North Cumbria University Hospitals NHS
NHS Trust

Report to the Meeting of the Trust Board of Directors Held in Public

Date of Meeting: 23 July 2013 **Enclosure: 6**

Title of Report	Revised Complaint and SUI Process
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Executive Lead	Chief Executive
Responsible sub-committee	N/A
Date of paper	18 July 2013
Executive Summary	During the last four months, work has been progressed to improve the timeliness of investigating serious incidents and complaints. The key rationale for this has been reducing the general 'backlog' but more importantly ensuring that the key themes and learning is being embedded across the organisation. In May 2013, the Keogh Rapid Response Review took place and it reported on its findings in July 2013. This also highlighted that improvements were required in key areas relating to serious incidents and complaints. This report summarises for the Board the improvements which have been introduced during the last two months.
Assurance Framework reference	2.1, 3.2, 3.23
Level of assurance	Significant
Recommended changes to risk rating (if applicable)	No changes recommended.
Legal implications/ regulatory requirements	Ensuring we learn from incidents and complaints is a core component of meeting our regulatory requirements with the CQC.
Actions required by the Board	That the Board approves the report.

1. EXECUTIVE SUMMARY

During the last four months, work has been progressed to improve the timeliness of investigating serious incidents and complaints. The key rationale for this has been reducing the general 'backlog' but more importantly ensuring that the key themes and learning is being embedded across the organisation.

In May 2013, the Keogh Rapid Response Review took place and it reported on its findings in July 2013. This also highlighted that improvements were required in key areas relating to serious incidents and complaints:

- Timeliness of completing investigations into serious incidents and sharing the learning outcomes to ensure these are embedded.
- Increasing the resource in the complaints team to ensure more timely responses to complaints.

This report outlines the work which has been completed and work which is planned to achieve and sustain these important improvements across the organisation.

2. SAFETY PANELS

In June 2013 weekly Safety Panels were established, which have a rolling set agenda:

Week one	Reviewing Serious Incidents
Week Two	Mortality Review Group
Week Three	Reviewing Serious Incidents
Week Four	Reviewing Serious Complaints and Litigation
Week Five	Patient Experience Results which are 'under performing'

Members of the Safety Panel are:

- Medical Director (chair)
- Associate Medical Director
- Director of Nursing
- Deputy Director of Nursing
- Director of Governance
- Head of Governance

Representation has also included one of the Non-Executive Directors of the Board.

The role of the safety panel is central to the improvements that are being implemented in relation to the investigation and overall management of serious incidents and complaints.

The role of the Safety Panel is to:

- Identify common themes and contributory factors in relation to serious incidents and complaints, this includes where incidents and complaints are happening in relation to individual hospital sites and services.
- Ensure that investigations into serious incidents and complaints are completed in a timely manner and thoroughly investigated.
- Ensure that lessons are shared and embedded through formal audit of recommendations to confirm implementation and changes in practice where required.
- Ensure issues of individual competency or concern are managed effectively.
- Provide leadership support to clinical teams and the business units on improving clinical governance across the organisation.

The outputs of the Safety Panels will be recorded on a 'cumulative basis' so that data is collected on the themes arising from serious incidents and complaints, which will be reported to the Board on a monthly basis.

3. IMPROVING HOW WE INVESTIGATE SERIOUS INCIDENTS

The investigation of serious incidents has predominantly focussed on a small number of individuals and a 'lengthy' Incident Management Policy. Significant changes have been made during June and July which are outlined below.

3.1 Staff Training on Serious Incidents

Mandatory Training for senior clinicians, managers and nurses commenced on 28 June and to date 62 members of staff have completed their training. Further training will take place in July and August 2013. The training is being provided by DACbeachcroft Healthcare and Regulatory Legal Department and the Acting Director of Governance.

In addition to this, formal Root Cause Analysis (RCA) training is being arranged for October in order to achieve having an 'expert' group of staff who are trained in RCA.

3.2 Guide to Investigating Incidents

A guide for staff on how they investigate serious incidents has been developed with key reference tools included on how you investigate serious incidents. The material in this guide is being updated into the Trust's policy, however from implementing this guide we will by default implement our Trust procedure for investigating serious incidents. It is also important to note that the feedback from the staff is to provide more useful tools that allow policies to be implemented which it is hoped this with achieve.

3.3 New Templates

New templates for completing investigations into serious incidents have been developed in order to provide greater consistency and quality of serious incident reports across the organisation.

The guide and new templates has been 'launched' with all staff as part of their mandatory training.

3.4 Categorisation of Serious Incidents

A new form of categorisation for serious incidents has been implemented. The key reason for this is to distinguish between serious incidents which are catastrophic and those where serious harm has been caused but it has not resulted in a catastrophic outcome or is not an 'uncommon' event. This is also to ensure that immediate learning regarding catastrophic incidents is escalated across the organisation.

GRADE	DEFINITION	National Grade
A	These will be incidents that are catastrophic, resulted in death and or permanent harm. These may also include serious service or system failures. *To be completed within 7 days*	2
B	These will be incidents that have caused serious harm, have required significant intervention or have resulted in service or system failure. *To be completed within 30 days*	1 or 2
C	These will be incidents where harm was caused, however they are not uncommon, for example falls resulting in a fracture, c-difficile or hospital acquired grade 3 and 4 pressure sores. Category C SIs may also include occasions where there is significant learning to be gained across the organisation. *To be completed within 60 days*	1

This process commenced in June 2013 and 'Category A' serious incidents which have been declared have been reviewed by the Safety Panel in the agreed timescale.

3.5 Information for staff

The information for staff on risk management and investigating incidents held on the intranet was out of date and was not focussed on the tools staff need to complete investigations. This has been updated to reflect the new guide for staff and the templates/tools to be used when investigating incidents.

3.6 Identification of a Case Manager and Case Investigator

The previous process for investigating SUIs focussed on establishing 'SUI panels' which resulted in delays to the investigation process as well as a lack of clarity on roles and responsibilities for completing an investigation.
A key change to the new process is based on identifying two key roles when an incident is declared which is the Case Manager and the Case Investigator who have clearly defined roles:

Case Manager

The Case Manager is responsible for:

- Co-ordination of the investigation and completion of the SUI report and presentation of this to the Safety Panel.
- Ensures any other associated policies are implemented where necessary, for example Human Resource policies
- Supports the case investigator with co-ordinating the investigation
- Maintain confidentiality
- Ensure communication with the patient and or family in accordance with Duty of Candour
- Ensuring all statements and other factual pieces of evidence are complete and included in the report
- Ensure the SI policy is followed
- The recommendations are Specific Measurable Achievable Realistic and Timely.

Case Investigator

The Case Investigator is responsible for:

- Conducts the investigation and ensures all necessary 'hard' and 'soft' evidence is included
- Ensuring the scope of the investigation is correct and addresses the key issues to be investigated
- Highlighting any issues of patient safety that require immediate action
- Ensuring the final report is shared with CPG where necessary
- Identifies any contributory factors to the incident
- Concludes the root causes of the incident and the actual care or service delivery issues identified
- Contributes to the recommendations

The responsibility for identifying the Case Manager and Case Investigator is the Clinical Business Unit Director and Deputy Business Unit Director.

3.7 Building a safety culture and being open and transparent

Through the Safety Panels and identification of common themes, review of cases at Clinical Policy Group and supporting the Business Units as they take a greater lead on investigating Serious Incidents, the new processes we have put in place should start to impact on building a safety culture.

Improved reporting on serious incidents is now a key feature of the public report on safety and quality, which will continue to be strengthened through reporting on the outputs from the Safety Panels as they become embedded during quarter 2.

3.8 Serious Incidents Reported in 2012/13

It is important to include reference to the outstanding serious incidents declared in 2012/13. The key issues resulting in these incidents remaining as outstanding is the finalisation of investigation reports. A plan has been agreed with the Safety Panel which involves a member of the panel leading on specific outstanding Serious Incidents in order to support the team completing the final reports.

The date for completion of all serious incidents reported in 2012/13 is 1 September 2013.

4. IMPROVING OUR COMPLAINTS PROCESS

One of the recommendations from the Keogh review was to introduce additional capacity to deal with complaints. Accordingly, additional administrative support has been implemented and the member of staff is currently being trained on the procedures, which will take approximately 4-6 weeks. A change in the office environment for the complaints team is also planned for August 2013 which will allow for an opportunity for streamlining office processes, general reorganisation and for the new administrative person to be fully part of the team.

Additional capacity is also being sought to provide assistance in dealing with the actual investigation of complaints, where there remains to be a backlog. This will commence in August 2013. The target for the Trust is to have no complaint over 50 days by 30 September 2013.

In addition to the extra capacity which has been identified, a review of the complaints process has also been completed in June 2013, which is described below.

4.1 Complaints Workshop

In June 2013 a complaints workshop was held with over 60 senior managers and nurses. At the beginning of the session we assessed how staff felt we responded and investigated complaints which were generally scored as poor and needing improvement.

The aims of the workshop were to outline:

- Context and external environment in relation to the national review of the NHS Complaints procedure
- Examples of where improvements nationally need to be made on how we deal with complaints from patients and their families.
- Rights of patients under the NHS constitution

- 'Good complaints handling' as set out by the parliamentary and health service ombudsman:

    - Getting it right
    - Being customer focused
    - Being open and accountable
    - Acting fairly and proportionately
    - Putting things right
    - Seeking continuous improvement

- How complaints are a core part of your clinical governance systems
- What our current process is for dealing with complaints and what needs to change

The workshop also looked at good and bad examples of complaint responses from the Trust and listened to a patient story of a serious complaint which has resulted in the complaint being investigated as a serious incident to demonstrate how complaints inform clinical governance issues which may not be escalated by the clinical teams.

The workshop concluded with group work on what improvements we need to make to our current process, which is summarised below:

- Greater verbal communication and engagement with the complainant as soon as the complaint arrives.
- Agreeing with the complainant what specific issues require investigating, how these will be taken forward and when this will be complete.
- Reducing the number of internal administrative steps in the process to reduce bureaucracy.
- Being clearer on the learning that arises from complaints and where action needs to be taken so that this can be audited and monitored for improvement.
- Being clear on roles and responsibilities for complaint leads.

Accordingly, a revised process has been developed, which will be implemented by 1 September 2013. This will include:

- Development of a guide to investigating complaints for staff.
- New mandatory complaints training.
- Updated complaints policy

It has also been suggested that we receive comments from patient representatives on our new process and the guide we develop, which the Trust fully supports and will progress during August 2013.

4.2 Learning lessons from complaints

As part of the Safety Panel described in section two of this report, the first review of serious complaints took place in July by the Safety Panel where open serious complaints received for the previous month and closed complaints upheld as serious were reviewed. The outputs from this are included in the various reports on safety and quality to the Trust Board this month.

From September the key learning arising from complaints to date as well as serious incidents will be mapped onto a single framework for each of the clinical services to ensure our improvement programmes and audit priorities support embedding this learning across our clinical teams. This will also provide clarity on how the outcomes from these investigations have been discussed with the clinical teams involved.

4.3 Non-Executive Director review of complaints

It has also been agreed that one of the Non-Executive Directors will review a small number of complaints each month to look at how well the complaint has been investigated both in terms of timeliness but also any learning which has been identified as a result. This process has started in July 2013.

5. CONCLUSION

A significant amount of work has been completed during June and July to make the necessary improvements on how we investigate serious incidents and complaints. However we must continue to be embed these improvements to our processes over the forthcoming months as we further reduce the backlog of both complaints and serious incidents and more importantly review the learning that has arisen from these investigations.

It is also important to highlight that supporting the clinical teams in the business units will remain a priority to ensure we sustain the improvements we are starting to make.

The role of the Safety and Quality Committee will also provide additional scrutiny and ultimately assurance to the Trust Board on our performance on dealing with serious incidents and complaints as well as how this is informing our improvement programmes across the organisation.

6. RECOMMENDATIONS

That the Board approves this report.