Raising Awareness Policy

Document Details		
Title		Raising Awareness
Main points		Regarding the raising awareness policy
Who is the document aimed at?		All staff
Author		
Approval process		
Approved by (Clinician/Manager)		EMT
Most recent approval date		May 2024
Category		Clinical administration
Sub Category		Raising awareness
Next review date		January 2026
Distribution		
Who the policy will be distributed to		All staff
Document Links		
Required by CQC		
Other		
Amendments History		
No	Date	Amendment
1	05/03/2020	Changed reporting and investigation sections to reflect new process
2	28/05/2024	Updated detail around Area Leads
3	12/09/2024	Updated link to new RA form
4		
5		

Introduction

Improving the quality and safety of patient care is the key clinical governance priority in primary healthcare. Hope Citadel believes SEA (Significant Event Analysis) and more general Raising Awareness has a central role to play in achieving this aim. This policy specifically describes the process for reporting, investigating and responding to all significant and adverse events. We have heavily relied on 'best practice' in the formation of this policy.[1,2]

Purpose

The purpose of this policy is to ensure that

I. all members of staff have the confidence to report incidents that *may* require investigation
II. that each clinical team has the tools to reflect on these events and change their systems and practices appropriately and,
III. that the Leadership of the company can be made aware of the performance of the governance systems at practice level and influence what happens there.

Culture

Recently released GMC guidance[3,4] sets out standards for the medical profession in dealing with adverse events and the required culture that;

> *"allows all staff to raise concerns openly and safely."*

At Hope Citadel we believe that our culture is one of our most effective clinical tools. We have worked hard to create an open, truthful, reflective and humble atmosphere where we jointly share our teams, and patients, successes and challenges. This is achieved by clinicians and managers leading by example; by viewing reporting as a success; by being transparent about what has been reported and the sequelae of these reports, by Significant Event Analysis being timetabled into regular meetings; and, by strongly enforcing a 'no blame' culture where each investigation seeks to discover the root systemic cause of the event and learn what changes to these systems need to be enacted. No individual should feel that they are 'on trial' in any Hope Citadel SEA meeting. This emphasis on culture and candour is in keeping with many of the recommendations made by Robert Francis QC in his report on the public inquiry into the problems at Mid Staffordshire Foundation NHS Trust.[5]

Reporting

The reporting process will be introduced to each staff member, clinical or non-clinical, within their induction and/or their first attendance of a practice meeting where there is a discussion about SEAs/incidents. They will learn how to identify a significant event.[6] When they have a significant part in or witness an incident, they will complete a Raising Awareness form which can be found on Raising Awareness Form (office.com). This will be done independently and as soon as possible after the event. Although there exists a common consensus about what may constitute a Raising Awareness incident, staff will be encouraged to report any event they believe to be of value, including causes of celebration and potentially minor incidents that, nevertheless, occur in significant frequency.

Investigation

Completed forms will be sent to the practice manager, who will review the form and discuss it with their clinical lead. Low risk incidents will be discussed at the next practice meeting with the whole team. Any SEAs or incidents with moderate or severe risk will be highlighted to the Executive Management Team through the Area Lead or Head of Operations. You may also alert Lisa Nolan and Laura Neilson urgently for more time pressing situations. If the practice manager and clinical lead are finding it difficult to triage the risk, then they should speak to Lisa Nolan, Laura Neilson or their Area Lead for advice. At that stage the initial investigation may be deflected back into the next practice meeting, or brought to the next suitable EMT meeting.
A discussion will contain the following features

a) The basic ground rules of shared ownership and 'no blame' culture will be reiterated as often as the manager feels appropriate.
b) Minutes will be kept
c) An open, honest and facilitated discuss will take place to discover the root causes of the event.
d) An action plan will be formed, and its implementation checked at the next meeting

There are various ways an incident can be discussed, including the Glasgow Grid '5 Whys' analysis, or a case discussion including other key stakeholders. This will be to the discretion of the clinical lead and practice manager.

Reporting Grid

The form will populate a reporting grid which holds all the forms from across the company. The purpose of the reporting grid is to allow the company leadership team to have an at-a-glance view of the current clinical governance issues. It also allows EMT and the board to carry out 'trend analysis' about persistent/deteriorating incidents that would merit intervention or discussion at a wider scale, such as changes to the appointment book or repeat prescribing systems.

External reporting

At Hope Citadel we are committed to sharing our learning and reports within our locality clinical governance structures. Normal confidentiality policies apply. We will also share any information concerning significant events that could benefit patients and practices unaffiliated to our company. This will happen via local clusters or directly to the CCG Clinical governance lead depending on the severity of the incident and/or the appropriateness of learning point.

Conclusion

This policy demonstrates our values of care and openness as well as our commitment to patient safety. We believe we have and can keep a culture where reporting is seen as a positive and collaborative process. In keeping with current best practice, we will aim to keep the leadership, frontline practitioners and patients as closely connected as possible in the maintaining of high clinical standards.

Appendix 1 – Examples of events that should be highlighted as Raising Awareness Events

Clinical events

Any death - particularly unexpected, mental health associated, or child deaths
Delayed diagnosis
Wrong diagnosis of serious condition
Medication issued for wrong patient
Lost referrals
2ww delays
Significant rejections from referrals - pattern recognition
Medication errors- adding meds but not stopping them, wrong dose
Unavailability of drugs
Mislabelled bloods.
Bloods taken from wrong person
Notifiable illness
Ambulances being called
Sectioning patients

Patient Behaviour

Police being called for anything
Zero tolerance letters
Patients being removed from the list
Episodes of violence or aggression
Stalking of staff

Safeguarding issues

High level concerns either child or adult
Trafficking
Grooming
CSE

Non clinical issues

Day without adequate clinical cover
Clinic cancelled short notice
IT issues - EMIS down, docman down
Build up of clinical admin , results being delayed-
Delayed tasks with clinical consequences.
Letters being sent to wrong patient
Data breaches
Security issues - alarms, locks, doors,
Injuries sustained at work or for patients at the surgery

Things that arrive by letter

Coroners letters
Complaints letters
NHSE letters investigation
Ombudsman letter

Appendix 2 – Glossary of Harm for triage purposes

Prevented Patient Safety Incident – *'Near Miss'*

Any unexpected or unintended incident which was prevented so no harm occurred.

No Harm Patient Safety Incident

Any unexpected or unintended incident which ran to completion but no harm occurred.

Harm

Harm is defined as injury, suffering, disability or death.

· Levels of severity of 'Significant Events'

'None'

A situation where no harm occurred: either a Prevented Patient Safety Incident or a No Harm Patient Safety Incident.

'Low'

Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons.

'Moderate'

Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.

'Severe'

Any unexpected or unintended incident which caused permanent or long term harm, to one or more persons.

'Death'

Any unexpected or unintended incident which caused the death of one or more persons

[1] NHS Education for Scotland (2011) *Significant Event Analysis- Guidance for Primary Care Teams* http://www.nes.scot.nhs.uk/media/346578/sea_-_full_guide_-_2011.pdf

[2] Bowie P., McKay J. *Seven steps for significant event analysis for primary care teams*. http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59804

[3] General Medical Council (2013) *Good medical practice* London, GMC (paragraphs22-25)

[4] General Medical Council (2012) *Raising and acting on concerns about patient safety* London, GMC

[5] www.midstaffspublicinquiry.com http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

[6] BMJ (2012)*Quality and Outcomes Framework for 2012/13 - Guidance for PCOs and practices* p153,157-9