The Family Practice Group

4. Monitoring Quality

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4.1 PERFORMANCE INDICATORS AND PERFORMANCE MANAGEMENT POLICY

4.1.1 Introduction

The object of the Performance Management Policy is to provide guidance as to the various tools that Brigstock Family Practice use to manage performance.

The following outlines the different aspects of Performance Management and gives Managers guidance as to which method of performance management is to be used when.

Brigstock Family Practice place great emphasis on ensuring that performance is dealt with efficiently and effectively and any queries relating to this policy should be directed in the first instance to Registered Manager.

4.1.2 Training Development and Sponsorship

The organisation recognises that its future prosperity depends largely on the knowledge, skills, expertise and motivation of its employees. The relevance of training and development is fundamental in achieving the strategic objectives of the Practice.

In summary, the policy is to train and develop for the following reasons:

- Obtain skills to meet Practice /market needs
- Reinforce existing skills
- Modify current skills to suit a shift in market requirements
- Develop the individual for other/greater duties and responsibilities

The identification of training and development needs, takes place throughout the course of employment and there are a number of sources of information used for such identification. All training and development must be in line with business aims and objectives.

4.1.3 Induction

The objective of the induction process is to help new employees settle into their new job as quickly as possible to become familiar with the Practice, their job role and their colleagues. The Practice's policy is to ensure that all new joiners start the induction process within one week of joining, ideally on the first day. The Induction Procedure is available is available in the shared folder on the Practice Network and the training log book can be found in appendix 28.

4.1.4 Probationary Review

Approximately three to six months after joining, new employees will be invited to a Probationary Review with their Manager. This review is intended to give individuals the opportunity to reflect on their first three to six months of employment with the Practice. Issues covered at this meeting will include work undertaken since joining, areas of concern, communication, the Practice as an employer, training needs and career aspirations.

Thereafter, a further review with their Manager should be undertaken on a quarterly basis.

4.1.5 Performance Reviews

The performance review is one such time where an employee's aims and objectives for the forthcoming period are formalised in an action plan with a specific timescale for completion (see appendix 27 for a performance review form). The performance review encourages employees to identify future training and development or other support that is required to fulfil personal and business aims and objectives. Performance indicators include:

- Investigation and discussion of significant events where staff behaviour and / or performance is a contributory factor
- Patient complaints whether verbal or written, relating to performance, behaviour or attitude of any member of staff
- Customer related numbers:
    - New customers acquired
    - Status of existing customers
    - Customer Attrition
- Turnover
- Review of Patient Questionnaires (Appendix 13)

4.2 PERFORMANCE INDICATOR IDENTIFIED TRAINING NEEDS

4.2.1 Introduction

The Organisation's use of the performance indicators will identify training needs and the performance review is one of the primary tools for identifying and developing these needs. However, training and development requirements may also be forthcoming from elsewhere. These may stem from customer requirements, a change in tasks or a need to keep up to date (e.g. legislative changes). Ad-hoc training requirements throughout the review period are considered through informal discussion between you and your manager or Human Resources.

4.2.2 Methods of Training and Development

- **Third party** - attendance at a pre-defined course or seminar focused towards a specific skill or discipline.

- **Brigstock Family Practice awareness** - in-house courses or workshops held to increase the participants understanding of an activity directly related to the companies operations (e.g. induction).

- **On the job** - learning by working under the direct supervision from another member of staff.

4.2.3 Sponsorship

From time to time the Practice may consider sponsorship, particularly where it is recognised that a vocational qualification would satisfy one or more of the key training reasons outlined above.

4.3 CLINICAL RECORD SYSTEMS AND NATIONAL ENQUIRIES

4.3.1 Clinical Records system

Brigstock Family Practice records the details of all consultations using the Brigstock Family Practice's Emis system. The handling of patient data is done so in line with the data protection act and the organisations Information Management and technology protocols. See Appendix 12 for details all of the IM&T protocols.

4.3.2 National Enquiries

Brigstock Family Practice is committed to participation in national confidential enquiries (such as the National Confidential Enquiry into Peri-Operative Deaths). To this end all requests to comply with these enquires will be dealt with promptly.

4.4 PARTNERSHIP STRUCTURE AND JOB DESCRIPTIONS AND JOB ROLES

4.4.1 Summary

Brigstock Family Practice is a small organisation and a brief Schematic of the structure is detailed in appendix 91. It is essential that all staff have a good understanding of the respective and common responsibilities of each team member. For this reason on induction all staff will be provided with a job descriptions and details of their job roles. The job descriptions and Job Roles can be found in the following Appendices:

Responsible Manager:	**Appendix 6**
Responsible Individual:	**Appendix 7**
Receptionist:	**Appendix 8**
Managing Partner	**Appendix 10**
Administrator	**Appendix 11**

4.5 COMPLAINTS PROCEDURE

4.5.1 Summary

Brigstock Family Practice aims to ensure that all the services it provides are of the highest quality. Good patient care is at the heart of the organisation's ethos and this will never be intentionally compromised.

Complaints are an invaluable tool in ensuring quality of care provision and are an integral part of governance procedures. The organisation's philosophy is to welcome any complaint, comment or suggestion for improvement as a positive tool supporting continuing self improvement.

Such a philosophy is a foundation of the clinical governance process. The organisation is committed to resolving complaints in as timely, helpful and informal a way as possible. It guarantees that patients' treatment or future care will not be affected by a complaint they may have previously made.

As an employer Brigstock Family Practice places great emphasis on ensuring that people are treated with dignity and respect. Extra care will be taken to ensure that the most vulnerable of patients are reassured that their concerns are listened to and acted upon. Fairness, kindness, impartiality and, above all, speedy resolution will underpin all procedures.

For more details see Brigstock Family Practice Complaints and Staff Concerns Policy; Section 11.1 Complaints Policy and Procedures.

4.6 SIGNIFICANT EVENTS AND LEARNING OPPORTUNITIES

4.6.1 Policy Context

The management of risk is a fundamental corner stone of the delivery of healthcare. Whether there is the chance of something detrimental happening that impacts on the public's health, patient and staff safety or the organisation's ability to provide care, or whether something actually happens, there needs to be a framework that ensures proactive and appropriate management of those occurrences.

This policy describes Brigstock Family Practice's approach to recognising and reporting those incidents, and more importantly learning from them so that they do not occur again. The policy is intended to address both clinical and non clinical incidents – patient and staff harm, and organisational concerns.

The principles of the policy are that:

- Direct Brigstock Family Practice recognises patient safety as paramount to the organisation.
- A clear process is needed for reporting, internally and where necessary externally
- Learning from all events must take place
- Learning must be translated into improved practice
- An open and just culture is promoted that encourages reporting and supports learning from practice.

4.6.2 Purpose of the Policy

This document sets out the key requirements for the organisation to manage report, analyse and learn from adverse incidents. The aim is to:

- ✓ Reduce the risk of harm to future patients through improving patient safety and quality of care.
- ✓ Reduce the risk of harm to staff whilst carrying out their duties.
- ✓ Ensure organisational fit for purpose.

It is not sufficient for organisations and individuals involved in provision of care to learn and improve only from things that go wrong. Engaging in proactive risk management activity, in addition to the reactive process of incident management, will enable the identification of many things that could go wrong as part of a systematic approach to risk assessment. This is a fundamental requirement set out in the Department of Health Risk Management System standard (6). The need for sound 'clinical' risk management is further reinforced through the clinical governance agenda.

The cornerstone of the requirements set out in this policy is the need to establish the underlying cause(s) of serious incidents through root cause analysis. Unless the causes of adverse incidents are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in the risk of harm to future patients, or the organisation.

In many instances, the root causes of adverse incidents lie in the management and organisational systems that support the delivery of service, and blame cannot, and should not, be attributed to individual health care workers. Identifying and addressing dysfunctional systems is, therefore, the key to reducing future risk of harm.

The organisation will collect and analyse incident and other patient safety information and provide timely and relevant feedback to healthcare organisations, health care professionals, and patients/carers in a way that promotes learning and risk reduction through:

✓ environmental and/or systems changes
and/or
✓ changes in organisational, management or clinical practice.

This policy should be read in conjunction with the following policies:

- Risk Management Policies
- Disciplinary policy
- Health and Safety Policies

4.6.3 Scope

A 'traffic light' system, where red denotes serious reportable incidents, and green acceptable risk, has been developed in recent years. This approach is being supported by national agencies such as the National Patient Safety Agency (NPSA). The organisation has adopted the same principles within this policy for ease of compliance with national reporting guidelines.

The requirements presented in this policy with respect to red adverse patient and organisational incidents are applicable to all of primary care, including independent contractors. Complying with the requirements of this policy will enable the organisation to meet those mandatory Department of Health incident management and reporting standards.

To maximise learning the policy not only relates to adverse incidents that could have or did lead to harm, but also relates to non-clinical incidents and those not directly involving people. The policy describes a holistic and integrated system covering management, reporting, analysis and learning from practice.

The policy is congruent with the Medical Devices Agency mandatory 'vigilance' reporting scheme for medical device and equipment manufacturers and the voluntary system for reporting adverse incidents involving medical devises.

This policy is congruent with the Medicines Control Agency (MCA), which operates a national voluntary system for reporting suspected patient adverse drug reactions (ADR).

4.6.4 Definition

The following definitions underpin this policy.

An ***adverse incident*** is defined as "any event or circumstance arising that could have or did lead to unintended or unexpected harm, loss or damage" (8)

Harm is defined as "injury (physical or psychological), disease, suffering, disability or death" " (9)

A ***significant event*** is any event or circumstance, which is noteworthy and relates to both good and adverse events. (10)

A ***hazard*** is defined as an identifiable risk likely to cause injury, loss or harm.

A ***near miss*** is defined as any event or circumstance arising during that could have lead to unintended or unexpected harm, loss or damage.

4.6.5 Key Requirements

All individuals involved **directly or indirectly in patient care, including the organisational delivery of healthcare services,** are aware of what constitutes an adverse incident.

Incident reporting, grading and root cause analysis is part of the induction training for new staff. Training is also provided for those conducting investigations. Updates will be available.

Lessons will be learned from individual adverse patient incidents, from local aggregate reviews and from wider experiences, including feedback from the National Patient Safety Agency, other agencies/bodies, and benchmarking. Improvement strategies aimed at reducing risk will be implemented and monitored. Where appropriate, local staff will learn lessons and change practice in order to improve the quality of care for patients and the safety for patients, staff and organisation.

4.6.6 Reporting Arrangements

Internal Reporting Arrangements

- Flow charts directing the handling and reporting of adverse incidents occurring within Brigstock Family Practice are detailed in Appendix 2. These charts should be laminated for display in all service delivery areas so they are available for immediate reference.

- An Incident Reporting Form (see Appendix 26) must be completed for all incidents relating to clinic's clinical services and organisational business. All identified risks will be added to the Risk Register and subsequently removed when all necessary action has been taken to eliminate or minimise to prevent future recurrence.

- All reported incidents are graded either Red, Amber, yellow or green, according to the actual impact on the patient(s), potential future risk to patients and to the organisation, and reviewed to establish stakeholder reporting requirements e.g. MDA. The individual reporting the incident will carry out the grading.

Seriousness	**Likelihood of Recurrence**				
	Rare	Unlikely	Possible	Likely	Almost Certain
low	Low	Low	Low	Moderate	Moderate
	Low	Moderate	Moderate	High	High
Medium	Low	Moderate	High	High	Extreme
	Moderate	Moderate	High	High	Extreme
High	Moderate	High	High	Extreme	Extreme
	Moderate	High	Extreme	Extreme	Extreme

- Patient(s) and/or relatives must be informed of any incident which directly affects their care or well-being. This should be carried out by the most senior or experienced member of the team who is caring for the individual. In cases where there are many involved this many be delegated to a number of experienced individuals.

- All incidents will be subject to an appropriate level of investigation and causal analysis and, an action plan will be prepared and implemented. With the exception of red incidents and some amber incidents, this process will take place at first line

External Reporting Arrangements

- The organisation will report any significant incident, clinical, organisational or financial, to the appropriate external agency within the required timescale.

- It is the responsibility of the organisation to report significant incidents to the appropriate external agency, for example Medical Devices Agency, Health and Safety Executive.

- Patient incidents graded as red are reported to the National Patient Safety Agency within 3 working days of the date of occurrence. For category red adverse events only (i.e. where serious actual harm has resulted), this information is also reported to the Care Quality Commission. (This should be read this in conjunction with the major incident policy.)

- For all category red incidents, a full root cause analysis will be undertaken reported to appropriate agency and the SHA within 45 working days of occurrence of the incident.

  Patient(s) and/or relatives as a priority must be kept up to date with any investigation process, outcomes or action

No statement should be made to the media. ***In all cases relating to patient(s) and/or their relatives must be advised of media interest and consulted about statements that will be made. This must be documented***

Police/Coroners Office

- Staff who come across deaths that are sudden and unexpected or, caused by violence, including self harm, and which are suspicious and unexplained must report them to the Registered Manager
- The police should be informed. The Police will inform the Coroners Office if the death is a matter for their consideration.

4.6.7 Health and Safety Executive

The following incidents should be reported to the HSE without delay.

- A member of staff who sustains a major injury whilst on Trust business, is then off work for over three days (including non work days). This will be carried out by Registered Manager
- A member of staff who sustains an injury due to a violent incident whilst on organisations business. This will be carried out by Practice Manager
- Under RIDDOR 1995 fatalities or serious injury and dangerous occurrences must be reported to the HSE immediately by phone or fax and followed up a written report on Form F2508 within 10 days. This is the responsibility of The Practice Manager
- The MDA will be informed of any concern about medical equipment utilising the current reporting procedures. This will be carried out by the Registered Manager

4.6.8 Root Cause Analysis and Investigation Procedures

- Root cause analysis (RCA) is a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it. RCA is required for all significant incidents.
- If there is evidence of criminal intent or a gross breach of professional conduct a report must be made to the appropriate professional body. However the ethos behind this policy remains that “Improvement strategies which punish individual clinicians (people) are misguided and do not work. Fixing dysfunctional systems on the other hand is work that needs to be done” (11). A no blame culture should prevail wherever necessary.

4.6.9 Monitoring

Reporting of incidents is a standing item on the practice meeting agenda

The annual report will contain a list of all category red adverse event root cause analysis carried out over the year, together with information on improvement strategies.

References and Sources

1. DOH (2001); *A Commitment to Quality, a Quest for Excellence*. HMSO
2. DOH (2001); *An Organisation with a Memory*. HMSO
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4. Neale, G. Woloshynowych, M.Vincent, and C. Exploring the causes of adverse events in NHS hospital practice. *Journal of the Royal Society of Medicine* 2001; 94:322-330.
5. Bristol Royal Infirmary Inquiry (2001*). Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. Command paper: CM5207.
6. DOH (2001); *Risk Management System Standard Controls Assurance*.
7. NHS Litigation Authority (2001); *CNST Risk Management Standards*.
8. DoH; National Patient Safety Agency (2002) *Doing less Harm*. (Draft) HMSO. (8-10)

11. Weingart; S.; Harvard Executive, session on medical error and patient safety. Cited by DoH; National Patient Safety Agency (2002) *Doing Less Harm*. (draft) HMSO.

4.7 CLINICAL AUDITS

4.7.1 Policy context

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.

4.7.2 Principles of clinical audit

"Clinical audit has a mixed history in the NHS, and for every success story there are just as many projects that have run into the ground without demonstrating any significant contribution to quality of services."
NICE 2002

4.7.3 The five stages of audit

All audits should be planned with the following in mind:
Preparing for audit
Selecting criteria
Measuring levels of performance
Making improvements
Sustaining improvement

> The NICE Best Practice Guide has detailed sections on each stage and should be consulted in planning clinical audit.

4.7.4 Setting audit priorities

Audit topics should generally be drawn from:

9. Best practice from guidance issued by NICE. From April 2006 NICE guidance will routinely be accompanied by audit criteria.
10. Best practice from National Service Frameworks.
11. Best practice as described in evidence-based clinical guidelines developed by a medical Royal College or similar body.
12. Priorities identified by the Healthcare Commission and other related inspection processes.
13. Best practice as part of the Standards for Better Health.
14. Topics identified following significant event analysis.
15. Audits measuring staff or patient experience.
16. Identified deficiencies in care.
17. Audits related to mortality or morbidity statistics.
18. Reviews of individual practice.

4.7.5 The audit calendar

The clinic will aim to conduct three or more substantive clinical audits each financial year. Reminders are placed on the shared calendar to ensure that all members of staff informed. The audit will cover the following:

12. Side Affects
13. Adverse Incidents
14. Note Keeping