports demonstrates compliance with the range of policies and procedures in place.

Clinical Governance Committee / Non-clinical Governance and Risk Committee
The Governance Committee provides the Governance and compliance overview on behalf of the Board of Directors. Through reporting lines it receives reports on Serious Incidents, Complaints, Claims and risk registers for each division.

Strategic Risk Group
The Strategic Risk Group is responsible for logging, reviewing and monitoring all Serious Incident investigations and keeping the commissioners informed of progress with those investigations, findings and any related learning and actions.

The Group also monitors all new Coroners Investigations of patient deaths and Inquest hearings in particular where these overlap with a Serious Incidents.

The Group reviews all new requests for records where a claim for compensation is considered and monitors the progress of individual claims where necessary.

Quality and Safety Improvement and Effectiveness Board
A monthly Exception Report is provided to QSIEB covering Serious Incidents, Inquests, Complaints, Claims, and Incident Trends by *frequency* and by *severity.*

Health and Safety Committee
The Health & Safety Committee receives a quarterly non-Clinical Incident Report.

Divisional Governance Groups
Each Division is expected to have a formal Governance/Risk Structure with an overarching Governance Group (this may vary between Divisions). Risk management Exception Reports are provided to each Division on a monthly basis supported by other data analysis as determined by each Divisional Management Team.

PROCESS FOR IMPROVEMENT
The process for improvement within the Trust ensures both local and organisational learning from incidents, complaints and claims and other aspects of risk. The Risk management process comprises identification of risks through investigation of individual incidents: analysis of various sources of patient experience including SIs, incidents, complaints, claims, coroner's inquests and other related concerns; and plans of action aimed to change and improve practice and the safety culture. These improvement plans may be from an individual case analysis or part of business planning; national or local CQUINS programme.

An overview is provided on the attached improvement flowcharts at Appendix 5.

PROCESS FOR SHARING SAFETY LESSONS
In order to ensure that learning and improvements are shared with a wider audience both within and outside the Trust there are a range of communication processes which are in place and used appropriately:

Internal
- Email or memo from the Strategic Risk Group providing recommendation for action to Divisional Teams for discussion at Divisional Governance meetings

- Discussion of action plans at Divisional Governance meetings
- Action plan sharing Trust wide (if not specialty specific)
- Key learning points from safety lessons included in quarterly 'Risky Business' bulletin

External

- Sharing of issues and actions at Local/Regional Networks (e.g. Chief pharmacists)
- Written communication shared with relevant external stakeholders:
    - SI Reports to the local Commissioner
    - Quality review meetings with the Local Commissioner

PROCESS FOR MONITORING

Monitoring arrangements are as identified for the Committees structures outlined in the Risk management strategy and summarised in the monitoring matrices attached.

REVIEW DATE
December 2013

CROSS REFERENCE DOCUMENTS AND POLICIES

NICE Guidance (December 2007) How to Change Practice
NPSA NLRS Root Cause Analysis Investigation Tools (2010)

The need for change and identification of improvements may require reference to a cohort of policy and procedural documents under the NHSLA Standard 5 Learning from Experience. The most recent versions of the following documents are available on the Trust's intranet site:

- Incident Reporting
- Serious Incident Procedure
- Raising Concerns
- Complaints Policy and Procedures
- Claims Policy and Procedures
- Best Practice
- Being Open
- Risk Management Policy and Procedures
- Procedure For The Use Of Root Cause Analysis
- Clinical Audit Policy and Procedures

Appendix 1

Levels of Investigation appropriate to the severity of the event(s)

The Trust supports a systematic process for investigation following the identification of an SI or other incident, complaint, claim or inquest/unexpected death. Incidents will be investigated at an appropriate level of management and the requirements of the Being Open policy will be followed.

Investigations will be commenced in line with the Three levels of RCA investigation – NPSA guidance (Sept 2008).

Level 1 – Concise investigation

Most commonly used for incidents, complaints, claims or concerns that resulted in no, low or moderate harm to the patient. Conducted by staff local to the incident. It commonly involves completion of a one page structured template (e.g. summary RCA form or an IR2 form) and use of selective RCA tools. This style of short form RCA also applies to routine C-Difficile or MRSA summaries.

Level 2 – Comprehensive investigation

Usually conducted for actual or potential severe harm or death outcomes; likely to be a Serious Untoward Incident (SUI) from incidents, claims, complaints, or concerns. Conducted to a high level of detail, including all elements of a thorough and credible RCA investigation. Investigation led by an experienced investigator/senior manager and overseen by a Director. It requires a full report with executive summary, statements, appendices, and robust recommendations.

Level 3 – Independent investigation

As per level 2 but in addition: must be conducted by those independent of the Trust. Commonly where there is high level of public interest or media attention or where article 2 of the European Convention on Human Rights is or likely to be engaged. (For the Trust this tends to be serious inquests, where external experts may be instructed via solicitors; serious clinical care failings or safety incidents where external organisations may be engaged).

APPENDIX 2

PROCEDURE FOR ROOT CAUSE ANALYSIS

STATEMENT OF INTENT

It is the policy of the Trust that it will adopt Root Cause Analysis as its main investigation tools for reported incidents.

ROOT CAUSE ANALYSIS FOR SAFETY RELATED INCIDENTS

This procedure can be applied to both clinical and non clinical adverse events. The procedure details the involvement of and the actions to be taken by the investigation team / manager, so that the Direct, Contributory and Root causes associated with an incident can be identified and recorded. The information obtained can then be analysed and common causes and trends highlighted. Appropriate preventative action can then to be taken to avoid recurrence.

DEFINITIONS

Direct Cause:

Direct cause is defined as the immediate cause(s) which triggered the incident.

Contributory Cause:

Contributory cause is defined as that cause which contributes to the occurrence of the incident, but which itself would not have caused the occurrence.

Root Cause:

Root cause is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent a recurrence.

CRITERIA FOR UNDERTAKING A ROOT CAUSE ANALYSIS

This procedure must be applied consistently across all relevant policies. Investigation requirements and criteria are also referenced in the following policies and procedures:

- Incident Reporting Policy
- Serious Incident Procedure
- Complaints Policy and procedures
- Claims Policy and procedures
- Coroner's Inquests
- Other policy documents where RCA may prove beneficial

The opportunities to perform a Root Cause Analysis to identify learning and recommend improvement are varied. Root Cause Analysis events are challenging and require dedicated time/resource to be effective. The assessment and selection of an incident by a manager or team for RCA is important to its success. The following criteria are suggested to aid the decision:

1. Unexpected death that was directly related to an incident
2. Incidents that resulted in suspected permanent damage or injury, loss of function or body part
3. Incidents where further surgical intervention is required or transfer to intensive care
4. Incidents that were prevented, but considered by the investigating manager to be worthy of an in-depth review.

5. All incidents that trigger external investigation such as coroner's, complaints, claims and criminal investigations

Reference should also be made to guidance documents available separately for incident investigation and risk assessment including detailed training documents provided as part of the Trust's Corporate Curriculum which includes Investigation of Incidents & Claims for managers and the 3 day Health & Safety Course, there are also NPSA tools to support Root Cause Analysis available on the Trust Intranet on the Risk Management Sharepoint.

Trust policy requires the risk rating of all clinical and non-clinical incidents. Any incident graded as Extreme or High with an impact/severity score of 4 must be considered for investigation by Root Cause Analysis. The incident must be reported in the normal manner on an eIR1 indicating within the investigation section that Root Cause Analysis will be undertaken and a time scale.

Any incident graded as Moderate or Low must be analysed by root cause analysis if the incident statistics indicate that a particular incident type is recurrent. This does not preclude the use of Root Cause Analysis, or parts of the process, for any incident if deemed appropriate by the investigating manager / team but a short form RCA is appropriate for most routine incident investigations.

PROCESS FOR UNDERTAKING A ROOT CAUSE ANALYSIS

Root Cause Analysis must be carried out by a designated manager with appropriate training or equivalent experience in incident investigation and RCA. This will include Directors, Assistant Directors, Risk Manager or Non-Clinical Risk Adviser, Matrons and Lead Nurses and certain Departmental Managers.

Where an incident had been reported to any external agency consideration must be given to including a relevant representative as part of the Root Cause Analysis investigation team (See Serious Incident Procedure).

It is considered best if a team approach is used. The team must include a Director or Manager appropriate to the severity of the incident (see Table 1). The team ideally would include the Risk Manager or Non-Clinical Risk Adviser, the Departmental Manager/Lead Nurse and any other persons with first hand knowledge of the event or with specialist knowledge. It is not expected that the team would normally comprise more than five members. The team must contain at least one person who has been trained in Root Cause Analysis or an equivalent training in investigation techniques including the Trust's Health & Safety Management Course. Directors must ensure that adequate numbers of staff are trained.

The Trust has trained staff available across a number of specialties who may be accessed to support a Root Cause Analysis event. There may be added benefit from including an individual from another Division or Department to provide independence. Please contact the Risk Manager (2209) or Patient Safety Lead (4572) for a nomination should this be required.

The purpose of the investigation is to identify the Direct, Contributory and especially the Root causes of the incident, and recommend remedial actions. The output will

also enable wider learning from the incident to be shared across the organisation, and externally, to prevent further repetition

It is not proposed in this procedure to undertake a detailed explanation of the Root Cause Analysis Further details and investigation tools can be found at www.npsa.nhs.uk. However, Root Cause Analysis would normally follow the following process:

- Identify the incident to be investigated
- Form the investigation team
- Preserve direct evidence from the scene
- Chart the event with current knowledge
- Gather documentary and other evidence
- Review / carry out a Risk Assessment
- Review / implement a Safe System of Work
- Review / implement Training
- Arrange and carry out interviews
- Review the chart/fishbone diagram
- Identify causal factors
- Analyse causal factors
- Decide on and cost the options for improvement
- Provide a report
- Ensure implementation of improvement plans, phased if necessary
- The identification of any significant media risk requires immediate notifications to the Communications Officer (3771) or the Duty Manager out of hours

A robust and systematic analysis of an incident will help to clarify exactly what happened and why an event occurred. Having identified the problems an action plan can be implemented which will help to minimise the likelihood of it recurrence. Risks, Underlying Causes, Action Plans and Cost must be recorded and signed off by the Designated Manager.

IDENTIFICATION AND CLASSIFICATION OF CAUSES

The main Underlying Causes or Root Causes to any untoward event are likely to include the following problem:

Inadequate Information
Inadequate Induction Training
Inadequate Ongoing Training
Inadequate Supervision
Inadequate Staffing
Inadequate Policy / Procedure
Inadequate Safe System of work
Inadequate Maintenance
Inadequate Work Environment
Inadequate Plant / Equipment
Personal Factors (Specify)
Other (Specify)
Natural Disaster or Criminal Activity
Other Contributory Factors (Specify)

ACTION PLAN AND REMEDIAL PROGRAMME

The Root Cause Analysis will produce:

- A range of options to reduce the potential residual risk of the incident
- A range of costs and time-scales associated with the above options

The Trust must determine to which level the residual risk is produced. The authority to determine the level of residual risk lies with the grade of management as determined by Table 2.

Risk assessments must be recorded on the Risk Assessment Form, Risk Action and Treatment Plans described in the procedure 'How to Carry Out a Risk Assessment'

All documents can be obtained from the Health and Safety Department (2465) or Risk Management Department (2209).

MONITORING AND GOVERNANCE

Routine monitoring of Root Cause Analysis will be maintained by Divisional Departmental Risk/Governance Groups. Interim and Final Reports must be made to the Strategic Risk Group. Reports or a summary will be provided to the Quality & Safety Improvement and Effectiveness Board, Health & Safety Committee and for Governance Committee Review as necessary. Identification of Extreme or High rated risks must be escalated to a Director/ET in accordance with the Risk Management Procedures.

REVIEW OF THIS PROCEDURE

The operation of this procedure will be monitored by the Director of Quality & Strategy in line with this policy document.

REFERENCES

There are a range of tools available for in-depth investigation of Incidents. The primary resource for the NHS and referenced in this procedure is the Root Cause Analysis Toolkit from the NPSA. The toolkit provides useful documents/templates used for analyses including:

- Protective Barrier Analysis
- Reactive Barrier Analysis
- Brainwriting
- Change Analysis
- Five Whys
- Nominal Group Technique
- Time line
- Fishbone

Further information can be found at www.npsa.nhs.uk

APPENDIX 3

Corporate Reporting

The Trust requires analysis of risk management databases and associated reporting by the Risk Management Departments as a minimum quarterly. The schedule below provides details of the intended frequency and groups responsible for this.

Group/ Committee	Report	Period/ Frequency
Non-Clinical Governance and Risk Committee	• Non-Clinical/ Health & Safety Incident Trends • SIs (each meeting) • Complaints • EL/PL Claims (each meeting) • Risk Registers (each meeting) • Board Assurance Framework • Annual Governance Report	Quarterly Trend Reports with interim updates where necessary (NCR&GC held bi-monthly).
Clinical Governance and Risk Committee	• Clinical Incident Trends • SIs • Complaints • Clinical Negligence Claims • Inquests • Risk Registers • Board Assurance Framework • Annual Governance Report	Quarterly Trend Reports with interim updates where necessary. (CGC held bi-monthly).
Strategic Risk Group	• SIs • Claims • Inquests	2 weekly (or as required)
Quality & Safety Improvement and Effectiveness Board	• High & Significant Incidents • Corporate Incident Trends • Division Incident Trends • Annual Governance Report	Monthly Quarterly Quarterly Annual
Health & Safety Committee	• Health & Safety Incidents • Annual Governance Report	Quarterly Annual
Patient Experience Group	• Corporate Complaints • Divisional Complaints • Annual Report	Quarterly Quarterly Annual
Medicines Management	• Medication Incidents • Annual Report	Bi-monthly Annual
Executive Team	• Board Assurance Framework	As required (Weekly meetings)
Risk Management Team	• Individual Case Review/Analysis	As determined

Local Analysis and Reporting

Each Division (including sub-specialties) has a responsibility to have in place local Risk Management and Governance arrangements whose role it is to undertake prospective risk assessment and reflective review of risk management data/information. This arrangement may vary from weekly risk/incident reviews through to quarterly risk/governance meetings.

It is the role of that group(s) to ensure a local systematic process to consider risk management trend reports and other risk management activity including Root Cause Analysis within the Division. It is required that established groups to produce minutes of their meeting in order that a process of monitoring and review can take place within the Division and Corporately through the Clinical and Non-Clinical Governance & Risk Structure. Analysis of risk management data will be provided routinely and on a bespoke basis to support the local processes.

Criteria For Analysis

The production of reports is controlled by criteria and parameters for reporting identified corporately, locally and externally (e.g. DoH Complaints Annual Reporting criteria). At a corporate level data is aggregated and analysed to show:

Clinical Risk Analysis

- Total incidents over a rolling 12 month period
- Types of incident by
  - 5 most frequently reported incident
  - Severity scoring of incident
- Grade of staff reporting incidents
- Total Incidents, Complaints and Claims by quarter for a 12 month period
- Total Incidents, Complaints and Claims as above by Division/Specialty.

In addition, each Directorate receives its own quarterly report direct from the Risk Management Team providing data for each Specialty.

Health & Safety Analysis

- Total incidents over a rolling 15 month period
- Quarterly analysis by Type/Location of incident
  - RIDDOR
  - Medical Sharps
  - Moving & Handling
  - Violence, Abuse & Harassment
  - Security
  - Fire
  - Other

Complaints Analysis

- Total complaints over a rolling 12 month period
- Total performance targets and response times
- Performance targets and response times by Division
- Parliamentary and Health Service Ombudsman reviews
- Quarterly analysis by:

    - Subject area
    - Specialty
    - Profession
    - Location
    - Severity
- Equality & Diversity
- Care issues

Claims/Inquest/SI Analysis

- Totals over a rolling 12/15 month period
- Quarterly analysis by:
    - Subject (case review)
    - Service area

APPENDIX 4

PROCESS FOR FOLLOWING UP RELEVANT ACTION PLANS

The Quality Assurance and Governance Officer coordinates, monitors and reports the progress of high level action plans identified through SIs, complaints, inquests and risks arising from clinical audits.

Serious Incidents and Inquests

The final report following investigation of every SI includes an action plan based on the recommendations in the report. When the action plan has been agreed and signed off at the Strategic Risk Group a copy will be sent by email to all named action leads and the Quality Assurance and Governance Officer by the Director of Quality and Performance.

The actions will be entered on to the HealthAssure on-line system by the Quality Assurance and Governance Officer.

Any actions which are due to be completed up to the present month or the following month will be reported monthly the relevant divisional governance committee by a member of the risk management team. An update for each of these actions will be provided by the committee, either detailing further work needed for completion or that the action is complete. If an action has not been completed it will continue to be reported until it has been reported as complete by the committee. Discussions will be minuted for evidence.

This information will be reported back to the Quality Assurance and Governance Officer who will update HealthAssure. Any ongoing failure to report on actions or not complete actions will be escalated to the Strategic Risk Group.

Any action plans or actions which fall outside the remit of the clinical divisional governance committees (eg estates / IT / facilities SIs) will be followed up directly by the Quality Assurance and Governance Officer with the individual named action leads and reported on HealthAssure as above.

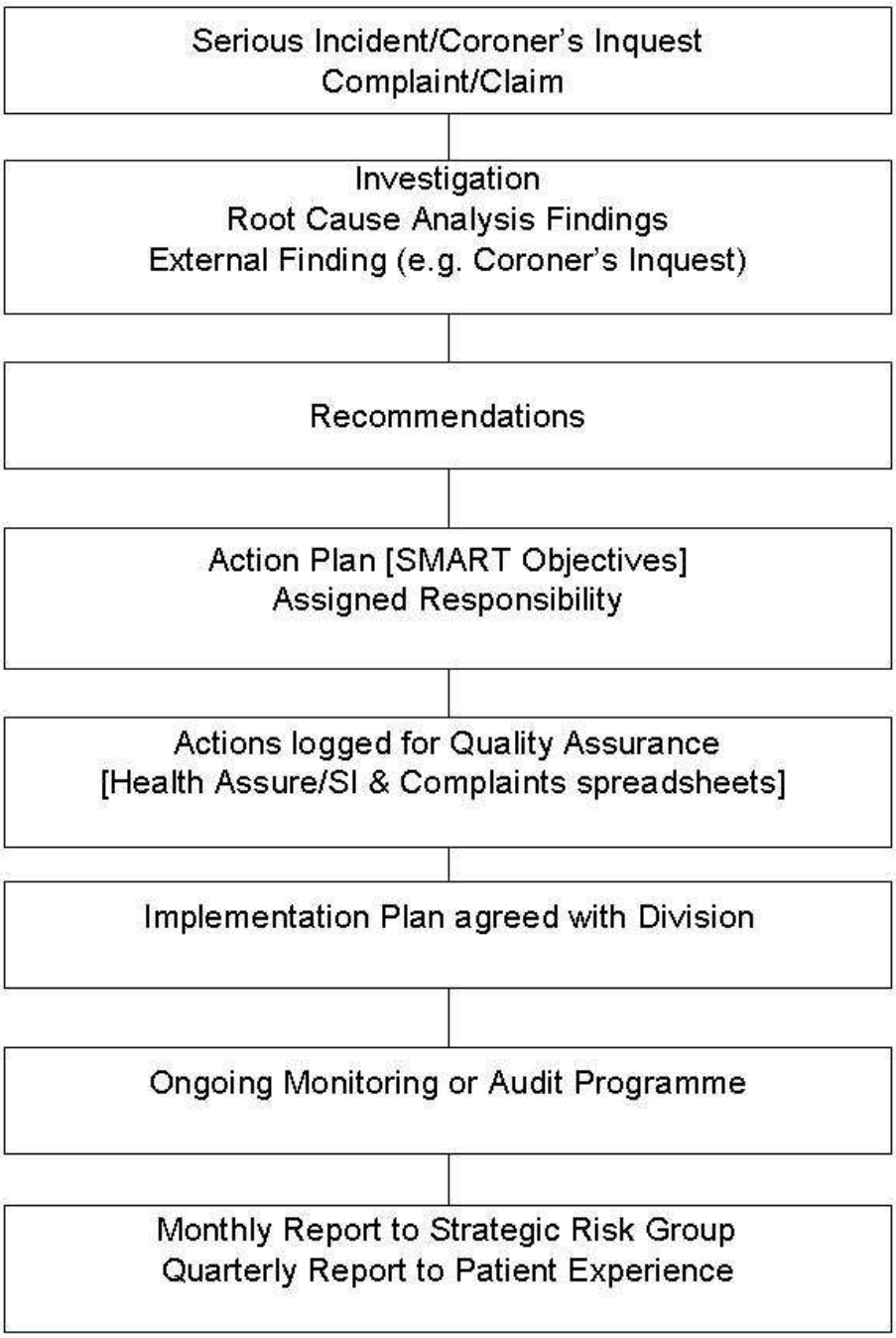
Complaints

Actions arising from complaints will be monitored as detailed in the Complaints Procedure. Any actions following review of a complaint by the Parliamentary and Health Service Ombudsman will be logged on Health Assure by the Quality Assurance and Governance Officer, and progress monitored with individual named action leads.

Other High Level Action Plans

There may be other instances where an action plan is required to be monitored. This will be logged on the Health Assure electronic system and monitored as detailed for Serious Incidents and Inquests above.

Improvement Process



Improvement Process 2

Improvement Process 3