Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Clinical Outcome Review Programme Policy

Incorporates:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Confidential Enquiry into Maternal deaths, stillbirths and perinatal deaths (MBRRACE, formerly CMACE)
National Confidential Inquiry into Suicide and Homicide (NISH)

This procedural document supersedes: CORP/COMM 20 v.2 – Clinical Outcome Review Programme Policy

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor:	Sewa Singh
Name and title of author/reviewer: (this version)	Dr. Padma Gopal Trust NCEPOD Reporter
Date revised:	October 2017
Approved by (Committee/Group):	Policy Approval and Compliance Group
Date of approval:	8 November 2017
Date issued:	22 November 2017
Next review date:	October 2020 **– extended to October 2023**
Target audience:	Trust Wide clinical staff

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	22 November 2017	• Introduction: Child Health work commissioned • Changes made to accommodate change of responsible staff. Mothers and babies: reducing risk through audits and confidential enquiries (MBRRACE)	Dr. P Gopal
Version 2	25 November 2014	• Policy now reflects the Clinical Outcome Review Programmes • Changes made to accommodate organisational changes to clinical management structure and reporting lines	Mandy Dalton/ David Northwood/ Andrea Squires
Version 1	June 2012	• This was originally part of CORP/COMM 10 v.2 - Policy for the receipt, distribution and review of national reports and guidance (incorporating NICE, NSF's, National Confidential Enquiries and High Level Enquiries) Now a stand-alone document: please read in full	Mandy Dalton and David Northwood

Contents

1 INTRODUCTION

The Clinical Outcome Review Programme (previously known as Confidential Enquiries), are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

The programme aims to complement and contribute to the work of other agencies such as NICE; Clinical Governanace Committee (CQC), the Royal Colleges and academic research studies with the aim of supporting changes that can help improve the quality and safety of healthcare delivery.

The Clinical Outcome Review Programmes are commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England, DHSSPS Northern Ireland, the Health Department of the Scottish Government, the Welsh Government, the Channel Islands and the Isle of Man.

Current programmes and suppliers:

- **Medical and Surgical programme:** National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- **Mental Health programme:** National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) - University of Manchester).
- **Child Health programme:** The Child Health Work started beginning of this year, Commissioned by H*P* on behalf of England, Wales, Northern Ireland, Scotland and the Offshore Islands. NCEPOD reviews the quality of care provided to children and Young People.
- **Maternal, Newborn and Infant programme: MBRRACE-UK** – Mothers and Babies: Reducing Risk through Audits and confidential Enquiries across the UK.
- **National Review of Asthma Deaths: Royal College of Physicians**
- **Children's Head Injury Project*:** University of Cardiff *not included in 2012/13 Quality Accounts.

  This procedural document has been developed to ensure that the Trust has in place, a systematic approach for participation in all of these programmes. It will demonstrate:

  - a system is in place to respond to requests for data and information
  - a systematic approach to reviewing the findings and responding to the recommendations of the clinical outcome programmes
  - a process to identify shortfalls and deficiencies within the Trust following review of the recommendations of the clinical outcome programmes
  - how clearly defined action plans with agreed staff responsibilities will be formulated to deal with any identified shortfalls and deficiencies.

2 DUTIES AND RESPONSIBILITIES

2.1 Board of Directors (BOD)

The Board of Directors (BOD) receives details of all clinical outcome review programmes within the Trust via the Clinical Governance Committee.

In accordance with annual guidance from CQC, a report on the Trust's participation in Clinical Outcome reviews will be submitted as part of the Quality Accounts.

2.2 Medical Director

The (BOD) delegates the responsibility of participation in all clinical outcome reviews to the Medical Director.

Some of these responsibilities are mutually agreed and delegated to the Local National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Reporter, Local Reporter (LR) and Mothers and babies: reducing risk through audits and confidential enquiries (MBRRACE) reporter.

2.3 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Reporter Will:

- Provide data returns as described in **section 4**
- Receive new NCEPOD reports and ensure the relevant Care Group Clinical Directors and Care Group Clinical Governance Leads are aware of these.
- Inform the Medical Director, Deputy Director of Quality and Governance and appropriate Care Group Clinical Governance Leads about planned NCEPOD studies.
- Receive and ensure completion of Organisational questionnaires as requested by NCEPOD.
- Ensure initial study data requested by NCEPOD is collated and dispatched according to designated deadline.
- Ensure individual clinicians receive questionnaires and act as a source of help and information for clinicians.
- Maintain an overview of individual clinician compliance with regard to data submission to NCEPOD.
- Supply information to the Head of Audit and Effectiveness to enable completion of the annual Quality Accounts.

- Submit an annual report regarding NCEPOD activity to Clinical Governance Committee via the Patient Safety Review Group
- Inform the Medical Director, Deputy Director of Quality and Governance and appropriate Care Group Clinical Governance Leads about launch dates for NCEPOD reports.
- Ensure Care Group Clinical Governance Leads and Care Group Clinical Directors receive finalised NCEPOD reports/summaries relevant to that speciality to enable review of recommendations made.

2.4 Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries (MBRRACE) Reporter Will:

- Receive new MBRRACE reports and undertake a gap analysis. (**Appendix 1**)
- Report to the Clinical Director, Head of Midwifery and General Manager of the Children and Families Care, the findings of the gap analysis.
- Report the recommendations and any actions to be taken to the Maternity Services Clinical Governance Group.
- Submit an annual report regarding MBRRACE activity to Patient Safety Review Group
- Assist the Medical Director in co-ordinating Trust response to recommendations which cross speciality boundaries.

2.5 National Confidential Inquiry into Suicide and Homicide (NCISH)

All incidences of suicide and homicide that occur in the UK are examined by the Centre for Suicide Prevention to determine if mental health services have been involved. The Trust contributes in providing data to this survey via HM Coroner.

2.6 Head of Audit and Effectiveness

The Head of Audit and Effectiveness maintains a database of relevant clinical outcome review activity to inform preparation of the Annual Quality Accounts.

2.7 Care Group Clinical Director

The Care Group Clinical Director is ultimately responsible for ensuring actions are taken in response to any clinical outcome reviews relevant to their specialty. This includes timely submission of data by clinical staff, review of published reports, gap analysis of practices and processes against recommendations and actions to be taken to address identified deficiencies. This co-ordination will be delegated to the **Care Group Clinical Governance Lead.**

2.8 Clinical Governance Committee (CGC)

The Clinical Governance Committee receive gap analysis reports from Care Group Governance Leads and monitor action plans identified for progress and completion.

Receives annual report from Local NCEPOD Reporter and Lead MBRRACE Reporter or matron.

Ensures compliance with this policy throughout the Trust, and reports to the Trust Board issues of non-compliance and service deficiencies identified from the gap analyses.

Documents the reasons for considered rejection of any confidential enquiry recommendations.

2.9 Medical Staff

The General Medical Council consider it to be good practice for all doctors to contribute to National Enquires. *Good Medical Practice* (2013 - para 14) and *Confidentiality* (October 2009 - para 30).
Consultants, whose patients are included in an NCEPOD study, are responsible for submitting the relevant data with accuracy, completeness and within the specified deadline.

3 PARTICIPATION IN CLINICAL OUTCOME REVIEWS

3.1 MEDICAL AND SURGICAL PROGRAMME : The National Confidential Enquiries into Patient Outcome and Death (NCEPOD)

The National Confidential Enquiries into Patient Outcome and Death (NCEPOD) are conducted by an independent body which accepts suggestions from various stakeholders to investigate the standards of secondary care in England, Wales and Northern Ireland (including the Independent Sector).

Uniquely, the data collected by NCEPOD is submitted to peer review by practising healthcare personnel.

Quality of the process of delivering care is usually assessed using a 5 point scale:

1. Good practice
2. Room for improvement – clinical
3. Room for improvement – organisational
4. Room for improvement – clinical and organisational
5. Less than satisfactory.

These judgements are reviewed and each NCEPOD report will contain several recommendations based on the results which will improve the quality of patient care when implemented.

Participation will involve identifying and submitting data and patient details as requested by NCEPOD: the receipt, distribution and review of the subsequent reports; and the recognition of relevant recommendations and their implementation.

3.2 MATERNAL, NEWBORN AND INFANT PROGRAMME: 'MBRRACE-UK' Investigating Maternal Deaths, Stillbirths and Neonatal Deaths

This enquiry covers both Maternal deaths and Perinatal deaths including late fetal loses from 20 weeks or 400gms where gestation uncertain, stillbirths and neonatal deaths to 28 days.

The following two processes apply:

Maternal Deaths

In line with the Guideline on Maternal Death (Maternity service guideline 121) the on call maternity manager attending or being informed of the incident informs the Consultant on call, Executive on call, Head of Midwifery and General Manager, The Coroner will be informed electronically by the on call Consultant or Registrar where the death has occurred within Maternity Services. One Clinician should co-ordinate the completion and submission to MBRRACE in liaison with a nominated Matron or Bereavement Midwife. Initial contact by phone. The Head of Midwifery (HOM) oversees the process.

Perinatal and Infant Deaths-

Reporting of perinatal and infant deaths is made by a designated Neonatal Unit Sister – currently Regional Co-ordinator, direct to MBRRACE,

MBRRACE Reporters enter details of the perinatal deaths onto the electronic MBRRACE reporting system.

4 PROCESS FOR ENSURING THE TRUST RESPONDS TO REQUEST FOR DATA

LR reviews the NCEPOD website at least monthly to identify new proposals for studies and their protocols.

NCEPOD send request to LR for initial data to identify patients to be entered into a new study and for submission of organisational data.

Appropriate staff identified and tasked by LR to obtain data and prepare this for submission to NCEPOD in required format. Copy of data stored by LR prior to submission to NCEPOD.

Requests for information from individual consultant staff is made via two possible routes:

1. NCEPOD sends request for information directly to individual concerned. LR informed by NCEPOD of consultants involved in the study and the deadlines for data submission.

   LR updated quarterly by NCEPOD about data returns received.

   LR encourages Consultants to submit data, and reminds those who have not to do so.

2. NCEPOD sends all requests for information to LR, who then distributes these to each consultant identified.

   LR updated quarterly by NCEPOD about data returns received.

   LR encourages Consultants to submit data, and reminds those who have not to do so.

   Compliance with data returns recorded by LR to form part of annual report to Patient Safety Review Group (PSRG) and submission to annual Quarterly Accounts.

   Repeated non-compliance by individuals reported to Medical Director.

   The On call Supervisor of Midwives will ensure that any maternal death is reported to the local supervising authority.

5 PROCESS FOR IDENTIFYING RELEVANT DOCUMENT

Relevant documents are identified as:

- Data collection questionnaires
- Guidelines concerning accurate completion of questionnaires
- NCEPOD reports and summary reports.
- Gap analysis forms.

All relevant documents can be found on the NCEPOD website at www.ncepod.org.uk

The LR identifies documents requires for each phase of each study and informs appropriate participants to obtain them from the website, or sends copies of the documents directly.

NCEPOD may send relevant documents directly to medical staff, LR or Medical Director.

6 IDENTIFICATION OF CLINICAL OUTCOME RECOMMENDATIONS RELEVANT TO THE SERVICE: PROCESS FOR CONDUCTING AN ORGANISATIONAL GAP ANALYSIS

Confidential enquiry reports are received by the NCEPOD reporter and the lead MBRRACE Reporter/bereavement midwife or matron. The NCISH report is received by the Medical Director. All of these enquiries will have a gap analysis undertaken. (**See Appendix 1).** The LR sends the NCEPOD report to Care Group Leads and Care Group Clinical Directors of the relevant specialities with a request that a gap analysis is performed after review of the recommendations in the report.
LR suggests a deadline for completion of gap analysis (usually 3 months). Deputy Director, Quality and Governance is informed of gap analysis requested and deadline, to enable completed analysis to be placed on PSRG agenda.

NCEPOD "self-assessment checklist for Trusts" sent with each NCEPOD report to facilitate completion and documentation of gap analysis.

Gap analysis conducted under auspices of relevant Care Group Clinical Governance Lead.

Should cross speciality gap analysis be required, the Deputy Director, Quality and Governance will be informed by LR who will form a cross speciality working group to complete the task.

7 PROCESS FOR ENSURING THAT RECOMMENDATIONS ARE ACTED UPON THROUGHOUT THE TRUST

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Recommendations Contained in the Confidential Enquires	Deputy Medical Director for Clinical Standards Local NCEPOD Reporter	Within 4 months of publication of a study	1.Action Plans from cross specialty working groups are presented to PSRG by Working group Lead 2. Reported to Trust board Quality Meeting via PSRG minutes

8 PROCESS FOR DOCUMENTING ANY DECISIONS NOT TO IMPLEMENT CLINICAL OUTCOME REVIEW RECOMMENDATIONS

Recommendations not considered relevant for implementation are recorded in PSRG and the appropriate Care Group Clinical Governance meeting minutes, having been identified during the gap analysis process.

Non–implementation of recommendations due to circumstances outside the control or influence of the Trust will be entered onto the corporate risk register after review by the CGC.

9 TRAINING/SUPPORT

Individual training requirements from Care Groups will be met by the local NCEPOD reporter.

10 MONITORING OF COMPLIANCE WITH POLICY

LR to monitor compliance with initial data capture and dispatch to NCEPOD, and individual Consultant reporting.

LR gives annual update to PSRG and Head of Audit and Effectiveness for inclusion into annual Quality Accounts.

Standing item on PSRG agenda to receive progress reports from Care Group Clinical Governance Leads regarding gap analyses and action plans relevant to NCEPOD recommendations.

Trust Board receive Annual report via minutes of the Clinical Governance Committee (CGC).

11 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 2).

12 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

CORP/EMP 4 – Fair Treatment for All Policy
CORP/EMP 27 – Equality Analysis Policy
CORP/COMM 10 – NICE Guidance

13 ABBREVIATIONS USED IN THIS POLICY DOCUMENT

BOD	Board of Directors
CEMACH	Confidential Enquiry into maternal and child health
CGC	Clinical Governance Committee
HOM	Head of Midwifery
HQIP	Health Quality Improvement Partnership
LR	Local NCEPOD Reporter
LSA	Local Supervising Authority
MBRRACE	Mothers and babies: reducing risk through audits and confidential enquiries. New body to continue the work of CMACE, investigating maternal deaths stillbirths and neonatal deaths
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Inquiry into Suicide and Homicide
PSRG	Patient Safety Review Group
QA	Annual Quality Accounts

14 REFERENCES

1. Reports from the National Confidential Enquiry into patient Outcome and Death (NCEPOD) are available at: www.ncepod.org.uk.

2. Reports from Maternal, Infant and Perinatal Programme (formerly Maternal and newborn programme, led by the centre for maternal and child enquiries (CMACE) are available at : www.hqip.org.uk.

3. Reports from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

4. Good Medical Practice (2013 - para 14).

APPENDIX 1 – GAP ANALYSIS DOCUMENT

TITLE OF REPORT:

Gap Analysis – DATE

Gap Analysis

No.	Recommendation	Compliance	Comments	Action required (if non or partial compliance)	Timescale	Responsibility

NCEPOD REPORTER/MBRRACE REPORTER/ MEDICAL DIRECTOR Authorisation.

Name:..... Signature:.....

Please return your complete form to the Audit and Effectiveness Department

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
CORP/COMM 20 v.3	Medical Director	Padma Gopal	Existing	20 October 2017

1) Who is responsible for this policy? : Corporate Medical Directorate

2) Describe the purpose of the service / function / policy / project/ strategy? To ensure compliance with National Confidential Enquires

3) Are there any associated objectives? Legislation, targets national expectation, standards: No

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] - No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **October 2020**

Checked by: **Ray Cuschieri** **Date:** **November 2017**