BrisDoc Patient care by people who care

NHS

Governance Handbook

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Alerts Management

The BrisDoc Governance team receive national alerts from MHRA and NHSE via our brisdoc.alerts@nhs.net email account. If the alert is applicable to our service the contents of the alert should be disseminated to Clinical and Operational leads for dissemination as appropriate. If the alert relates to medication held in stock, the Facilities Team will manage.

The alerts inbox also receives the weekly HSE newsletter, the NHS Resolutions newsletter and NICE newsletters. Theses emails need scanning for any relevant news/learning form BrisDoc and sharing accordingly.

More information can be found in the following policy (available on radar): Alerts and NICE Guidance dissemination

Compliance Audit

BrisDoc has an annual programme of compliance audits. The Governance Team are responsible for maintaining a central log and reporting compliance status to the Quality Board monthly.

The team will liaise with the audit's owner to ensure regular evidence is supplied to update the log and provide assurance levels to the board.

The Quality Board will monitor the progress of the programme, receive and review audit reports and report learning.

Ad hoc audit reports (or a summary) should be included on the Clinical Toolkit and learning cascaded through newsletters.

Audit Southwest Annual Core Review

BrisDoc is a member of Urgent Health UK. This is a federation of Social Enterprise Unscheduled Primary and Community Care Providers. since 2018.

As members, an annual audit / core review is completed and a report given to us to help identify areas for improvement.

Overall Aim
The overall aim of the core review process is to aid members in improving their services through reviewing and assessing their internal systems and controls and, where appropriate, benchmarking performance. The review process provides assurance to the UHUK Executive and to individual member organisations that a range of appropriate systems and processes are in place, with agreed action plans established if any gaps in controls have been identified. The review is designed to cover all the organisation's services
Approach
In both Part A and Part B of the core review we will be assessing organisations in a range of individual areas.
The date of the annual audit is agreed – This is usually around October or November. A few weeks prior to the audit the auditor from Audit Southwest (ASW) shares the latest versions of the following documents

- Terms of Reference (TOR)

- Understanding the Organisation
- Guide for UHUK members
- Overview of review areas
- Documents and Information required

The Governance team member managing the audit will share the TOR with the service/clinical leads and key managers along with a link to the 'prior audit documents and information required' spreadsheet.

The completed 'prior audit document' pack is shared with the auditor by the agreed date

Once the auditor has the document pack, they will request further documentary evidence and a schedule of interviews with auditor nominated individuals

The auditor will continue to request further documents and/or interviews as the audit progresses

Once the audit is complete the auditor will share their initial findings and BrisDoc will have an opportunity to challenge any proposed action plan.

Once the final audit report is received it is shared with Service/Clinical Leads.

Action plans are shared with individual service leads, these must be updated regularly and returned to ASW.

Care Quality Commission

Brisdoc is registered with the Care Quality Commission (CQC). Changes to the registration or notifications to CQC are managed by the Governance Team.

BrisDoc holds regular engagement meetings, attended by named CQC inspectors, Governance Leads and Registered Managers.

As part of the registration, BrisDoc has a requirement to hold and maintain a statement of purpose. The document needs to be reviewed regularly and amended when changes to the service occur.

Copies of CQC registration changes / certificates and notifications should be kept in the Governance CQC folders

Child Death Enquiries

The death of any child in BNSSG is reviewed, even if it is expected due to a known life limiting condition. Notifications of child deaths will come into the Governance Team.

The Governance Manager is required to respond to an enquiry by completing details on an online portal. A search by the governance team and PPG will need to be performed and details of any contact will be submitted by the Governance Manager.

Child Death Review meetings (CDR).

A CDR meeting may be held for which Severnside will be asked to attend if there had been contact with the child. The request is sent to the Governance Manager

When a CDR meeting date is set Sarah Pearce will be notified and attendance will be confirmed from Severnside. It is a sharing and learning opportunity and should be written up by whoever attends for feeding back. PPG and BrisDoc should be represented where there were both 111 and CAS/F2F contact. PPG or BrisDoc may attend if contact was only 111 or CAS/F2F respectively.

Attendance and any immediate learning should be reported to the Severnside Quality Group.

Chronology Writing

BrisDoc may be asked to provide a chronology for a partner organisation – typically in relation to a safeguarding case review.

The request will usually come from the Local Authority safeguarding team relevant to where the patient lives/d and be accompanied by a template to complete. Sometimes the request for information comes from the CCG Safeguarding Leads.

A chronology is a date/time account of what took place, where and by whom for the patient.

The investigations being undertaken may be a rapid review (RR), safeguarding adults review (SAR), child safeguarding practice review (CSPR), serious case review (SCR), domestic homicide review (DHR).

The request for information should be included in the IR database and a folder set up.

Clinical Guardian Support

The Clinical Guardian Team is a team of clinicians who perform audits on IUC cases to support the effective clinical audit of treatment and advice provided to patients by IUC. Effective audit will assure BrisDoc of the clinical safety and efficacy of the care provided by its clinicians, and support Clinicians through learning and development.

The Clinical Guardian Team meet every two weeks on a Friday morning. Admin support is provided by the Governance Team in the form of:

Room booking:

The Clifton Room is booked out as a recurring meeting by the Governance Team. If schedules change or additional meetings are needed, the CG Team will request the booking is amended.

Call recordings:

Telephone calls are reviewed as part of the audit process, the CG team will routinely provide the names of clinicians and request a sample of three of their calls for review.

Clinical Guardian software:

The Governance Manager will support the team my making admin changes to the audit software and linking in with software developers here needed.

Contract Management

Contract Types

NHS Standard Contract (including a sub-contract) is used for all hospital, mental health, community and NHS 111 (and therefore by default IUC services).

https://www.england.nhs.uk/nhs-standard-contract/

The NHS Contract is made up of sections on Service Conditions, General Conditions, and Particulars. The contract is updated annually by NHSE and a variation issued by the commissioner rather than reproduce a new contract each year. Variations are negotiable and should be issued for any change made to the contracted service e.g. additional income to deliver the NHS 111 first programme. The

timetable for finalising the new national contract always over-runs however, drafts for consultation are issued with proposed changes tracked so preparation can be made for changes and therefore variations.

The CCG contracts with BrisDoc for the IUC service i.e. we are the prime contractor holding the NHS Standard Contract for Integrated Urgent Care Services. This service includes NHS 111 which BrisDoc sub-contracts to PPG. As prime contractor BrisDoc issues a sub-contract to PPG, manages that contract and is responsible for the performance of the NHS 111 service.

The contract includes performance and quality indicators relevant to the service. These have to be reported on to the commissioner and discussed at contract meetings.

The IUC service includes services delivered by GPs (i.e. the old OOHs service) which means the contract must include Schedule 2I. Schedule 2I includes the equivalent contractual requirements as an APMS contract.

General Medical Services (GMS), Primary Medical Services (PMS), Alternative Provider Medical Services (APMS) contracts are used for GP surgeries.

https://www.england.nhs.uk/gp/investment/gp-contract/

BMC/HHS/CKMP have APMS contracts because of the way they were commissioned – BMC was set up as an equitable access service, HHS is not a typical GP surgery but a service and CKMP was tendered through the short-term contract framework because the GP Partners resigned their contract with the CCG. A GMS contract is held where a partnership of GP own and manage their surgery. PMS contracts are also a partnership model that attracted more income for doing more for the patients. These are no longer issued and the income is gradually being aligned with that received under a GMS contract.

The BMC contract initially attracted an enhanced fixed income that has now been aligned to the GMS contract model i.e based on list size and quality performance.

Complaints Management

A complaint is an expression of dissatisfaction about an act, omission or decision of BrisDoc, either verbal or written, and whether justified or not, which requires a response. A few examples of complaints expressed are:

- Something which is against the choice or wishes of a patient
- The way treatment, service or care has been provided to a patient
- Discrimination against a patient
- How a service has been managed
- Lack of a particular service
- The attitude or other behaviour of staff

Serious Complaints

If a complaint is an allegation or suspicion of any of the following, it should immediately be investigated as a formal complaint:

- Physical abuse
- Sexual abuse
- Financial misconduct
- Criminal offence

In a situation where a person discloses physical/sexual abuse or financial misconduct, it must be reported as a Safeguarding concern, even if the person does not want to make a complaint.

Confidentiality should be maintained in such a way that only the managers and staff who are leading the investigation know the contents of the case. Anyone disclosing confidential/sensitive information to others who is not directly involved in the case should be dealt with under BrisDoc's disciplinary procedure.

Any complaint, whether informal or formal, may not be straightforward and may lead to one or more of these apart from the complaint's procedure:

- Disciplinary procedure
- Reporting to the Police
- Claims process
- Investigation into sexual harassment
- Grievance procedure

If BrisDoc is aware of a significant complaint or event (that is one where death or permanent injury occurred), the relevant Clinical Commissioning Group and the Commissioning Support Unit may be informed at the beginning of the next working day depending on the severity of the issue.

We aim to respond to all complaints within 33 days, if this is not possible, the complainant should be fully informed and a timeframe should be mutually agreed.

The response can be verbal or in writing depending on what the complainant requires.

Response letters are generally written by clinical or operational leads although, several complaints are closed verbally either by a service/clinical lead or a member of the governance team (manage the patient's expectation).

If a response is shared verbally, ensure a copy of the voice recording is saved in the complaints folder

When the response has been shared with the complainant the BOB entry can be updated and marked as closed.

Compliments Management

BrisDoc sometimes receive compliments from patients or service users. It is important to capture and report on the number of compliments to provide a balanced picture of service delivery. Where individual staff can be identified, the compliment will be shared directly.

Filming on BrisDoc Premises

There are occasions when a BrisDoc service or staff member is contacted about being filmed at work. This may be for a news item or a documentary type programme. Filming for news items is typically requested for a "same day" or "next day" basis. Often requests come via the Communications Team in CCG.

Requests for filming should be approved by a director. If not via the CCG it is sensible to let the CCG know as they provide BrisDoc's professional Comms Support when needed.

The key requirements of the film crew before they can set foot on site are the following:

- Their risk assessment for filming at this location (typically this may include covid/IPC management, hazard management of associated props e.g. trailing wires, maintaining confidentiality)
- A copy of their company's public liability insurance certificate

- If patients are to be involved a copy of their information for patients and consent form to participate
- Signed third party confidentiality agreement (S:\IM&T\Information Governance (IGMS) 2021\Supporting IGMS Information\3rd Party Confidentiality Agreements\1. MASTER TEMPLATE\MASTER TEMPLATE)

We have to notify our public liability insurer that a film crew will be working in our premises (including outside areas). Send to Perry Appleton a description of the project, the risk assessment and liability insurance certificate. Ideally the insurer's approval is received before filming starts but this isn't a deal breaker.

You need to assure yourself that the film crew is working with integrity. They could push the need for a deadline over providing their risk assessment. They all know a risk assessment has to be done so the bottom line is always "until we have the required paperwork they are not allowed onto our premises or to work with our clinicians".

Keep a folder of the saved paperwork and emails for each episode of filming.

Frequent user reviews

Healthcare resources are finite and will become even more stretched as the population lives longer with increasing number of long-term conditions and increasing levels of ill-health and disability. One impact of this is constraint in primary care capacity and appointments in hours with the consequence that people look for alternative ways of accessing a primary care service. This may be at an A&E department, a minor injury unit, or a GP Out of Hours service. None of these alternatives are geared to providing a comprehensive primary care service provided by a GP practice.

All providers of healthcare services will need to work together to maximise the use of available resources and to ensure services are delivered efficiently and effectively for individual patients across the interfaces of in and out of hours, and primary and secondary care.

To support patients, access the service most appropriate to their needs GP Practices need to be aware of and understand the number of attendances their patients have during out of hours periods within defined timescales.

To be supportive of the patient's usual GP Out of Hours clinicians need to provide treatment and advice that is consistent with care plans agreed between individual patients and their usual primary and community clinicians. These care plans may comprise a Care Programme Approach (CPA) for mental ill-health, a long-term condition self-management plan, a Learning Disability care plan, or an advance care plan for end-of-life care.

Frequent callers are those who have contacted the GP Out of Hours service 4 or more times in a 28 day period.

Healthcare professional feedback forms HPFF

Severnside has created a HPFF to allow health care professionals to report concerns or learning opportunities. The form is also used between PPG and BrisDoc to pass cases for investigation between each part of the service.

The form is Severnside branded and contains the Severnside email address for return. Once received into the inbox, the relevant side of the organisation will pick up and manage through the process. Occasionally HCFF's are received which need to be jointly managed across the service.

Template forms can be found:

S:\GOVERNANCE TEAM\CONFIDENTIAL - DAC\LEARNING EVENTS\SevernSide Integrated Urgent Care Health Professional Feedback Form v2.docx

Any healthcare professional (outside of the organisation) should be directed to this form. Once received into the joint Severnside inbox, the lead investigator will be decided (PPG or BrisDoc) then logged and managed following organisations internal process.

Learning Event Management

BrisDoc encourages the reporting and management of Learning Events as a constructive way to reduce risk and learn from and remedy issues, processes, and behaviours quickly and positively. Thereby maintaining a safe and effective working and care environment for all.

Internal Learning Events should always be reported through the online Learning Event portal; links to the portal can be found on the BrisDoc Weblinks page or Clinical Toolkit.

When a Learning Event is reported through the portal an automatic email containing all the necessary information will be generated and sent to the BrisDoc Governance inbox.

On occasions, Learning Events are highlighted through other channels such as an email or shift reports. Learning Events from third parties will usually be reported via an email or telephone conversation.

Any form of Learning Event report will be excepted although staff will usually be directed to the portal to ensure they are aware of the process for future use.

All Learning Events need to be logged onto the Learning Event Reporting Information System (LERIS) found on the shared drive.

Upon receipt of an event report, The Governance Team will record on LERIS for the following events:

- Learning Events / near misses
- Serious Learning Events
- Safeguarding concerns
- Health Care Professional Feedback

Allocating Learning Events:

All Learning Events need to be allocated to a Learning Event manager; this is done in several ways as agreed locally with individual Teams.

IUC Operations Team – initially select ‘awaiting Ops Manager’ in Leris Data. This will automatically update the spreadsheet accessible by the managers (Leris Manager Access). The team managers monitor this daily where they will review the learning event and allocate it within their team appropriately.

Clinical Practitioner Team – Learning Events involving Clinical Practitioners need to be allocated to the staff members Line Manager, a list can be found: S:\GOVERNANCE TEAM\CONFIDENTIAL - LEARNING EVENTS\1. LERIS - Governance Team only Select the appropriate Manger and record on

LERIS Data. Send a copy of the Learning Event report form to the Manager, cc-ing the lead practitioners and save a copy of the email in the Learning Event folder.

GP related Learning Events – Some judgement is needed when allocating GP related Learning Events. There is a list (as above) of who the leads line manages, they also have a list of services that they lead on each such as F-ACE, IUC, HIUs. If the Learning Event is potentially serious, allocate to one of the Deputy Medical Directors for review. It is important to keep the workload even, to do this, look at the number of open Learning Events currently allocated to each lead and allocate as evenly as possible. Send the Learning Event report to the Manger you have selected and copy in the other leads, this needs to be saved in the LE folder.

Facilities – These need to be allocated to Facilities Manager primarily and emailed to them.

Controlled drug learning events – Send these to the Facilities Manager and Medicines Management clinical lead initially, they will review and will likely send it back to be reallocated to the clinician/ops staff members line manager to manage.

Practice Services – Practice Services related Learning Events are managed through GP Team net by Practice Managers and we do not routinely record them on LERIS. If a Learning Event report is received, send on to the Practice Manager and ask if they would like it recorded on LERIS.

Insurance Renewal

Insurance Renewal Information

Gallagher are BrisDoc's Insurance broker and manage our insurance cover for the following policies.

- Medical Professional Liability
- Commercial Combined incl Employers/Public Liability
- Fleet
- Personal Accident
- Cyber
- Management Liability
- Business Assist

Graham Letford is our contact. Policy renewal is annually on 30th June. Graham will initiate the renewal process between March and April each year.

The information that underpins each policy will need reviewing for changes e.g., the value of contents in our premises, organisational income and staff numbers.

A Key Risk Information (KRI) spreadsheet will need updating with the current profile of staff in each service by WTE and head count. Any income and activity changes need recording in the KRI also, as well as any changes to our service provision.

Changes to service provision need notifying to the broker as this may affect policy cover. If in doubt ring Graham to check.

You will need to share a "Notification of Circumstance with our broker for any event that may lead to a claim e.g., a complaint, Learning Event, Accident, or a disciplinary process that might

result in employment tribunal. This list is not exhaustive, please ask for advice if you are unsure. Clinical Negligence claims need to be notified to NHS Resolutions under the Clinical Negligence Scheme for General Practice (CNSGP

ISO 14001

BrisDoc is accredited with 14001 for having an Environmental Management System. The accrediting organisation is QMS.

We are audited annually, usually in August, against the standards to determine if we maintain our accreditation.

We are audited against our 14001 manuals and need to provide evidence of compliance.

Medicines Management Reports

The Medicines Management Group meet once a month, a member of the Governance Team will join that meeting to discuss Learning Events and themes surrounding medicines management and prescription management. Data is pulled a week before the meeting

The data is reviewed to confirm if there are any themes or increases in specific types of Learning Events, this is logged on the meds management dashboard along with a breakdown of each Learning Event to base and very brief description of the issue. This is saved in the medicines management folder for review during the meeting.

Notifications

- There are several situations in which notification to other bodies is required. These include:
- Learning events relating to actual harm caused.
- Significant events
- Allegations of abuse
- Allegations of clinical negligence
- Threat of claims against BrisDoc
- Accident at work that meets the RIDDOR categories that must be reported to the HSE
- Instances where there is potential for a claim to be raised against our insurance/indemnity cover
- Damage to BrisDoc vehicle or premises
- Theft
- Unaccounted controlled drugs
- Any event relating to the above list should be notified to the Governance Manager to consider if external notifications are required. This list is not exhaustive, if in doubt, please flag the issue.

Patient Safety Culture Survey

In conjunction with Urgent Health UK (UHUK) BrisDoc participate in an annual safety culture survey.

The survey supports research into organisational cultures and contains 14 questions considered to be key to obtaining a good indication of patient safety culture.

Audit Southwest deliver the survey and will contact the Governance Manager and send a link to the survey when it is due.

A link to the Patient Safety Culture Survey is emailed via rotamaster to all our employees and self-employed GPs with a covering email from Dr Kathy Ryan (BrisDoc Medical Director). The Survey remains open for approximately 18 days and a reminder email from Kathy is sent on day ten.

Results are analysed by Audit Southwest and summarised into a report. The results provide a powerful, research validated tool which can inform, what our culture of safety looks like across the organisation. Results are benchmarked against similar organisations; that data, along with data from previous years provides us with a starting point to make changes through, for example, focus groups or targeted work.

Policy and Standard Operating Procedure Process (SOP)

To ensure BrisDoc Policy and SOP documents are kept up to date and fit for purpose, each document has a review date and an “owner”. This SOP will outline the role of a Policy or Standard Operating Procedure owner and the process they must follow.

Governance Team – will maintain an index of Policy and SOP documents, the team will track dates and highlight to Policy / SOP owners when a document needs reviewing. When the document has been reviewed and a final version is issued, the governance Team will update the index / shared drive and radar. The Governance Team are responsible for highlighting updated policies through the BrisDoc newsletter and at relevant boards for approval.

Policy or Standard Operating Procedure Owner – Responsible for ensuring the Policy is reviewed and updated, including documenting all changes in the change register. The owner of the document is responsible for liaising with any other contributors and combining changes as necessary. For policies – the owner should get approval for the policy changes from the appropriate governance group meeting (eg: Quality group or LOB) The owner is responsible for sending a complete final version of the document to the Governance Team. If delays occur in reviewing the document, the owner is responsible for communicating this to the Governance Team

Patient feedback

Patient feedback is gathered from patients via a Patient Satisfaction Questionnaire (PSQ). The surveys offer patients and service users route to provide feedback about the service they have received. Information gathered from the surveys is analysed and used to inform service

improvements. Data is reported and monitored via quality meetings and reported to service commissioners.

To offer choice to patients and potentially appeal to a different cohort of patients, a digital option has been developed and is run alongside the traditional method of a postal survey. Results received via either version will be merged.

Patients are randomly selected from Adastra to receive a survey. The number of patients selected is set by and monitored by the Quality Board.

A link to a digital survey is sent via Adastra. The case should be randomly selected using the case search function and entered via case edit.

The Governance Team are responsible for the following:

- Creating and regularly reviewing a set of questions to be sent to patients
- Printing and sending postal surveys
- Sending digital links to patients
- Inputting / downloading results
- Analysing results data
- Sharing data with teams
- Sharing data at quality meetings
- Identifying and sharing themes and trends
- Providing positive feedback to staff

Detail of the process can be found in the PSQ SOP.

Insurance Notifications

Clinical Negligence claims need to be notified to NHS Resolutions under the Clinical Negligence Scheme for General Practice (CNSGP) This is the Government's state-backed clinical negligence scheme and came into operation on April 1, 2019 for claims prior to this the clinician will have held their own clinical negligence insurance.

BrisDoc is responsible for promptly notifying its medical professional liability insurer/CNSGP of claims and circumstances which may give rise to a claim under

the policy. Failure to do so may result in a negligence claim not being covered by the policy.

Such notice should include:

- details of what happened and the services and activities that were being performing at the relevant time; and
- the nature of any actual, or any possible, bodily injury; and
- details of how BrisDoc first became aware of the claim or circumstance; and
- all such further particulars as the insurer may require.

A “circumstance” is defined in the policy as: “any circumstances of which you become aware, or should reasonably have become aware, that may reasonably be expected to give rise to a Claim.”

Examples of a circumstance are:

- Any complaint, written or verbal, in which the patient or patient's representative expresses dissatisfaction regarding the treatment provided or a failure to provide and alleges that, as a result, the patient suffered bodily injury.
- A request for access to medical records received from a solicitor or third party on the basis that a Claim against you/your service (to include any of your employees) is being contemplated.
- Any Learning Event in which a Serious Learning Event Report is generated that involves potential or actual bodily injury
- Any unexpected or unusual death of which you become aware.
- Any adverse outcome or clinical "near miss" in which you believe there may have been a negligent act, error or omission, irrespective of whether the patient is aware of this or whether the patient or patient's representative has made a complaint.
- An event that involves potential of actual bodily injury that triggers the threshold for the statutory Duty of Candour
- An accusation of abuse, including organisational abuse, levied by patients, families, local authority, commissioner or any other entity.
- A notification by the Parliamentary & Health Ombudsman that they may/intend to investigate a Learning Event or complaint.

It is recognised that complaints have the potential to escalate if not handled satisfactorily. The Insurer can provide expertise in assisting with responding appropriately to complaints. Collaborating with the Insurer can support complaint resolution at an early stage, thereby reducing the risk of litigation. Draft complaint responses may be sent to the Insurer prior to sending to the complainant. In complex complaints where harm was caused through misdiagnosis or mis-treatment support should be sought from the Insurer.

When managing a complaint all statements, letters, phone calls and actions taken in an investigation must be documented, scanned and kept in the complaint folder for that individual on the BrisDoc shared drive as per CQC regulations and for clinical governance purposes. Where any documentation is sent to an external organisation it will be converted to pdf format before sending.

Each complaint will be entered into the BrisDoc Integrated Risk Management System BOB for Urgent Care and Business Services or in GPTeamNet for Practice Services. A comprehensive set of data will be entered into these databases so as to ensure BrisDoc can record response timescales; monitor progress with investigating complaints; capture learning outcomes and who has been involved; provide reports on complaint trends, categories etc. so as to support ongoing service improvement; and identify themes that may be a risk to the organisation.

How to make a notification to under the Clinical Negligence Scheme for General Practitioners (CNSGP) via NHS Resolutions This is the notification method for the majority of notifications received from 1st April 2019. Please click on the link below

If the patient was cared for prior to April 2019, or the claim could be against BrisDoc and/or the clinician please use the link below.

If you need to make a non-medical claim e.g., Contents damage, Theft, or Vehicle RTC or damage please contact our broker for the appropriate form.

IUC Monthly / Quarterly Reports

Each Month two separate reports are created by the Governance Team (using data pulled from LERIS) to summarise Learning Events reported through the previous month. The reports are separated and used as follows:

- Operational Learning Event report –Supplied to the quality lead Senior Team Manager to be used by the Ops team for discussion and review at their monthly quality meeting.
- Clinical Learning Event Report – Supplied to the Clinical Leads and Nurse Manager Team to be reviewed and discussed at the monthly clinical Learning Event meeting.

Each report will give a summary of the following areas:

- Number of Learning Events reported
- Breakdown of Learning Event categories
- Themes and /or trends
- Adherence to timescales for closing Learning Events
- Allocation split by Manager.

In addition, a Quarterly report is provided to the Ops Team to feed into the quarterly performance report.

Rapid case reviews

These are convened, usually by one of the BNSSG Local Authorities, to review safeguarding needs, practices, service interfaces of vulnerable people, some of whom may have died.

If a BrisDoc service has been involved in the care of a vulnerable person a report will be requested by the convenor using a set template. The Governance Team will lead this report's completion, liaising with a clinician as required. Attendance at any meetings will be by the Governance team on behalf of the organisation, with the clinician if needed.

Learning from the case review will be shared accordingly.

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. By law it is required for employers, as well as people who are self-employed and people who are in control of a premises, to report specified Learning Events in the workplace. These can include a wide range of things such as dangerous occurrences (when a serious accident was luckily avoided) all the way to work related deaths.

As an employer, it is a legal requirement to report all Learning Events, no matter how big or small, as well as ill health at work. To be legally compliant, a record must be kept of all Learning Events. Keeping RIDDOR records includes:

- Recording all reportable accidents, injuries, illnesses, dangerous occurrences, work-related deaths and specific injuries lasting more than seven days
- Keeping all records in a file, accident book, on a computer or a written log
- RIDDOR reporting is done through an online reporting system via the HSE website

- Understanding and patterns in injuries and/or accidents to be considered when undertaking risk assessments
- Keeping all records organised and up to date. In the event of a work-related claim, the insurance company will need to see your records – if they are not up-to-date or it is determined that there are Learning Events missing, this is against the law

All employees' RIDDOR records must be kept strictly confidential and are stored away securely. If the records are not kept confidential and stored properly, they will not be deemed compliant with the Data Protection Act

There are specific rules and regulations in regard to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations; aside from basic information such as keeping all records updated, the following is also important:

- A company with more than 10 employees must have an accident book
- Owners and/or occupiers of quarries, mines and factories must have an accident book
- RIDDOR records must be kept for a minimum of 3 years after the date of the last Learning Event in the book
- It is advised that RIDDOR records are kept for 5-6 years in order to allow time for any civil litigation to be made
- Learning Events must be reported within a 10-day timeframe after the occurrence

What kind of Learning Events do I report in RIDDOR records?

- Work-related death
- Serious injuries
- Over-7-day injuries (where the person is unable to work for at least a week)
- Work-related diseases
- Injuries to members of the public (ie. not employees)
- Dangerous occurrences – when an accident almost happens
- Dangerous gas fittings in a workplace (Gas Safe registered gas fitters must report this)

A report must be received within 10 days of the Learning Event. For accidents resulting in the over-seven-day incapacitation of a worker, you must notify the enforcing authority within 15 days of the Learning Event, using the appropriate online form

Risk Register Review & Updates

The master version of the risk/issues register is "owned" by the Director of Nursing, Allied Professionals and Governance. Each risk is assigned to a Board to manage and review the risk at each meeting.

The Severnside register incorporates the IUC service risks/issues for both PPG and BrisDoc and is used for the IUC performance report. Red risks/issues are shared with the commissioner in the performance report.

Risk assessments of each risk are carried out and monitored via a central log. The Governance Team are responsible for maintaining the log and reporting compliance levels through the Health and Safety Group.

Risk assessments are all managers' responsibility and should be reviewed each summer or as often as necessary. The Quality Manager can help managers complete their risk assessment by providing education and advice.

Safeguarding Process

Each week, the Governance Team will run a report to extract details of all cases flagged with safeguarding. The cases will be loaded onto a spreadsheet for the lead Clinical Practitioner team to audit. This should be a priority task on a Monday morning.

Details for this process are detailed in the safeguarding policy.

Service Level Agreements

A service level agreement (SLA) is a commitment between a service provider and a customer. Aspects of the service – quality, availability, responsibilities – are agreed and set out in an SLA, which also defines the price, the level of service expected setting out the metrics and standards by which the service will be measured.

An SLA can be legally binding or informal. They may be time bound e.g. for a pilot.

A well-defined and typical SLA will contain the following components:

- **Type of service to be provided**: It specifies the type of service and any additional details of type of service to be provided.
- **The service's desired performance level**, especially its reliability and responsiveness: A reliable service will be the one that suffers minimum disruption in a specific amount of time and is available at almost all times. A service with good responsiveness will perform the desired action promptly after the customer requests it.
- **Monitoring process and service level reporting:** This component describes how the performance levels are supervised and monitored. This process involves gathering different type of statistics, how frequently these statistics will be collected and how they will be accessed by the customers.
- **The steps for reporting issues with the service:** This component will specify the contact details to report the problem to and the order in which details about the issue must be reported. The contract will also include a time range in which the problem will be investigated and when the issue will be resolved.
- **Response and issue resolution time-frame:** Response timeframe is the time by which the service provider will start the investigation of the issue. Issue resolution timeframe is the time period by which the current service issue will be resolved and fixed.
- **Repercussions for service provider not meeting its commitment:** If the provider is not able to meet the requirements as stated in SLA then service provider will have to face consequences. These consequences may include customer's right to terminate the contract or ask for a refund for losses incurred by the customer due to failure of service.

A Memorandum of Understanding (MOU) has a similar purpose to an SLA. An example is the MOU between BrisDoc and AWP for HHS nurses working in joint roles.

Severnside Quality Group

The purpose of the Severnside Integrated Urgent Care Quality Group (SQG) is to coalesce all clinical and service quality across the NHS 111, Clinical Assessment Service (CAS) and face to face care elements of the Severnside Integrated Urgent Care (SIUC) service, provided by Practice Plus Group (PPG) and BrisDoc, with a focus on monitoring and reviewing quality, and identifying and sharing learning.

This will uphold the principles of providing high quality patient care by the SIUC service in accordance with BrisDoc's corporate objectives and core values, provide assurance, and continuously drive performance.

The SQG will operate within BrisDoc's corporate governance framework to ensure services are always, high performing and compliant and safe for both staff and patients.

The Governance Manager will chair the SQG, and all members of the team will bring data relating to their agreed areas. Details can be found in the TOR for the group and on the standard agenda.

Tackling Violence

Special Allocation Service (SAS) is a scheme where potentially violent patients are added to Tackling Violence list to alert services that they must only be refereed to SAS and seen in a secure setting.

Patients are added to the list and reviewed after a year; at this point they may be removed if appropriate.

A list of patients will be emailed from the ICB and received in brisdoc.governance@nhs.net email in box and will include details of any names added to the scheme and the names of patients who have been removed. The list can sometimes come in different formats, although should contain the name and NHS of each patient and whether they have been added or removed.

Each patient placed on the list will need a special patient note to indicate this, if they are removed from the list, the note needs updating to reflect this.

Instructions for this process are detailed in the Tackling Violence SOP

Change Log

Version	Date	Author	Changes
1.0	01/12/2022	Governance Team	Initial document
2.0	06/05/2023	Governance Team	Tackling violence added and PSQ section
3.0	06/09/2024	Sarah Pearce	General review , names reviewed where possible. Process changes added and links to sops removed (pointed to radar).