London Ambulance Service NHS
NHS Trust

Governance Development Unit Consolidated Risk Information Reporting Process

DOCUMENT PROFILE and CONTROL.

Purpose of the document: This document is intended to describe the process used by the London Ambulance Service NHS Trust for ensuring a systematic approach to the analysis of incidents, complaints and claims.

Sponsor Department: Governance Development Unit

Author/Reviewer: Head of Management Information. To be reviewed by July 2010.

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Amendment History			
Date	*Version	Author/Contributor	Amendment Details
31/07/07	0.1	Head of Governance	Major

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP005	Trust's Risk Management Policy	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

This document is intended to describe the process used by the London Ambulance Service NHS Trust for ensuring a systematic approach to the analysis of incidents, complaints and claims. This core process for risk management is set out in support of the overall objectives of the Trust's Risk Management Policy (TP005).

The document is set out using the five headings as recommended in the pilot version of the NHSLA Risk Management Standards for Ambulance Trusts published in May 2007. It is intended to achieve compliance with a component identified as one of the criteria from Standard 5: Learning from Experience. This document may be changed, subject to the approval of the Clinical Governance Committee as the effectiveness of the process is reviewed or so that it continues to meet new requirements issued by the NHSLA, the Healthcare Commission, or NHS London.

1.1 The headings are described below.

Duties	This section encompasses the strategic and operational roles of committee groups and individuals in aggregating the data, producing analyses, and reporting to the Board subject to approval by the Audit Committee using the mechanism of the Risk Information Report.
Coordinated Approach	This section sets out details of how the report represents a coordinated approach.
Frequency	This section describes when the Clinical Governance Committee will receive the Risk Information Report.
Information	This section describes the information provided within each section of the report including qualitative and quantitative analysis.
Communication	This section describes how the information from the report and any recommendations related to it made by the Committee will be conveyed to individuals and the Trust Board.

2. Duties

The Clinical Governance Committee, with responsibility for ensuring the progression of high quality clinical care within the LAS, receives the Report and makes recommendations regarding the management of risk based on the analyses it contains. These recommendations if relating to a new risk, or regarding an existing risk already in the Risk Register, are made to the Risk Compliance and Assurance Group which is the Risk Management Committee of the Board.

The Audit Committee and the Risk Compliance Group may request the Risk Information Report is placed on their agenda, after it has been considered by the Clinical Governance Committee. Only the Audit Committee will make recommendations, based on the analysis from the Risk Information report, to the Board.

The Head of Governance is responsible for the collation, quality and presentation of the Risk Information Report to the Clinical Governance Committee in the first instance.

The Head of Legal Services is responsible for providing qualitative and quantitative analysis relating to claims, potential claims, and inquests.

The Complaints Manager is responsible for reporting qualitative and quantifiable data relating to external complaints and Serious Untoward Incidents.
The Senior Health and Safety Adviser is responsible for all incident reporting.

The PALS Manager is responsible for reporting on concerns/enquiries received by the PALS team.

The Diversity Manager is responsible for contributing analysis of the Trusts compliance with national guidance on diversity by the Trust including implementation of the Trust's Race Equality Scheme and related action plans that may represent risks to the achievement of the Trust's principal objectives.

3. Coordinated Approach

The report will contain data in the topic areas of Complaints, Claims and SUIs, Inquests, Incidents, Control Services, Concerns raised with the PALS team and the approach to Diversity.

Each data set will contain details of reports from every operational area. The recommendations in each section will make explicit links between different sections, for example if an increase in concerns about treatment of mentally ill patients has been mirrored by an increase in complaints.

Contributors to each section of the report liaise routinely with each other to identify whether a theme or trend is represented across more than one topic area, for example if incidents about patient care which have been reported by staff correlate to an increase in complaints around the same or similar aspect of patient care.

Each topic area will report for the same standard period (i.e. 3/4 months) so that a minimum of two Risk Information Reports are presented to the Clinical Governance Committee during the financial year. The reports will include details of lessons learned, actions taken, and where organisation-wide change has been made as a direct result of an action plan from an investigation, this change must be described in detail. Where new risks are identified then the contributor should provide a completed Risk Report form as detailed in the Trust's Risk Reporting and Assessment Procedure (TP035) and deliver it under the agenda item Risk Register Update at the same meeting of the Clinical Governance Committee.

At alternate meetings of the Clinical Governance Committee, when the Risk Information Report is not presented, contributors to the Report will collate a themed report with comprehensive information from their respective topic areas including analysis and suggested risk management action to be taken. If this is agreed then the action will be communicated as set out under the heading 'Communication' below.

4. Frequency

The report will be provided for a minimum of 2 and no more than 3 times per financial year to the Clinical Governance Committee, and key points relating to lessons learned, risk controls and action taken will be summarised for inclusion in the annual report of the Clinical Governance Committee to the Board.

5. Information

5.1 General

Each section of the report will include data of activity for the quarter with comparison against the previous quarter. Qualitative analysis, identifying trends and themes, identifying new risks will be set out at the end of each section and provided in summary format to introduce the report and highlight recommendations/analysis/risk management action for the attention of the Committee.

5.2 SUI's

- Brief description of any SUI reported during the period covered by the Report, including action taken to comply with the SUI Policy specifically reporting details communicated within advised timescales to NHS London and the NPSA.
- Update on implementation of SUI recommendations completed since the last SUI report.
- Action taken as a result of recommendations from an SUI report, i.e. clinical advice published trust-wide in Patient Care News.

5.3 Complaints

- % written complaints for which a local resolution was completed within 25 working days.
- % acknowledgment within 48 hours (quarterly).
- % of completed outcome reports (quarterly).
- Number of 2nd stage complaints referred to the Healthcare Commission.
- Summary of outcomes/actions taken as a result of complaints that contributed directly to improving patient care/provide evidence of organisational learning/will prevent reoccurrence.
- Breakdown of complaints by subject and service area.

5.4 Claims, Potential Claims and Inquests

- Closed Clinical Negligence Claims and 'Problematic' Inquests. Summary to include date of incident, synopsis, result, review of action taken by Medical Director, and any outstanding actions still to be done (including dates for implementation).
- Trend analysis by quarter of; patient claims opened, obstetric claims opened, clinical claims breakdown by type, number of problematic inquests.

5.5 Incident Reporting

i) Number of incidents per quarter logged on Datix compared with number of logged incidents for previous quarter.

ii) Table of 15 most common incidents classifying by incident type on one axis and by Risk Rating category from the Trust's Risk Scoring Matrix, as set out in the Risk Reporting and Assessment Procedure.

iii) Incidents by type. Graph using the following categories;

- Accidents to Patients
- Accidents to Staff
- Clinical Accidents/Risk
- Violence and Aggression
- Others

Using data from current quarter to be compared with previous quarter.

Accidents to Patients

- Table with incident descriptor, e.g. slip, trip or fall, on one axis against risk rating category from the Trust's Risk Scoring Matrix.
- Analysis to compare number of patient accidents with previous quarter, with commentary on the level of risk rating most prevalent.

Accidents to Staff

- Table of 10 most frequently reported types of incidents/accidents to staff, again using risk rating. Analysis to include number of staff accidents with same category as in previous quarter. Graph to compare incidence and prevalence of three most common incidents/accident.
- Table of clinical incidents and near misses to include actions taken arising from investigation. This table is compiled from LA52s that are also reported to the NPSA. It should only include data from the current quarter and the previous quarter.

5.6 PALS

- Table of Activity, broken down by monthly comparison with data from the previous quarter to include analysis of case management.
- Table of PALS cases referred to complaints and outcome of referral, i.e., complaint investigation underway.
- Classification table using 10 most frequent concerns raised by public, compared with data from previous quarter.
- Summary of information from PALS case management circulated monthly to managers during the period covered by the report.
- Twenty outcome reports from PALS cases where there is evidence of improvement in patient care, reduction of risk, to include reference to working in partnership with other agencies that occurred during the period covered by the report.

5.7 Diversity

- To include tables, analyses to provide information for the Committee to assess progress against the milestones within the Trust's Race Equality Scheme and subsequent requirements of legislation relating to equality (i.e. Single Equality Scheme).

5.8 Control Services

- Without duplication of information previously presented as part of the Area Governance report, the data, formats, and analysis will follow the outlines given above for other sections of the report.
- This will mean that trends, themes and risk management treatment will be reported with comparison with previous quarterly report on this area and analysis to identify trends, themes, forecasts and new risks.

6. Communication and Monitoring

After the Report has been considered, lessons learned to be shared trust-wide from all sections of the report and the main decisions taken by the Committee regarding the management of risks highlighted in the report will be given to all area governance groups to be distributed to frontline staff at complex level. Feedback from frontline staff will be encouraged so that it can be included in Area Governance Reports. This is the process by which the organisation ensures that lessons learnt from analysis result in change in either organisational culture or practice.

At strategic level the Clinical Governance Committee will respond to recommendations and proposed new risks by referring them to the Risk Compliance and Assurance Group who act as the delegated Committee that manages risk on behalf of the Trust Board.

The Risk Information Report summary will be reported as a component of the Clinical Governance Committee report containing analysis of key improvements in risk management and learning outcomes during the period covered in the Risk Information Reports

6.1 Review of Effectiveness

The Committee agenda will include a review of the effectiveness of Risk Information Report after considering the final Risk Information Report each year, and the information given in reports during that period. The Clinical Governance Committee will give feedback to contributors, so that the process for producing the Risk Information Report remains an effective tool for assessing the quality and quantity of risk management in the Trust.

IMPLEMENTATION PLAN	
Intended Audience	For all LAS staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	
Monitoring	See section 6.0