Policy:

MD 017 - Responding to National Confidential Inquiries and Other National Inquiries and Reviews

Executive Director lead	Executive Medical Director
Policy Owner	Head of Clinical Governance
Policy Author	Lead Nurse for Patient Safety and Clinical Risk

Document type	Policy
Document version number	V3
Date of approval	21/11/2019
Approved by	Executive Directors' Group
Date of issue	26/11/2019
Date for review	30/11/2022

Summary of policy
The Trust will contribute to the national systems and processes, such as the National Confidential Inquiries, that enable the NHS and social care to collate and analyse the information needed to gain an understanding or learn lessons from when things have gone wrong.

Target audience	Directors and Senior Clinical Staff for Cascade

Keywords	National, confidential, inquiries, reviews

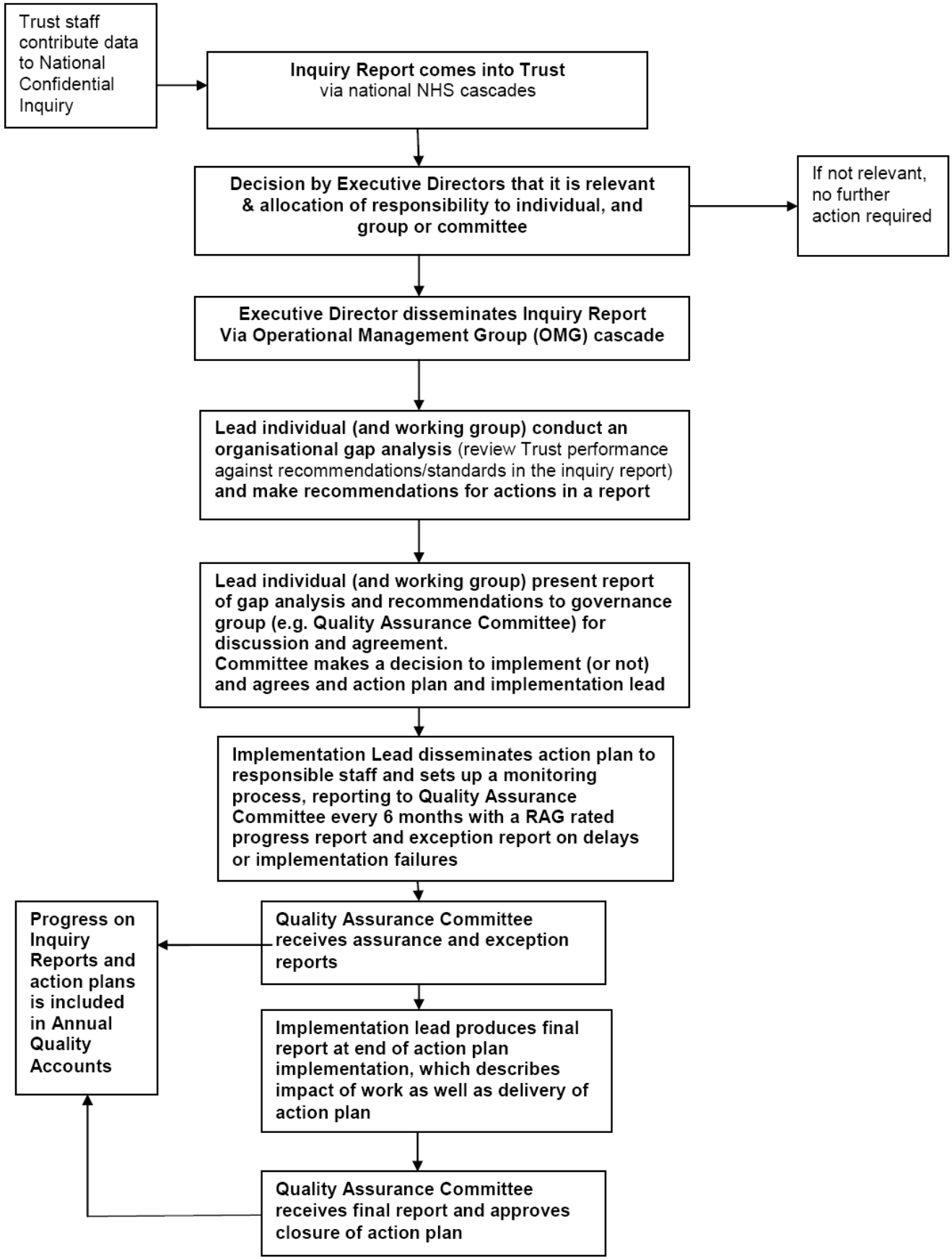
Storage
This is version 3 of this policy and replaces version 2 (ratified November 2016). This version was reviewed and updated as part of an on-going policy document review process.
This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance. Any printed copies of the previous version (V2) should be destroyed and if a hard copy is required, it should be replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
V2 DO. 1	New draft policy created	01/10/2016	Mapped onto new policy document template. Minor changes: Update and amendments to job titles, contact details throughout.
1.0	Approval and issue	01/11/2016	Finalised and issued.
V3 DO.1	Review / approve / issue	31/10/2019	Early review undertaken to update the policy to in order to comply with new regulatory requirements.

Contents

Flowchart


Trust staff contribute data to National Confidential Inquiry
Inquiry Report comes into Trust via national NHS cascades
Decision by Executive Directors that it is relevant & allocation of responsibility to individual, and group or committee
If not relevant, no further action required
Executive Director disseminates Inquiry Report Via Operational Management Group (OMG) cascade
Lead individual (and working group) conduct an organisational gap analysis (review Trust performance against recommendations/standards in the inquiry report) and make recommendations for actions in a report
Lead individual (and working group) present report of gap analysis and recommendations to governance group (e.g. Quality Assurance Committee) for discussion and agreement.
Committee makes a decision to implement (or not) and agrees and action plan and implementation lead
Implementation Lead disseminates action plan to responsible staff and sets up a monitoring process, reporting to Quality Assurance Committee every 6 months with a RAG rated progress report and exception report on delays or implementation failures
Quality Assurance Committee receives assurance and exception reports
Progress on Inquiry Reports and action plans is included in Annual Quality Accounts
Implementation lead produces final report at end of action plan implementation, which describes impact of work as well as delivery of action plan
Quality Assurance Committee receives final report and approves closure of action plan

Introduction

Sheffield Health and Social Care NHS Foundation Trust is committed to learning from the experience of others. The Trust believes that it is important for the safety and welfare of service users, carers and staff that it takes steps to learn from national inquiries and reviews. It will also contribute to the national systems and processes, such as the National Confidential Inquiries, that enable the NHS and social care to collate and analyse the information needed to gain an understanding or learn lessons from when things have gone wrong.

This policy describes how the recommendations from National Confidential Inquiries and other national inquiries or reviews will be identified, assessed for relevance to the Trust, reviewed and any appropriate actions taken as a result. It includes a description of how the Trust will monitor the effectiveness and impact of any such actions.

It also describes how the Trust will respond to requests for data for the National Confidential Inquiries.

NHS Trusts are required to participate in National Confidential Inquiries by the Department of Health guidance on clinical governance (Clinical Governance Reporting Processes November 2002), on quality in A First Class Service: Quality in the New NHS (1998)and on quality accounts (Quality Accounts toolkit 2011).

The NHS Resolution Risk Management Standards require trusts to have effective systems in place for participation in the Inquiries and acting upon their recommendations.

The General Medical Council states that clinicians should 'contribute to confidential inquiries and adverse events recognition and reporting, to help reduce risk to patients' (Good Medical Practice 2006).

2 Scope

This is a Trust–wide policy which applies to all Networks and services without any exceptions. This policy also applies to staff that work in Trust services but are not employed by the Trust. Where staff employed by the Trust work in services provided by other organisations they have a duty to follow the policies of the organisation they are working in, and comply with their process for external visits.

3 Purpose

The purpose of this policy is to ensure:

- An efficient, effective and timely response to requests for data from National Confidential Inquiries and other national inquiries or reviews;
- The effective identification of relevant National Confidential Inquiries and other national inquiries or reviews;
- The prompt dissemination of National Confidential Inquiries and other national inquiries or reviews;
- A clear process for reading the reports from relevant inquiries, assessing their recommendations and any gaps or areas of non-compliance the Trust may have;
- A process to determine what action, if any, the Trust needs to take in response;
- A co-ordinated approach to the implementation and monitoring of any actions agreed;
- The completion and impact of any actions is monitored and reviewed.

4 Definitions

National Confidential Inquiries

National confidential inquiry is a form of national clinical audit and is a method of assessing the quality of care to help identify potentially avoidable factors associated with adverse outcomes. Examples include:

- The National Confidential Inquiry into Suicide and Safety in Mental Illness (NCISH);
- The National Confidential Enquiry into Patient Outcomes and Death (NCEPOD);
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)

Other National Inquiries or Reviews

Other National Inquiries or Reviews are those following the breakdown of safe patient care (e.g. Francis Report or Shipman Inquiry).
In responding to these inquiries or reviews, the Trust will follow the same procedures as for the National Confidential Inquiries.

5 Oversight

The Trust Committee with the primary role in overseeing and monitoring compliance with any actions arising from the National Confidential Inquiries is the **Quality Assurance Committee**, a Board Sub-committee. The Quality Assurance Committee will receive a report on new inquiries together with notification as to whether they are relevant or not and the plans (with leads and timescales) to take forward any recommendations. The rationale for the decision *not* to take forward any inquiries or review reports will be recorded in the committee minutes and any risks associated with this decision will be entered on the Trust Risk Register.

For some high level national inquiries and reviews, the **Board** itself will need to have oversight of the process of reviewing the recommendations and completion of agreed actions. This will usually be determined by the content of the inquiry report itself and its recommendations. Where it is unclear, the Executive Directors' Group will decide on the most appropriate committee to have oversight.

The **Quality Improvement Group** and the **Service User Safety Group** will also play a role in disseminating inquiry reports and recommendations, and sharing good practice and lessons learnt.

6 Duties

The **Chief Executive** is ultimately responsible for the quality and safety of services and is the main contact point for the Trust when receiving reports from the National Confidential Inquiries and other national inquiries. He must ensure they are cascaded effectively to the rest of the organisation.

The **Executive Medical Director**, the **Executive Director for Nursing and Professions and Director of Infection Prevention & Control (DIPC)** may also be first contact points for relevant inquiries and reports, and as such must also take responsibility for cascading appropriately.

The **Executive Directors** are responsible for determining if an inquiry is relevant to the Trust or not. This decision may be taken by the accountable Executive Directors or by the Executive Directors Group.

The **Deputy Chief Executive** has executive responsibility for risk management and patient safety in the Trust and as such has the responsibility for ensuring there are effective systems and processes in place for the National Confidential Inquiries and other relevant national inquiries.

The **Director of Corporate Governance** is responsible for supporting the Chief Executive in distributing national briefings such as the Chief Executive Officer Bulletins from the Department of Health which will alert the Trust to new Inquiry Reports.

The Head of Clinical Governance is responsible for co-ordinating the response to requests for information from the National Confidential Inquiries, with the support of admin staff in the Service Development Directorate. She is also responsible for making sure Inquiry Reports are notified and put onto the agendas of the relevant committees for review, assurance and monitoring.

The **Clinical and Service Directors**, **Associate Directors and Professional Leads** are responsible for ensuring that the staff they manage comply with the requirement to contribute information to the National Confidential Inquiries. They must also ensure that, through their governance structures, compliance with inquiry recommendations is reviewed and any action required are identified and action taken accordingly.
All staff are required to contribute to the National Confidential Inquiries upon request. All staff must also comply with any actions arising from the national inquiries and agreed by the Trust.

7 Procedure

7.1 The process for responding to requests for data from the National Confidential Inquiries

Requests for data will be directed to the Head of Clinical Governance, who will normally be able to respond from Trust records (e.g. the Safeguard System for incident reports or Insight, the Trust's Patient Information and Care Record System).

If any further information is needed, she will seek it from other records or from individual staff, who have a responsibility to provide accurate data promptly.

Head of Clinical Governance will ensure responses are returned promptly, as fully as possible and within any required timescales.

Compliance with this process will be reported annually in the Trust's Quality Accounts. These accounts will list all the relevant National Confidential Inquiries and report on how many cases have been reported on, also expressed as a percentage of those required.

7.2 Identifying relevant National Confidential Inquiries, and other national inquiries and reviews

The Executive Directors Group is responsible for identifying relevant National Confidential Inquiry reports and those from other national inquiries and reviews, when they come into the Trust.

Notification will normally be by letter, circular, bulletin or email to the Chief Executive or to another member of the Executive team such as the Medical Director.
All National Confidential Inquiries that are pertinent to Trust service will be reviewed and appropriate action taken.

All other inquiries or reviews where the Trust is required to act by the Department of Health or a regulator or commissioner will be taken up for consideration and action.

If the Executive Directors' Group decides not to proceed with disseminating, reviewing and acting upon the reports of a relevant National Confidential Inquiry or inquiry or review mandated by the Department of Health, a statutory regulator or the commissioners, this decision must be noted in Executive Directors' Group minutes. There must also be account of the rationale behind the decision and an analysis of the risks of deciding not to proceed. Risks should be documented on the Trust Risk Register.

The Executive Directors or Board of Directors may also decide to take account of any other inquiries or reviews that they deem relevant to the work of the Trust.

7.3 Allocating responsibility to individuals, groups or committees

Once the Executive Directors' Group has decided that a particular inquiry or review is relevant to the Trust, they must also decide which individuals, groups or committees will be responsible for reviewing the report and its recommendations, conducting an organisational gap analysis, making recommendations for Trust action, developing and disseminating an action plan, monitoring the delivery of the action plan and reporting completion. A director or another senior member of staff will be given the lead responsibility for ensuring delivery of this work.

7.4 Disseminating inquiry reports and recommendations

The reports from the National Confidential Inquiries and other relevant national inquiries and reviews will be disseminated through the ODG cascade (all Executive and Associate Directors, Clinical and Service Directors, Corporate Directors, Heads of Service and Professions) by the appropriate Executive Director (e.g. the Executive Director of Nursing, Professions and Care Standards will cascade the National Confidential Inquiry reports).

The Committee which considers the inquiry report will decide how and to whom any actions arising from inquiry report recommendations will be disseminated and monitored. There is an obligation to inform any member of staff who is responsible for relevant services or required to be take any actions. Informing service users, carers and other stakeholders should also be considered.

7.5 Conducting an organisational gap analysis and determining any action needed

A gap analysis is an essential stage in the process. The allocated lead will review the findings and recommendations of the report and assess the Trust's current practice against it, using all available suitable sources of information, including incident and complaints reports, the Trust Risk Register, feedback from staff, service users and carers, audit and service evaluation reports, team governance reports, equipment inventory etc. They may choose to commission additional audits or surveys if necessary, or visit key areas of the Trust and talk to staff and service users.

This process is similar to the familiar Clinical Audit process, where standards are specified and a service assessed against these standards using a variety of methods.

Using the information collected, they will make a judgement as to whether the Trust is meeting its obligations to provide safe and effective care, or if there is a gap or breach in the Trust's systems or processes, or poor practice in any area. They will assess the level of risk any gaps present to the organisation, using the guidance in the Trust's Risk Management Strategy, and record the risks if necessary on the Trust's Risk

Register. They will record their findings from the gap analysis and present them to the appropriate committee for discussion and review.

From this review a set of actions will be agreed and an action plan will be drawn up with specific, measureable actions, timescales, lead responsibilities and the desired outcomes clearly specified. Any additional resources required to implement the plan should be identified at this stage. A person to co-ordinate, follow up and progress chase the delivery of the action plan should be identified. They will be responsible for reporting on progress towards the completion of the action plan. They are also responsible for ensuring that all staff who have actions allocated to them in the action plan are informed of these tasks.

7.6 The decision not to implement National Confidential Inquiry recommendations or those of other national inquiries and reviews

At this stage, the Trust may decide not to proceed with implementing the action plan. The rationale for this decision must be recorded in the minutes of the meeting. Any risks, especially risks to patient safety that result from the decision not to implement must be assessed using the guidance in the Trust Risk Management Policy and entered onto the Trust Risk Register with any necessary mitigating action. The Risk Register process will ensure the level of risk and the effectiveness of the mitigating action will be reviewed systematically.

7.7 Implementing and monitoring delivery of the action plan

All staff who have been allocated tasks in the action plan are responsible for carrying them out within the specified timescale and reporting back on progress to the lead co-ordinator/ progress-chaser.

The lead co-ordinator of the action plan will compile a progress report on the action plan to an agreed schedule (normally every 6 months) to the agreed Committee (normally the Quality Assurance Committee). The progress report will be Red-Amber-Green or RAG-rated to show actions completed (green), making progress on agreed timescales but not yet completed (amber) or overdue for completion (red). Explanations should be provided for any red items, together with what will be done to ensure completion or a rationale for deciding the action is no longer needed.

The impact of completing the action plan should be assessed at the end of the implementation process, as well as reporting on the completion of tasks in the action plan. This may be done by an audit across all the relevant areas or by a repeat of the gap analysis carried out earlier.

8 Development, consultation and approval

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
2.0	**Nov 2016**	**Nov 2016 via Communications Digest**	
3.0	**Nov 2019**	**Nov 2019**	

This is version 3 of this policy and replaces version 2 (ratified November 2016). This version was reviewed and updated as part of an on-going policy document review process.

20.10.2016 Initial draft revision created. Mapped onto new policy document template.
Minimal changes: Update and amendments to job titles, contact details throughout.
Consultation: N/A. Minimal changes.
Verification: Verified by the Deputy Chair of the Service Users Safety Group.

9 Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
3 yearly review	Review	Head of Clinical Governance	3 yearly	Quality Assurance Committee	Head of Clinical Governance	Quality Assurance Committee

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date should be written here – 30/11/2022.

10 Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Policy Governance	*30/11/2019*	26/11/2019
Make team aware of new policy	*Head of Clinical Governance*	*30/11/2019*	

11 Dissemination, storage and archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0				
2.0	Oct 2016	Oct 2016	Nov 2016	Mapped onto new policy document template.
3.0	Nov 2019	Nov 2019	Nov 2019	
4.0				

12 Training and other resource implications

No training is required in relation to this policy document..

13 Links to other policies, standards (associated documents)

- Risk Management Strategy
- Incident Reporting and Investigation Policy
- Policy for Management of External Agency Visits, Inspections and Accreditation
- Clinical Audit Policy
- Quality Improvement and Assurance Strategy

References

- The National Confidential Inquiry into Suicide and Safety (NCISH) website: www.manchester.ac.uk/nci
- The National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) website: www.ncepod.org.uk
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)
- The NHS Resolution: NHS Resolution website: https://resolution.nhs.uk/
- Clinical Governance Reporting Processes (Department of Health November, 2002)
- A First Class Service: Quality in the New NHS (Department of Health,1998)
- Quality Accounts toolkit (Department of Health and Monitor, 2011.)
- Good Medical Practice (General Medical Council, 2006)

14 Contact details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Chief Executive	TBC		
Executive Medical Director	Dr Mike Hunter	0114 2264838	Mike.hunter@shsc.nhs.uk
Executive Director of Nursing & Professions Director of Infection Prevention & Control	Liz Lightbown	0114 2716713	Liz.lightbown@shsc.nhs.uk
Deputy Chief Executive	Clive Clarke	0114 2163978	Clive.clarke@shsc.nhs.uk
Director of Corporate Governance / Company Secretary	TBC		
Head of Clinical Governance	Tania Baxter	0114 2718439	Tania.baxter@shsc.nhs.uk