Clinical Governance and Risk Management

Who are we?

Based in the Nursing Accommodation Building:

Adam Roberts - Risk & Litigation Manager
Ameer Chughtai - Clinical Governance Facilitator
Amirul Haque - Clinical Governance Facilitator
Cara Philpott - Clinical Governance Facilitator (interim)
Sarah Rogers - Clinical Governance Facilitator
Sophie Abela - Clinical Governance Administrator / Apprentice
Kingsley Twum - Risk & Litigation Apprentice

Based in Trust HQ:

Ash Tullett - Head of Clinical Governance
Garry Marsh - Executive Director of Nursing & Clinical Governance
Stacey Keegan - Deputy Director of Nursing and Clinical Governance

The Department of Health defines Clinical Governance as:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Department of Health 1998).

Clinical Governance Teams Responsibilities

- Incident reporting and management
- Serious incident investigations
- Litigation and Coroner’s inquests
- Risk Management
- Policies
- Compliance (Duty of Candour, NICE)
- CQC

A Just Culture for Clinical Governance

It is not just what we do as an organisation but it is also what we do as **individuals** to achieve high standards of clinical care.

Clinical Governance aims to provide:

- No Blame environment
- A safe platform to Question and Challenge behaviour
- Leadership
- Support for staff
- Improvements to patient and staff conditions
- Lessons Learnt from mistakes
- Lines of Communication between all stakeholders including patients

To achieve this, we all have a **professional duty** to put the interests of the patients we are caring for first and to protect them if we feel they may be at risk by challenging what we feel may possibly be poor or dangerous practice.

https://www.youtube.com/watch?v=zje765OEggs

What is an incident?

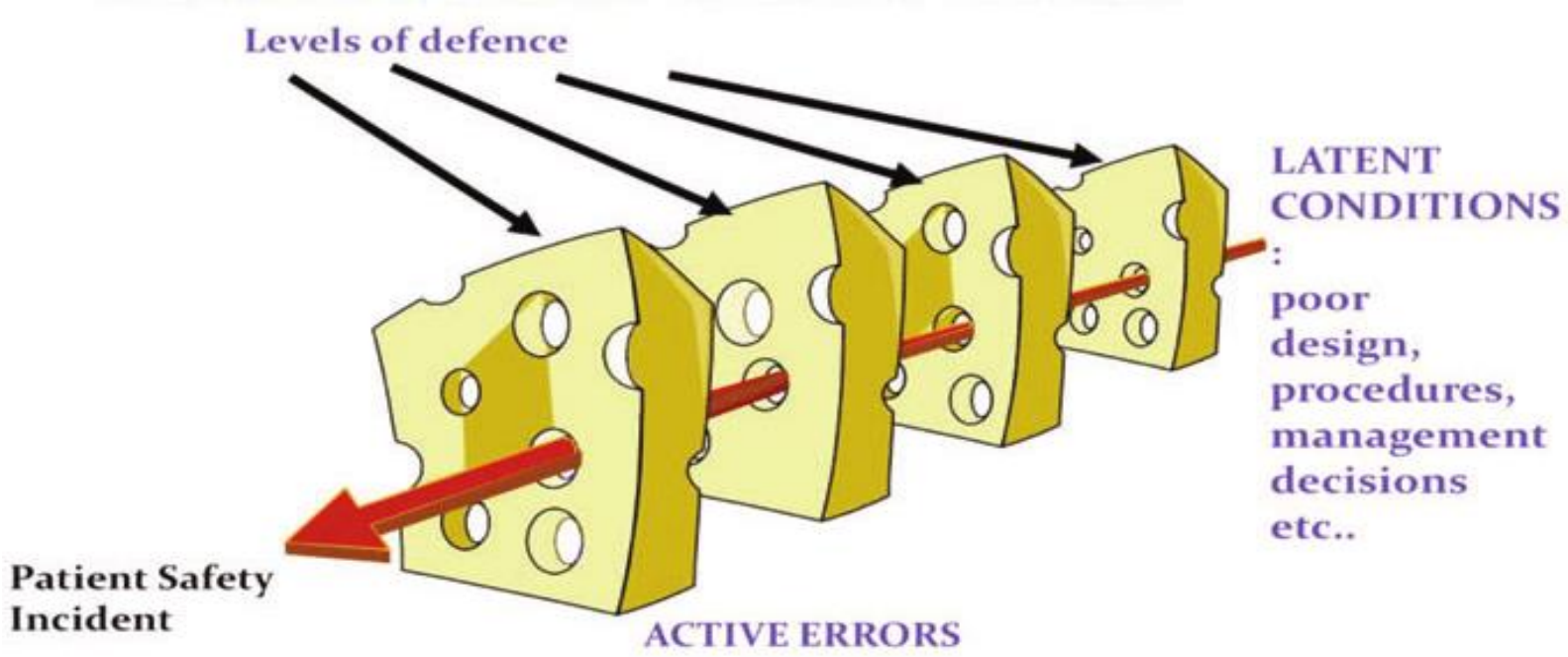
Incident - An unplanned or unexpected event that may or may not lead to injury, damage or loss to an individual or the Trust

Near Miss - An unplanned or unexpected event that had the potential to lead to injury, damage or loss to an individual or the Trust, but was prevented.

Levels of Harm

- 1 - No
- 2 - Low
- 3 - Moderate
- 4 - Catastrophic
- 5 - Death

Why do Incidents happen?



Example: Wrong Side Block – Never Event

WRONG SIDE BLOCK ← **Stop Before you Block** ← **WHO Check-list** ← **Clearly Mark Skin** ← **Check Patient's Wristband**

Incident Reporting

'The vast majority of NHS care is safe, but mistakes do happen, sometimes with tragic consequences. We can only prevent these problems if we learn from what goes wrong'

- **National Patient Safety Authority (NPSA): Medical Error**

We are all human and therefore make mistakes and have the ability to cause harm.

Why report incidents?

- Reporting Incident is a Statutory and legal requirement.
- By analysing the information gathered from incidents, we are able to Learn from mistakes and prevent incidents happening again.
- Helps ensure Trust is a safe place to work and visit

Example incidents to report:

- ✓Consent issues
- ✓Procedural Issues
- ✓Incorrect patient
- ✓Missing records
- ✓Medical Equipment
- ✓Cancellations or delays
- ✓Facilities issues
- ✓Security
- ✓Health and Safety
- ✓Inoculation injuries
- ✓Communication Issues
- ✓Violence and Aggression
- ✓Skill mix problem
- ✓Staffing

Don’t Report Issues such as:

X Running out of Printer Toner – Submit this with the IT Portal

X Personal Arguments and Disagreements – Discuss this with your Manager

Serious Incidents

- **Serious Incidents** in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so **significant** or the **potential for learning is so great**, that a **heightened level** of response is justified.

- Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

- There is no definitive list of events/incidents that constitute a serious incident. Some examples of Serious Incidents which have occurred in this Trust are:
  - Avoidable VTE (Blood Clots)
  - Grade 3 or 4 Pressure Ulcers
  - Delayed Diagnosis
- **Once Identified, serious incidents are reported to the Care commissioning Group (CCG)**

Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Some examples are:

- Wrong Site Surgery
- Wrong implant/prosthesis
- Incorrect route administration of medication
- Wrong Side Block
- Wrong Side Injection

Log on using the username and password you use to access your computer

Your Governance Homepage

Quick Links

- New Incident
- Manage Incidents
- Risk
- Safeguard Reports
- Actions

Outstanding Incidents

Click the grid below to open your Incident list

3	Waiting For Managers Form
3	Under Review
8	Actions
1	Questionnaires

Always Consider Duty Of Candour

The Duty of Candour Regulation 20 is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that led to significant harm. The intention of this regulation is to ensure that we are open and transparent with people who use our services and other 'relevant persons'. Duty of Candour aims to help patients receive accurate, truthful information from health providers. If you would like to know more about Duty of Candour requirement, contact the Governance Department on Ext 55432

What Is A Never Event?

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Some examples: Wrong Site Surgery, Wrong Implant/prosthesis, Wrong side block pain

June Incidents By Department

Filter: *ALL*

My Notes

Enter some notes below. These will automatically save when you stop typing or click out of the note.

This is only viewable by you - your own little note space!

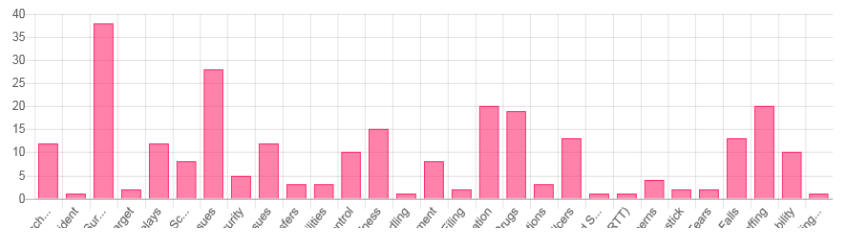
Helpful Documentation

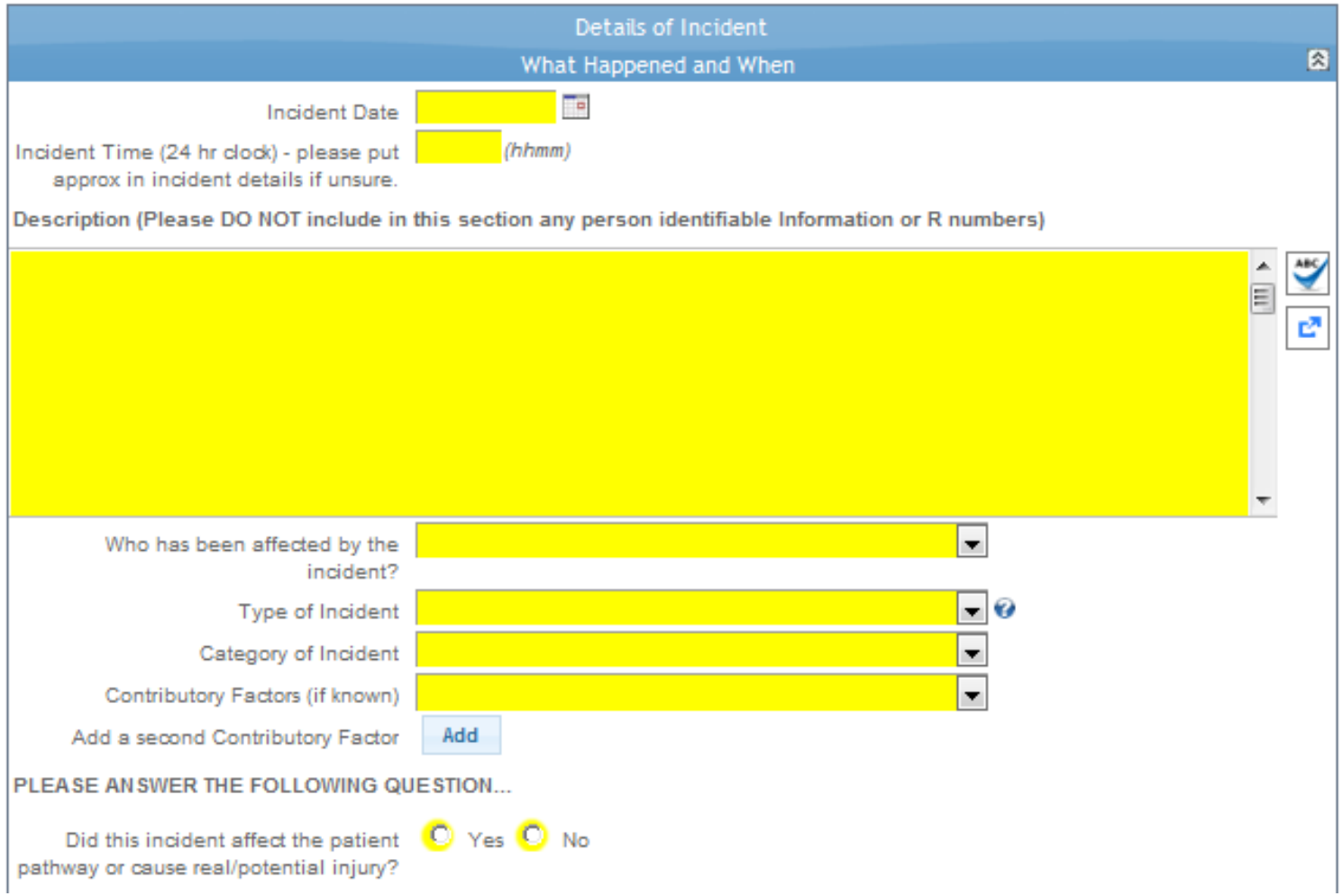
Please Click The Links Below for Additional Help :

- Incident leaflet 001.docx
- Incident management leaflet.docx
- RISK SCORING MATRIX.pdf
- letter to pt following Serious incident.doc
- DoC Letter Template 2018
- PALS Leaflet 2018
- RCA new Template.docx
- Never Events List 2018.pdf
- Serious Incident Reporting Management and Investigation Policy UPDATE 20.._.docx
- NHSi_just_culture_guide_A3.pdf

June Incidents By Department And Cause

Filter: *ALL*




Details of Incident
What Happened and When
Incident Date
Incident Time (24 hr clock) - please put approx in incident details if unsure.
(hhmm)
Description (Please DO NOT include in this section any person identifiable Information or R numbers)
Who has been affected by the incident?
Type of Incident
Category of Incident
Contributory Factors (if known)
Add a second Contributory Factor
Add
PLEASE ANSWER THE FOLLOWING QUESTION...
Did this incident affect the patient pathway or cause real/potential injury?
Yes
No

Additional Details

Please enter any immediate Actions Taken following the Incident

Location of Incident

Where did the Incident Occur?

Site

Dept/Location whch should manage this incident.

Specialty

Exact location (if an Inpt. fall)

Details of Service/Ward that Found the Incident (if different from above)

Risk Matrix

Please indicate on the matrix below the grading of this incident

Click here for Risk Assessment Guide

Likelihood (L)	Consequence (C)				
	1 - Insignificant	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
5 - Certain					
4 - Highly Likely					
3 - Likely					
2 - Possible					
1 - Remote / None					
Outcome:					

What do I need to say?

DO'S

- ✓ Give a full, objective and factual account of what happened:
  - Who was involved?
  - Why did the incident happen?
  - Where did it occur?
  - How did he incident happen?
- ✓ Include information on the immediate actions taken following the incident.
- ✓ Identify if there are any actions planned or taken to prevent a reoccurrence.
- ✓ Include the patient's full-name and ROH R. Number (and NHS Number if possible)
- ✓ Ensure the correct location and the most accurate Cause Groups are listed.
  E.G. List staff absences under Staffing Incidents, rather than communication Issues

DON'T'S

- X Don't include personal thoughts and opinions on the incident form.
- X NO CAPITALS PLEASE.
- X Don't include staff names or patient identifiable data in the main description of the incident. Please list these in the correct areas.
- X Don't include phrases such as "As above" or "See Previous Incident"

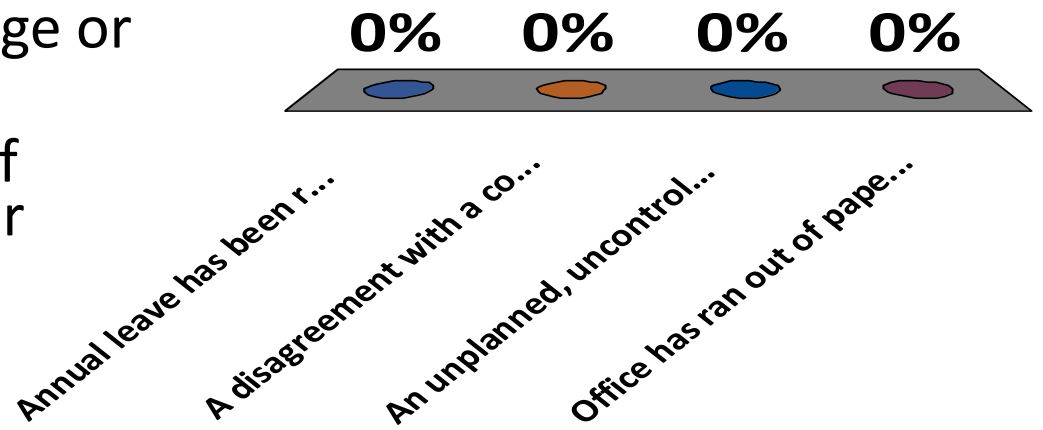
What is an incident?

A. Annual leave has been requested but not approved

B. A disagreement with a colleague about a personal issue

C. An unplanned, uncontrolled event which leads – or could lead to – injury, illness, damage or loss

D. Office has ran out of paper for the printer



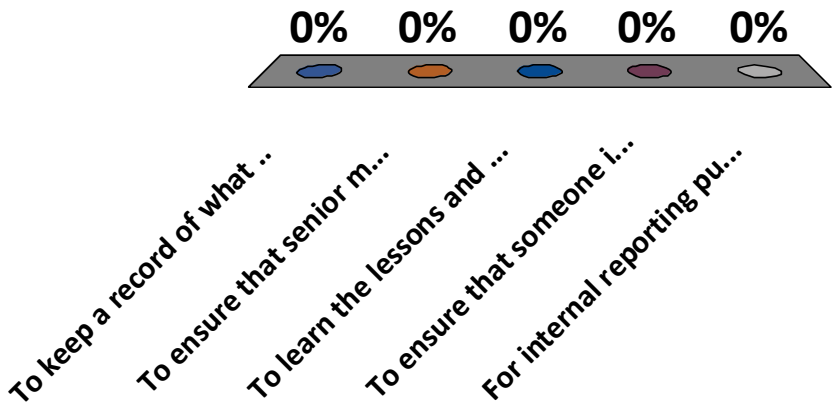
Reporting incidents

- **Make the patient or area safe.**
- Complete incident reports online for any incident or near miss.
- Report it to your team leader or manager.
- For Serious Incidents **immediately** communicate to: Nurse in Charge, Patient's Consultant, Governance department.
  Do Not Wait Until Your Next Shift.
- Make yourself available for incident investigations.
- Advice is available 24 hours a day, 365 days a year – on-call execs are there to help.

Feedback will be provided by the area line manager on the outcome of the investigation when it is complete.

Why do you need to report incidents?

A. To keep a record of what we do everyday
B. To ensure that senior management understands our frustration
C. To learn the lessons and take action
D. To ensure that someone is sacked
E. For internal reporting purposes



“I’ve sent an incident form in…what’s going to happen next?”

Management of incidents

- Relevant managers receive a copy of the incident and should check the following:

- Details
- Grading
- Actions

- Then:

- Give feedback to reporter
- Share learning appropriately

Duty of Candour: Regulation 20

- The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons‘
- Set of requirements that providers must follow when things go wrong with care and treatment, including
- Informing people about the incident
- Providing reasonable support
- Providing truthful information
- An apology when things go wrong.

*Under the contract with our Commissioners, this has to be done within **ten working days** of the incident being reported. Any breaches in the regulation can result in a fine up to £10,000

When does Duty of Candour apply?

- Incidents that, in the reasonable opinion of a healthcare professional, could result in, or appear to have resulted in
- Severe harm
- moderate harm
- Prolonged psychological harm.
- The death of the person using the service

These terms are defined in the Duty of Candour: Regulation 20

What we need to do:

- Apologise to the patient (verbal and written)
- The provider must make every reasonable attempt to contact the relevant person through all available means of communication. All attempts to contact the relevant person must be documented.
- If the relevant person does not wish to communicate with the provider, their wishes must be respected and a record of this must be kept.
- If the relevant person has died and there is nobody who can lawfully act on their behalf, a record of this should be kept.

ROH Duty of Candour Tracker checklist

VERBAL DOC

- ❑ Trust has been open, honest and transparent.
- ❑ Relevant Person notified
- ❑ Reasonable support offered, in Person
- ❑ Honest and accurate account of facts given
- ❑ Info on further enquires provided
- ❑ Verbal Apology given
- ❑ Written record of conversation

1st DOC Letter

- ❑ Letter Sent
- ❑ Letter includes:

- Details of Enquires
- Results of further enquires
- An apology

- ❑ If patient or family cannot be contacted, written record of attempts recorded.

2nd DOC Letter

- ❑ Invite to share report
- ❑ If meeting declined, report shared accompanying the 2nd DOC Letter.

Litigation

Patients wishing to pursue a negligence claim against the Trust must prove:-

- that the Trust were negligent in the discharge of their duty of care (known as ‘breach of duty’; and
- that the Trust’s negligence caused the injuries for which compensation is being claimed (this is known as ‘causation’).

Brief Overview: Litigation

- Currently have **32** open clinical negligence claims
- NHS Resolution act as our ‘insurer’. Pays out all costs associated with claims. We pay an annual premium.
- The Trusts annual premium contribution, payable to NHS Resolution as part of our membership of the CNST Scheme, **for the year 2018/19 was £4,209,526**.
- For the year 2019/20 our premium contribution is **£3,912,916**. This is a gross reduction of **£296,610**.
- Furthermore, given that on average our CNST premium contribution has risen by approx. £500,000 a year over each of the last 3 years, the reduction for 2019/20 could be viewed in effect as a net reduction of approx. £800,000.

- Average shelf-life of each currently open claim is approximately 5-6 years.

Purpose of a Coroner's Inquest

- All deaths in the UK are register
- In some cases, the local Coroner will need to investigate in the form of a public inquest, when:

- The cause of death is unknown

- The person died while in custody

- Someone is thought to have died in violent or “unnatural” circumstances

The Coroner will then make a decision as to whether the death should be investigated and if an inquest should be held.
The purpose of the Coroner’s inquiry is broadly to answer the following four questions in relation to the person who has died:

- Who they were
- When they died
- Where they died
- And how they died

- The Coroner would make decisions about what issues or facts they need to investigate in order to answer those questions.
- The purpose of an inquest is fact-finding process; not to blame anyone for the death.

Trust Support for Staff attending Inquests

- The Trust offers both emotional and practical support to help staff involved in an Inquest.
- The emotional support will come from colleagues and managers, as well as through HR and Occupational Health processes.
- To help prepare staff for giving evidence at an Inquest the Trust will provide advice and guidance on the drafting of witness statements. The Trust will also hold pre-inquest meetings for witnesses to help prepare for attending court. This involves going through what to expect on the day, in terms of the procedures and formalities of an Inquest hearing, and also provide insight into what questions may be asked at the Inquest.

- **For further support and advice please contact Adam Roberts (Risk and Litigation Manager)**

Who is liable?

- The Trust is the legal defendants in all litigation

- Personal Liability:
  - Crime
  - “Frolic”: acting outside area of expertise / authority, against Trust policies and procedures

Care Quality Commission Compliance (CQC)

There are five questions the CQC ask of all care services.

- **Are they safe?**

Safe: patients are protected from abuse and avoidable harm.

- **Are they effective?**

Effective: patients care, treatment and support achieves good outcomes, helps to maintain quality of life and is based on the best available evidence.

- **Are they caring?**

Caring: staff involve and treat patients with compassion, kindness, dignity and respect.

- **Are they responsive to people's needs?**

Responsive: services are organised so that they meet the needs.

- **Are they well-led?**

Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture

What to expect during a CQC inspection:

- Gathering the views of people who use services. This includes:
  - Speaking to people individually and in groups.
  - Using comment cards placed in GP surgeries or busy areas in hospitals.
  - Staffing pop-up engagement stalls before NHS acute hospital trust inspections.
  - Using information gathered from complaints and concerns from people who use services.
- Gathering information from staff.
- Other inspection methods include:
  - Observing care.
  - Looking at individual care pathways.
  - Reviewing records.
  - Inspecting the places where people are cared for.
  - Looking at documents and policies.

Controlled Drugs

Reporting Concerns and Reviewing Patients Regularly

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Examples include: morphine, pethidine and methadone. (The Misuse of Drugs Regulations 2001 has a full list of controlled drugs)

The CQC 'Safer management of controlled drugs annual update' report made the following recommendations relevant to ROH:

RAISING CONCERNS

- All Staff **MUST** report concerns about diversion and abuse of medicines by fellow colleagues and members of staff
- Any issues or concerns are handled sensitively and appropriately. Investigations are handled sensitively and support is made available where the health and welfare of members of staff are affected – both during and after an investigation
- You can raise concerns using the following methods;
- The Trust Ulysses incident management system
- The Trusts Controlled drugs accountable officers (Garry Marsh) or chief pharmacist (Maureen Milligan)
- Freedom to Speak up Guardian (Mandy Johal and Simon Grainger-Lloyd)

PRESCIBERS AND REGULARLY REVIEWING PATIENTS

- Prescribers must make sure that they review patients regularly, depending on their clinical need.

Objectives Review

- What is Clinical Governance?
- What is an incident?
  - Serious Incident
  - Never Event
- Reporting Incidents
- Duty of Candour
- Litigation
- CQC – Care Quality Commission
- Controlled Drugs

Further information?

Where to read more

- Trust Policies
- Local Policies and Procedures
- Governance Department
- Intranet
- Line Manager

Contact the Governance Team

- Governance Department 55432 or 55292
- Adam Roberts 55809