Lincolnshire Partnership
NHS Foundation Trust

LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST

Reporting and Management of Risk Policy
(including incidents, near misses, complaints and claims)

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Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

CONTENTS

1. Introduction
2. Purpose and Scope
3. Duties
4. Definitions
5. Development of Policies and Procedures
   - 5.2. Legal Framework
   - 5.3. Key Principles/Objectives
   - 5.4. Policy Development/Review
6. Consultation, Approval and Ratification Process
7. Review and Revision Arrangements including Version Control
8. Dissemination and Implementation of a Policy
   - 8.1. Staff Training
   - 8.2. Patient Feedback: Information for Service Users, Carers and Relatives
9. Policy Control including Archiving Arrangements
10. Monitoring Compliance with and Effectiveness of Policies and Procedures
11. References
12. Associated Documentation

Procedures

1. Procedure – risk management
2. Procedure for the reporting and management of incidents, near misses, complaints and claims
3. Procedure for the management of serious incidents
4 Procedure for the management of complaints
5. Procedure for the management of external visits, reports, and recommendations
6. Procedure for implementing and monitoring service and practice improvements.

Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

1. INTRODUCTION

The intention of this policy is to contribute towards a culture of safety and openness. This encourages staff to report and manage risks, incidents, near misses, complaints and claims. Incidents, complaints, and claims are closely related. They are ways in which the Trust can learn lessons and improve the safety and quality of the services it offers.

For the purposes of brevity the policy will refer only to incidents as a collective term to also include near misses, complaints and claims.

Lincolnshire Partnership NHS Foundation Trust (LPFT) has a non-punitive approach towards incidents, complaints and claims except where there is evidence of malicious activities, criminal activities, acts of gross misconduct, or professional malpractice.

LPFT's risk management system, in addition to being reactive to managing incidents, is also designed to be proactive. This helps in identifying things that can go wrong as part of a systematic approach to risk management. This approach is in line with best practice and national policy guidance.

All incidents and near misses will be investigated in a timely fashion, at a level appropriate to the severity of the incident. Staff will be engaged and communicated with throughout the process. There will be timely feedback to staff, and a clear process for disseminating all lessons learnt.

LPFT actively seeks feedback about its services and recognises the right of people to comment on or complain about any aspect of the service they receive. The Trust is committed to trying to resolve things that go wrong as soon as possible and to give service users and carers an outcome they are satisfied with. The Trust wants to make sure that it is easy for anyone to make a complaint and to give feedback about how services can be improved. The Trust acknowledges the importance of an effective and efficient complaints procedure. Complainants should be enabled and encouraged to speak openly and freely about their concerns. They should be reassured that whatever they say will be treated with the appropriate confidentiality, sensitivity and care.

LPFT staff will be responsible for reporting all incidents involving visitors, contractors, employees of other organisations that occur within their service area using this policy unless there is an agreement in place that allows alternative arrangements to be followed.

The Director of Nursing and Quality is the Trust Executive Director responsible for patient safety (including incidents and complaints). The Trust Secretary is the Trust Lead for claims management.

The Trust is committed to promoting equal opportunities and to recognising and valuing people's differences. It supports the legal obligations it has by law and this policy complies with The requirements of the Equality Act 2010.

2. PURPOSE AND SCOPE

This policy covers the broader risk management processes, and those specific to the reporting and management of incidents, near misses, complaints, and claims. Further specific detail is found in procedural guidance which can be obtained from the Quality and Safety Team.

The purpose of this policy and its accompanying procedures is to enable the Trust to comply with current NHS regulations and associated legislation. In addition to this policy and procedure there are extensive operational guidelines available through the Quality and Safety Team to:

- employees responsible for responding to incidents, near misses complaints and claims, including the Chief Executive, executive team, senior management, and front line employees;
- those stakeholders external to the Trust who will take on a role in the process, including the commissioners, regulatory bodies, local authorities, Care Quality Commission and Health Service Ombudsman.

It will also help users of the Trust's services, their carers and the general public to have a detailed understanding of how the Trust deals with risks, including incidents, complaints and claims.

By effectively managing incidents and listening to people about their experiences, services can get better, learning new ways to improve things for people who use the services and for the employees working in them.

The initial section of this document sets out overarching roles and responsibilities with regard to incidents, near misses, complaints and claims giving a clear description of roles and responsibilities and accountability when things go wrong and encourages a reporting and learning culture with safety at its heart. This is followed by six sets of procedural guidance: risk management; incidents, near misses, complaints, and claims; serious incidents; management of complaints; external visits, reports and recommendations; and service and practice improvements. This gives clear guidance on what employees should do following an incident, complaint or claim; how they should be managed and investigated with appropriate support for service users' families and employees.

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

- Clinical Care Policy
- Medicines Management and Medical Devices
- Human Resources and Workforce Development Policy Handbook
- Safety-Health-Environment-and-Fire-Policy
- Mental Health and Mental Capacity Policies
- Records and Information
- Safeguarding Policy

- The Board Escalation and Assurance Framework

3. DUTIES

This section sets out the overarching duties of key roles. Further detail regarding duties can be found in the procedural guidance.

All employees are expected to familiarise themselves with and practice within the legislative framework, to comply with any professional codes of conduct in place, to follow the procedures outlined in this policy, and to undertake all relevant mandatory training.

The Chief Executive will ensure employees adherence to legislation, guidance and policy, through appropriate management chains.

The Director of Nursing, AHPs and Quality will act as the lead Director for patient safety. This includes acting as the lead Director for the management of incidents and complaints. The Director of Nursing,AHPs and Quality will ensure that these processes are followed in a timely and effective manner, to enable the Trust to learn and improve the safety of the services it offers. This will be done through appropriate structural and management chains. The Director of Nursing, AHPs and Quality will provide assurance of effective risk management through aggregated reporting of incidents, complaints and claims.

The Trust Secretary will act as the lead Director for claims. This includes claims management. The Trust Secretary will ensure that these processes are followed in a timely and effective manner, to enable the Trust to learn and improve the safety of the services it offers. This will be done through appropriate structural and management chains

The Board of Directors will ensure that the Trust has in place the necessary policies, procedures, resources, and culture to enable staff to meet LPFT standards

The Director of Strategy will act as the lead for external visits and inspections. The post holder will manage the schedule of dates, maintain action plans, and liaise with appointed leads.

The Senior Leadership Team will have overall responsibility for the management of external visits, inspections and accreditations

Board sub-committees and Executive committees will receive relevant reports, and monitor action plans as appropriate.

The Divisional Management Team Meetings will monitor serious incidents, complaints and claims for assurance of organisational learning

The Associate Director of Nursing, AHPs and Quality will ensure the timely investigation of all incidents and complaints. The post holder will be responsible for all stages of the process including investigations, dissemination of lessons learned, and reporting both internally and externally. This will be achieved through appropriate structural and management chains. It is the responsibility of the post holder to ensure that other related staff including the Head of Quality and Safety, the Quality and Safety Team Leader, Patient Experience Lead and the Quality and Safety Specialist Practitioner are aware of their roles and responsibilities.

Medical Director and the Divisional Managers are accountable for the quality of service delivery and the way the organisation responds when things go wrong. They are responsible for facilitating the role and responsibilities of Clinical Directors and Service managers for the investigation of incidents, complaints and claims and for the management of follow up action to improve service quality.

Team co-ordinators, Ward Managers, Service Managers and Clinical Directors will be responsible for coordinating the investigation and analysis of incidents, complaints and claims and report on them as appropriate.

4. DEFINITIONS

The following definitions are the key definitions for this policy. More specific definitions (including exclusions) are found in the related procedural guidance.

A **Risk** is defined as circumstances or events that did or could have led to harm, loss or damage within the clinical care of patients, including employees, public and the organisation.

An **incident** is defined as: any unexpected event or circumstance that did or could have led to harm, loss or damage.

A **near miss** is defined as: any prevented incident that could have led to harm, loss or damage.

A **complaint** is defined as: any expression of dissatisfaction which requires a response.

A **claim** is defined as: a demand for compensation made following an adverse incident resulting in damage to property and/or personal injury

5. DEVELOPMENT OF POLICIES AND PROCEDURES

Legal Framework

Most health legislation made since 1977 has been summarised within three Acts of Parliament. They received Royal Assent on 8 November 2006 and came into effect on 1 March 2007 (subject to a few exceptions and amendments):-

- The National Health Service Act 2006
- The National Health Service (Wales) Act 2006
- The National Health Service (Consequential Provisions) Act 2006

These Acts of Parliament have been built upon by:

- The Health and Social Care Act 2012

These procedures also take account of and must be interpreted in a manner which is compatible with:-

- The Children Act 1989 Representations Procedure (England) Regulations 2006
- NHS Redress Act 2006
- Health Service Commissioners Act 1993
- The Human Rights Act
- The Race Relations Act 1976
- Race Relations (Amendment) Act 2000
- Local Government Act 2000
- Data Protection Act 1998
- Mental Health Act 1983 (as amended 2007)
- Health and Social Care (Community Health and Standards) Act 2003
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

- The Local Authority Social Services and National Health Service Complaints (England) (Amended) Regulations 2009 No. 1768
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) regulations 2015

Key Principles/Objectives

This policy is designed to ensure the Trust's continued compliance with best practice and legislative requirements with regard to the management of risk including incidents, complaints, and claims.

It will ensure full compliance with appropriate NHS regulations and associated legislation by implementing a flexible and responsive system for the management of incidents, complaints and claims

The Policy and its associated procedures is an integral part of the process in which services are continually revised and adapted to meet the assessed needs of service users and their carers. The key principle is to focus on facilitating quality outcomes.

The Policy recognises the rights and the values of service users, particularly those people who are vulnerable in society, who may have been discriminated against, and who may find it difficult to express their concerns or to challenge the system.

It is essential that the procedures can be readily used and are accessible to all people regardless of their age, gender, sexual orientation, culture, ethnic origin or disability.

The procedures should not be viewed in a negative or threatening way to staff. They should be seen positively as effective systems to resolve any concerns or problems which people may have about any aspect of service available from the Trust and is fair and equitable to both staff and service users

These key principles apply the National Patient Safety Agency's "Being Open" policy and Duty of Candour

Policy Development/Review

This Policy was originally written to comply with NHSLA Risk Management Standards for 2011/12. The policy was also reviewed against the NHSI Serious Incidents Framework (2015).

Although a review date is set for 3 years-time, there is ongoing work to further review and develop this policy in line with national, regional and local drivers.

6. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

The policy will be consulted upon, approved and ratified in accordance with COR11 through Quality Committee.

7. REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

This policy will be reviewed three-yearly by the policy author in accordance with COR11. Revision may occur earlier if relevant new legislation or guidance is issued.

The Executive Committee responsible for monitoring the effectiveness of the policy may also call for an early review on the basis of the reports it receives.

The available procedural guidance may be reviewed should national or local guidance change. This can take place without a full policy review, although any changes to procedure will be subject to ratification as laid out in COR11.

Corporate and Legal Services will maintain a version control sheet, as per COR11

8. DISSEMINATION AND IMPLEMENTATION OF A POLICY

This policy will be disseminated in accordance with the procedure for corporate documents and policies.

This policy applies to all relevant persons providing care or services within LPFT with a statutory obligation to comply.

Employee Training

Employee training is crucial to developing a culture within the organisation which values and encourages learning. Employees must feel confident that they know how the procedures operate and that they have the necessary skills to manage risks, incidents and complaints.

The Trust recognises that every single employee, whatever their role, may receive a complaint or witness an incident and therefore will provide basic training on the induction programme and will also encourage all employees to attend further training as part of their on-going professional development.

The Trust will work toward ensuring that those employees involved in conflict resolution, HR investigations, or investigation of incidents, complaints and claims are provided with the appropriate training to enable them to undertake this role.

It is important that all employees including bank workers, agency staff and locum medical staff receive suitable support and guidance. In the first instance this should be offered by the appropriate line manager and/or professional lead.

Patient Feedback: Information for Service Users, Carers and Members of the Public

All service users and carers should be provided with a copy of the “Making Experiences Count” leaflet when accessing services provided by the Trust which provides:

- Details of the services provided by the Trust
- A statement welcoming suggestions, compliments and complaints
- Procedure for complaints
- Contact details for the Trust and PHSO
- Information on advocacy services including the Independent Complaints Advocacy Service

Notices must be displayed in all Trust premises with information about how and where to complain/comment.

All complainants who have registered a formal complaint with the Trust will be provided with details of NHS complaints process

Advocacy supports patients and their carers wishing to pursue a complaint about their NHS treatment or care.

Special requirements will be considered to facilitate full access to the procedure taking account of culture, ethnic origin or disability.

All information relating to accessing the Trust's Complaints procedure and how to provide feedback about the services provided by the Trust will be included on the Trust's website.

9. POLICY CONTROL INCLUDING ARCHIVING

Corporate and Legal Services will retain a copy of each policy for a minimum of 10 years in line with the recommendations contained within 'Records Management NHS Code of Practice' (2006).

Individuals wishing to obtain previous versions of this policy should contact Corporate and Legal Services.

10. MONITORING COMPLIANCE

The Head of Quality and Safety will monitor this policy to ensure it conforms to current legislation and takes into account any changes or reforms to NHS regulations.

The key groups ensuring compliance are detailed below:

The Board of Directors will receive a monthly Risk Report. This report will detail all new externally reported incidents and provide an update on serious incident investigations overseen by Directors. This report will also detail complaints performance, and claims incidence. A separate report detailing the Organisational Risk Register will also be produced monthly.

The Quality Committee will receive reports from meetings which may raise risks or deal with incidents investigations as appropriate. The meetings include the 4 sub-committeesPatient Safety and Experience, Legislative, Organisational and Mortality Surveillance .

The Patient Safety and Experience Committee will explicitly manage the action plans for those themes that have been identified as patient safety priorities.

The Operational Performance and Clinical Governance meeting will receive a Patient Experience report, and an Incidents Trend report. These reports will provide an overview of performance, trend analysis, and lessons learned. This group will also receive and review the Divisional Risk Registers.

Divisional Management Teams (meetings) will ensure the timely completion of serious incident action plans and ensure implementation of any lessons learned. They will also provide a forum in which complaints and responses can be reviewed to ensure timely resolution and learning.

The Information Governance Group will ensure the timely investigation of information governance incidents, and manage the recommendations and lessons learned that arise.

Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

SYSTEMS	MONITORING AND/OR AUDIT				
Criteria	**Measurables**	**Lead Officer/Group**	**Frequency**	**Reporting to**	**Action Plan/Monitoring**
Systems in place to monitor number of incidents, complaints, and claims	Number and range received Take up of relevant training	Associate Director of Nursing and Quality Divisional Managers Divisional Managers	Monthly Risk Report Quarterly Patient Experience Report Quarterly Incident and trends report Monthly Divisional Risk Register Annual	Board Operational Governance meeting Operational Governance meeting Operational Governance meeting Workforce Committee	Quality Committee (Monitoring) Workforce Committee
Aggregation of Incidents Complaints and Claims	Number and range received	Associate Director of Nursing and Quality	Monthly Risk Report	Board	Quality Committee (Monitoring)
Systems in place to monitor implementation of service and practice improvements identified.	Number of service changes identified Implementation of actions plans Audit of improvements made as a result of implementation of actions plans	Quality and Safety Team Leader Head of Quality and Safety Divisional Managers	Bi-monthly Monthly Annual	Operational Governance meeting Divisional Management Team Meetings	Quality Committee (Monitoring)
Systems in place to monitor service users, carers and relatives are treated no differently as a result of raising a concern or complaint	100% satisfaction with standard statement through satisfaction survey	Patient Experience Lead	Annual	Divisional Management Teams	Divisional management Team (Action Plan) Quality Committee (Monitoring)

Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

SYSTEMS	MONITORING AND/OR AUDIT				
Criteria	**Measurables**	**Lead Officer/Group**	**Frequency**	**Reporting to**	**Action Plan/Monitoring**
Systems in place to report improvements to commissioners	Patient Experience report	Patient Experience Lead	Quarterly	Lincolnshire CCGs	CET (Monitoring)
Systems in place to learn from national reports and enquiries	Reports received by Quality Committee Action plans monitored	Quality and Safety Team Leader Quality and Safety Team Leader	Quarterly Monthly	Quality Committee Divisional Management Team Meetings	Quality Committee (Monitoring) Quality Committee (Monitoring)
Systems in place to learn from external visits	External visits logged on register Action plans monitored	Trust secretary Director of Strategy	Quarterly Quarterly	Quality Committee Quality Committee	Quality Committee (Monitoring Quality Committee (Monitoring)

Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

1. PROCEDURE - RISK MANAGEMENT

Overview of Risk Management

This procedural guidance aims to give an overview of the risk management process and how it links with incidents, complaints and claims, it should be read in conjunction with the Boards Assurance and Escalation Framework

Policy Statement

LPFT has a process of internal identification and reporting of risk. All staff authorised by their Divisional Manager or Head of Service (corporate teams) can recognise and identify risk through a standardised assessment tool on the Trusts electronic risk management system. This is then managed locally, via the divisional risk register or elevated to the organisational risk register (ORR).

The risk is owned at differing levels within the organisation dependent on its grading assessment.

- Divisional Risk Registers
    - risks of 12 and below.
- Organisational Risk Register
    - risks of 15 and above
    - risks of 12 and below that require Board intervention to resolve or with a severity rating of 5.

The Trust has adopted a systematic, organisation-wide approach to risk management. Risk may be identified in a variety of ways, for example, through:

Internal:

- Risk and Control Assessments (strategic objectives)
- Self-assessments (against national standards e.g. CQC Essential Outcomes)
- Risk assessment as integral part of business and service planning
- Risk assessment as integral part of project plans and management
- Generic risk assessments – operational level.
- Clinical risk screening and assessment of service users.
- Child and adult protection investigations.
- Whistle-blowing or open disclosure
- Incidents, complaints, or claims

External:

- Inspections of the Trust by external bodies e.g. CQC
- External inquiry reports.
- External bodies, e.g. HCC, NHSLA,HSE, MHRA
- NHS Executive and National Patient Safety Agency.
- Internal and External Audit.
- New case law with implications
- Whistle-blowing or open disclosure

Standards

The Risk Management process is followed by all staff within the organisation in respect of all identified risks.

Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

Assessing/Grading Risk

All risks, whatever source they arise from, will be graded according to the likelihood of occurrence and the actual and potential severity of outcome as soon as possible after identification.

The most senior person on duty in the department/clinical area at the time of the risk is identified or the incident or complaint occurs will do an initial grading.

The risk grading will be re-assessed using the same process throughout the risk management process as new information becomes available and any investigating officers or other relevant stakeholders will be informed.

All identified risks will be held on the relevant Divisional Risk Register and those escalated to the ORR (as per flowchart) will return to the Divisional risk register or closed upon achievement of the target score or if assessed as no longer requiring organisational oversight..

Risk owners will identify the required frequency of review for each risk but for those graded as 15+ or with a severity of 5 this must be each month as a minimum. Reviews will usually take place within the Divisional Management Team meetings or equivalent corporate meeting.

The identified accountable officer (risk owner) must ensure that all controls and/or actions are taken as per the registration document and on-going work identified.

The Divisional Manager (or nominated deputy) is accountable for escalating all risks which meet threshold for inclusion onto the ORR along with progress updates for risks already registered directly onto the electronic risk management system . The date for ORR report extraction is agreed on a month by month basis due to occasional irregularity of ET and Board meetings.

On escalating a risk to the risk register a target risk score is identified, this is the level of risk which the Division (for local risk register) or Executive Team (for organisational risk register) accept as a tolerable level for the risk. When this target score is achieved the risk shall be removed from the respective register.

Guidance on the use of the electronic risk management system can be found here

RISK APPETITE

Risk appetite can be defined as the amount of risk the Board is willing to take in pursuit of the Trust's strategic objectives. A range of factors will influence the Board's level of appetite to accept and manage risk. In February 2016 the Board of Directors approved the following **Risk Statement**:

Financial / VFM

The Board is keen to explore the use of transformational funding and available cash reserves to improve value for money and develop modern and effective services. The Trust will invest for the best possible return and accept the possibility of financial loss, subject to controls being in place. Resources will be allocated to support innovation, research and service re-modelling.

Compliance and Regulation

The Board acknowledges the constraints and provisions required to operate compliantly within legislation, but will actively seek to ensure that the legislation is proportionately applied to enable optimal service delivery. Where legislation appears to be restrictive to best practice the Board will explore appropriate methodologies to challenge the compliance requirements.

Innovation / Quality

The Board recognises the paramount importance of quality in the delivery of healthcare. The Board is firmly of the view that innovation will be required to make significant quality improvements. The Board will encourage the introduction of proven technology and evidence based practice.

Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

Where prior due diligence has been undertaken and controls are in place the Trust will actively participate in research and development of services particularly in relation to the integration of services.

The Board recognises the importance of risk assessment in the delivery of care to individual patients experiencing mental health issues. These assessments are required to provide care programmes to patients that include a proportionate approach to assessing and balancing risks to support the therapeutic intervention and life choices of individuals.

Reputation

The Board does not wish to see significant repercussions from events and will want to ensure that control measures and mitigations are in place to manage the impact of negative events.

The Head of Quality and Safety and the Trust Secretary are able to advise on risk grading of incidents and complaints.

Assignment of management responsibility for different levels of risk within the organisation is as follows:

Assessing the Risk

	Likelihood	Rare	Unlikely	Possible	Likely	Almost certain
Severity (Consequences)		**1**	**2**	**3**	**4**	**5**
Negligible	**1**	1x1 = 1	1x2 = 2	1x3 = 3	1x4 = 4	1x5 = 5
Minor	**2**	2x1 = 2	2x2 = 4	2x3 = 6	2x4 = 8	2x5 = 10
Moderate	**3**	3x1 = 3	3x2 = 6	3x3 = 9	3x4 = 12	3x5 = 15
Major	**4**	4x1 = 4	4x2 = 8	4x3 = 12	4x4 = 16	4x5 = 20
Catastrophic	**5**	5x1 = 5	5x2 = 10	5x3 = 15	5x4 = 20	5x5 = 25

1-3 Low risk
4-5 Moderate risk
8-12 High risk
15-25 Extreme risk

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			impacts on a small number of patients		
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

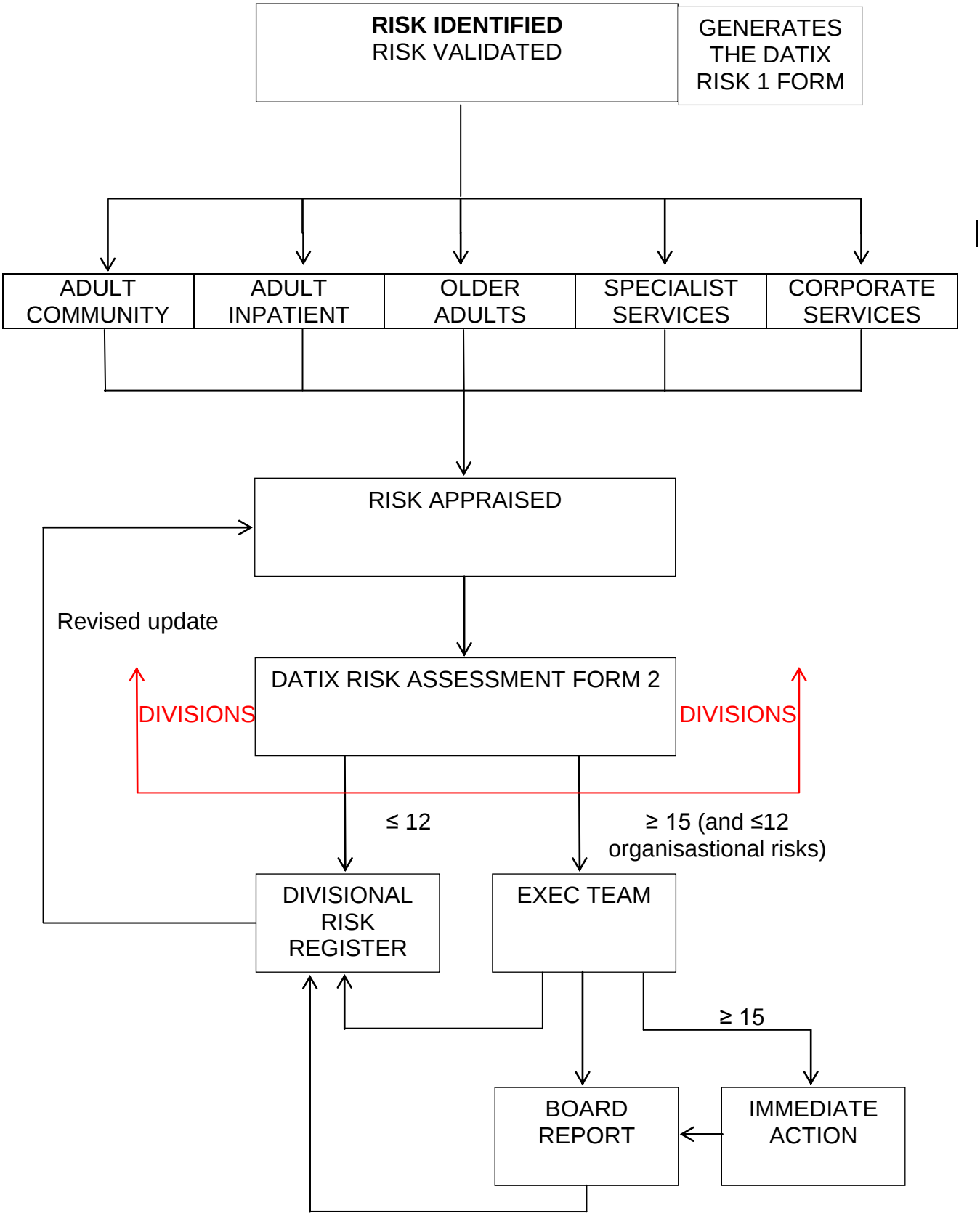
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

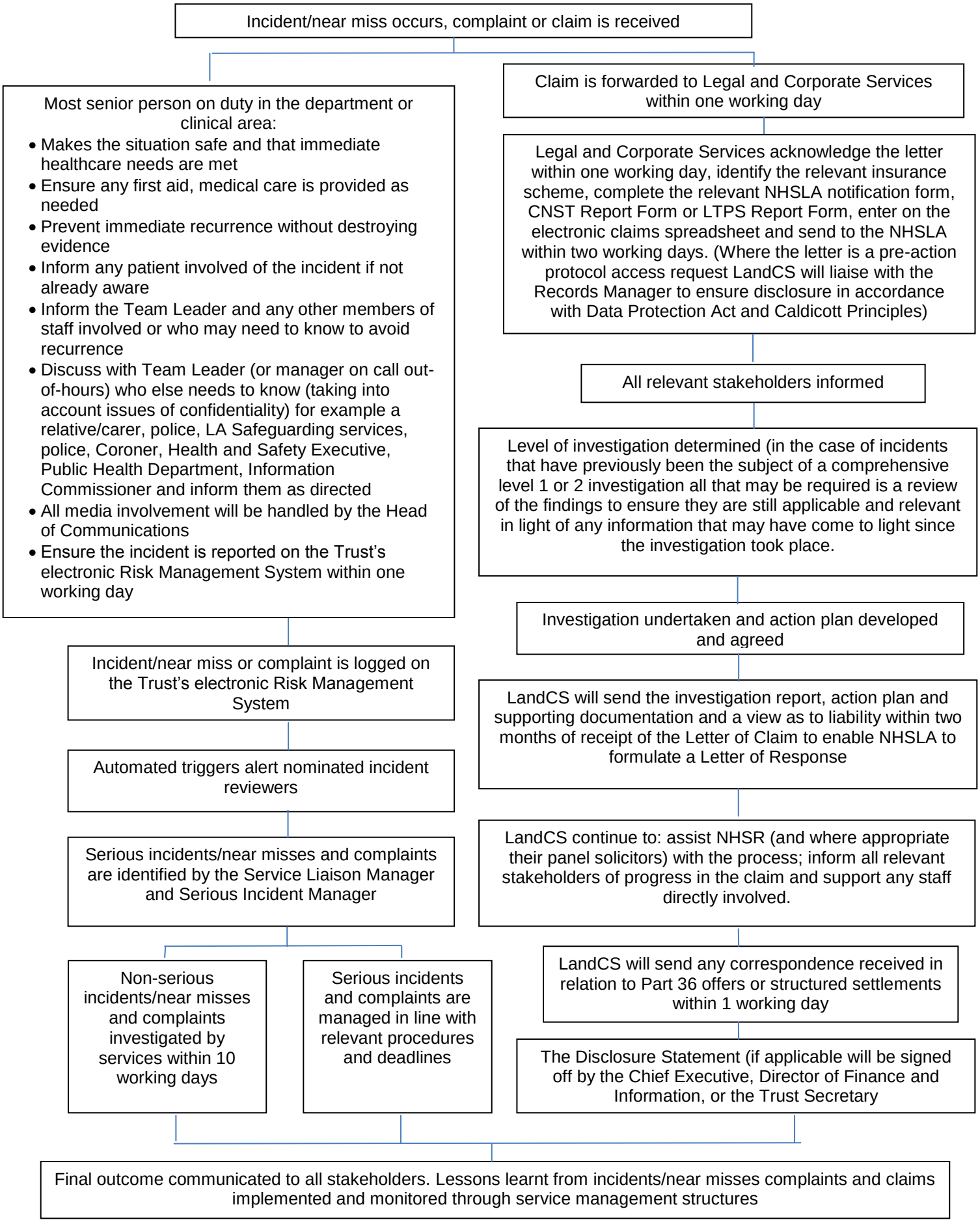
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

PROCEDURE – RISK MANAGEMENT



Reporting and Management of Risk including Incidents, Near Misses Complaints and Claims

2. Procedure for the reporting of incidents, near misses, complaints and claims



3. **Serious Incident (SI) Process** (version 3.6 July 2017)
Based upon the SI Framework (NHSI, 2015)

The following SI Trust process details the stages and timelines that must be achieved to ensure SI incidents and their subsequent investigations (Levels 1, 2 and 3), are robustly managed. In addition to the detail contained within the process described below, the following are requirements at all stages of the process:

- Where there is breach or risk of breach at any stage of the process, staff members must promptly alert, escalate and hold to account.
- Patients / service users and families / carers must be offered the option to be involved as much or as little as they wish, and be supported and kept informed throughout the SI process, ensuring Duty of Candour is met.
- Staff must be supported and kept informed throughout the SI process, including ensuring there are opportunities for debriefing made available.

Part A.
Level 1 Serious Incident (SI) Investigation Process

Level 1 Serious Incident (SI) Process			
Timeline	**Step**	**Action required**	**By whom**
Within 1 working day (from time of incident)	1	DATIX incident report and clinical records entry when necessary.	Team Coordinator / Ward Manager / Involved Clinician
		Inform relevant individuals including Service Manager, Divisional Quality Lead, and Divisional Manager.	
		Action required	**By whom**
Within 2 working days (from time of incident)	2	Complete Initial Review Report. This must evidence Duty of Candour and be submitted with sufficient time for Divisional quality assurance to be completed within 2 working days.	Team Coordinator / Ward Manager or delegated senior clinician
	3	Divisionally approved Initial Review Report submitted to Quality and Safety Team within 2 working days of incident.	Divisional Quality Lead/ Divisional Manager
	4	Confirmation made that incident meets SI criteria and level 1 investigation commissioned.	Divisional Manager or delegated deputy
	5	Make contact with patient / service user, carer/s and family impacted by SI to offer support and offer a meeting. Note: Ensure this contact is followed up within 10 days by letter (Duty of Candour). If the incident was an unexpected death, ensure the	Team Coordinator / Ward Manager

		Trust's bereavement leaflet is included with the letter.	
	6	Arrange for a staff debrief via the Trust's Staff Well-Being Service if appropriate. Include evidence on Initial Review Report)	Team Coordinator / Ward Manager
	7	Make arrangements for a senior manager from the service affected by the SI to make contact with the staff team to offer support. (Include evidence on Initial Review Report	Service Manager or Divisional Quality Lead
	8	Quality checks to be completed of the Initial Review Report. Input SI onto STEIS.	SI Specialist Practitioner Quality & Safety Team Leader
Within 3 working days	9	Approved Initial Review Report submitted to the Executive Team (ET), Associate Director of Nursing & Quality, Head of Quality and Safety, and commissioners. Ensure others receive report as required for the type of incident (e.g. safeguarding, CQC, HR, Legal Department etc.)	Quality & Safety Team administrator
Within 5 working days (from time of incident)	10	Division to identify investigator for Level 1 investigation. In most cases a 'buddy' who is a less experienced investigator will work alongside the named accountable investigator to support their learning.	Divisional Manager or Quality Improvement and Assurance Lead.
	11	Ensure the investigator knows date they are required to submit their investigation report (within 40 days from the incident being reported onto STEIS) and that they fully understand Duty of Candour.	Quality & Safety Team administrator/ Quality and Safety Team Specialist Practitioner
	12	Quality and Safety Team calculate and issue timeline to investigator, Divisional Manager and Divisional Quality Lead with clear deadlines to be achieved for the investigation.	Quality & Safety Team administrator
Timeline			
Within 10 working days	13	Quality check that the Duty of Candour letter has been sent to the patient / service user, carer/s or family and a copy has been sent to the Quality and Safety Team. If the	Divisional Quality Lead (copied to Divisional Manager)

		incident was an unexpected death, ensure the Trust's bereavement leaflet was included with the letter.	
	14	If Quality and Safety Team have not received a copy of the letter by day 8 then escalate to Divisional Quality Lead.	Quality and Safety Specialist Practitioner
	15	Investigator to arrange to meet with the patient and/or family to discuss investigation, terms of reference and confirm patient /family involvement during the investigation and plans for sharing the report.	Investigator
Within 30 days **Day 45** - **55**	16	Investigator arranges meeting with Service/Team/QIAL and or DM/significant others to review findings of the investigation	Investigator
	17	Divisional Quality Lead and / or Divisional Manager receive SI investigation and quality check report; and submit approved divisionally approved report to Quality and Safety Team.	Divisional Quality Lead or Divisional Manager/ Investigator
	18	Independent Executive and or Quality and Safety team Quality check/review of the Divisionally approved SI investigation report and action plan, ensuring any required amendments are completed by SI investigator in liaison with the Divisional Quality Lead or Divisional Manager. Director of Nursing and Quality, or the Medical Director	Executive team - Director of Operations, Director of Nursing/ AHPS and Quality, Medical Director, Quality and Safety Team
	19	Final Executive sign-off of SI investigation report obtained from the investigator.	Investigator
	20	Executive Director approved SI investigation report submitted to ET, commissioners and others as required for the type of incident (e.g. safeguarding, CQC, HR etc.). This timeline allows for a small amount of slippage to ensure no breaches of 60 day submission deadline.	Quality and Safety Team Administrator
	21	Final report sent to Divisional Managers, Quality Assurance and Improvement Leads, Investigator and Action Plan owner by Safety team	Quality and Safety Team Administrator
	22	SI investigation report reviewed by Quality and Safety Team to identify	Quality and Safety Team Leader or

		lessons for learning, including how these will be disseminated and embedded across services. Patient Safety and Experience Committee to review themes and identify any Trust-wide actions required.	Head of Quality and Safety
Action Plan Monitoring			
On-going		SI Action Plan is progress monitored within the Division, with regular progress reports to the most senior Divisional Meeting (the name of this meeting may vary by Division).	Divisional Quality Lead or Divisional Manager
		On completion of all actions the action plan and evidence to be submitted to the Quality and Safety Team.	
		Quality and Safety Team to monitor submission of SI action plans to timescale and escalating and exception reporting to the operations performance and clinical governance meeting.	SI Specialist Practitioner or Quality and Safety Team Leader
		All SI investigation reports and associated action plans stored safely and made easily accessible for sharing internally and to commissioners, Coroner, Police, and Legal Department etc. as appropriate.	Quality and Safety Team Leader or Head of Quality and Safety

Part B.

Level 2 Serious Incident (SI) Investigation Process

Following steps 1 to 9 of the SI process, Divisional Manager to liaise with Head of Quality and Safety, Director of Nursing/AHP's and Quality and or Associate Director of AHP's and Quality to confirm **Level 2** investigation is required and arrange commissioning.

Timeline	Step	Action required	By whom
Within 5 working days (from time of incident)	10	Identify external investigator and panel for Level 2 investigation. Note: A single investigator is accountable for the delivery to timeline of the SI investigation report. A panel will be convened to support the investigator and to provide guidance throughout the investigation process.	Director of Nursing/AHP's and Quality
	11	Identify Non-Executive Director who will review the Terms of Reference along with the Initial Review Report and return any comments/additions within 48 hours.	Trust Secretary

	12	Terms of Reference for the investigation to be set by the Executive Director.	Executive Director
	13	Level 2 investigation - Named administrator allocated to support the SI investigator from the Division in which the SI investigator works (Operational and Corporate Divisions)	Divisional Manager (or equivalent from Corporate)
	14	Quality and Safety Team calculate and issue timeline to investigator, Divisional Manager and Divisional Quality Lead with clear deadlines to be achieved for the investigation.	Quality and Safety Team administrator
Within 10 working days	15	Quality check that the Duty of Candour letter has been sent to the patient / service user, carer/s or family and a copy has been sent to the Quality and Safety Team. If the incident was an unexpected death, ensure the Trust's bereavement leaflet was included with the letter.	Quality and Safety Team administrator, Quality and Safety Specialist Practitioner
	16	First panel meeting to be arranged within 10 days of the incident being reported. Subsequent panel meetings to be confirmed.	Quality and Safety Specialist Practitioner
	17	Investigator to arrange to meet with the patient and/or family to discuss investigation, terms of reference and confirm patient /family involvement during the investigation and plans for sharing the report.	Investigator
Within 35 days	18	Investigator arranges meeting with Service/Team/QIAL and or DM/significant others to review findings of the investigation	Investigator
Within 40 – 45	19	Draft report sent to Non-Executive Director for review and comment, to be returned to author within 48 hours.	Named Non-Executive Director
	20	Investigator to have met with the service, Divisional Manager/Quality Improvement and assurance lead to review	Investigator

		findings and agree appropriate recommendations	
	21	Panel or lead Investigator to complete report with inclusion of recommendations.	Investigator
	22	SI SMART action plan (drafted by team, service or Division alongside the investigator with clearly identified action plan owner) is quality approved.	Investigator
Day 45 - 50	23	Independent Executive and or Quality and Safety team Quality check/review of the Divisionally approved SI investigation report and action plan, ensuring any required amendments are completed by SI investigator/panel in liaison with the Divisional Quality Lead or Divisional Manager.	Executive team, Quality and Safety Team
	24	Final Executive sign off of SI Investigation Report.	Director of Nursing/AHP's and Quality or Medical Director
	25	Executive Director approved SI investigation report submitted to ET, commissioners and others as required for the type of incident (e.g. safeguarding, CQC, HR etc.). This timeline allows for a small amount of slippage to ensure no breaches of 60 day submission deadline.	Quality and Safety Team Administrator
	26	Final report sent to Divisional Managers, Quality Assurance and Improvement Leads, Investigator and Action Plan owner by Safety team	Quality and Safety Team Administrator
First Board Meeting	27	Level 2 (panel investigation) SI reports submitted to the first Board meeting following approved SI investigation report submission to commissioners. The SI report is received by the Board.	SI Specialist Practitioner or Quality and Safety Team Leader
	28	SI investigation report reviewed by Quality and Safety Team to identify lessons for learning, including how these will be disseminated and embedded	Quality and Safety Team Leader or Head of Quality and Safety

		across services. Patient Safety and Experience Committee to review themes and identify any Trust-wide actions required.	
		Action plan monitoring as per Level 1 Investigation	

4. PROCEDURE FOR THE MANAGEMENT OF COMPLAINTS

Lincolnshire Partnership NHS
NHS Foundation Trust

Quality and Safety Team

Complaints Process

The following complaints process details the stages and timelines that must be achieved to ensure complaints are robustly managed and monitored. Detailed below are the complaints categories:

PALS	Direct contact from member of public to the PALS department regarding general health information, signposting and concerns.
	Response timeframe: Issues are resolved within 3 working days.
Service Resolution	(Level 1) Complaints received which are considered medium risk and can be responded to by operational services, with the support of the Quality and Safety Team. Service resolution complaints also include those complaints regarding Doctors/Consultants.
	Interventions: Investigation; Possible Face to face meeting; Outcome written response by service
	Response timeframe: 25 working days
Formal Resolution	(Level 2) A formal complaint is potentially linked to a serious incident (SI); or is deemed to be higher than medium risk; high level of complexity; involves a number of services / organisations; or has significant reputational risk to the Trust. The responses are to be drafted by Operational Services, approved by the Quality Lead and final sign off by an Executive.
	Interventions: Investigation; Possible Face to face meeting; Outcome written response by service; Exec Sign off
	Response timeframe: 45 working days
MP Enquiries	(A complaint about service(s) sent to MPs and MP office request a response from Trust) Responses to be drafted by Operational Services, approved by Divisional Manager/Quality Lead and final sign off by Chief Executive or Deputy in CEO absence.
	Interventions: Investigation; Possible Face to face meeting; Outcome written response by service; Exec Sign off
	Response timeframe: 25 working days

- All complaints are recorded on DATIX, therefore divisional / medical staff need access to the DATIX system.
- Correspondence relating to complaints must not be stored on any other clinical system.
- Correspondence regarding complaints to be sent to Quality and Safety Team using: patientexperience@lpft.nhs.uk

Service Resolution		
Timeline	**Action required**	**By whom**
Within 1 – 3 working days (from receipt of complaint)	Check clinical systems for information, for example, who is responsible for care relevant to complaint and any other supporting information.	Quality and Safety Team
	Register complaint on DATIX, including risk registering (see appendix 1).	
	Send acknowledgement letter to complainant (using standardised template)	
	If required, send consent forms to patient – (consent to share outcome of complaint with complainant / third party). See Appendix 2	
	Identify which Team Co-ordinator / Ward Manager the complaint should be sent to (cc Quality Improvement and Assurance Lead / Service Manager). Request a draft response letter is returned to the Quality and Safety Team within 15 working days for feedback.	
Day 1 – 15	Investigation to take place within service area. This may include a face to face meeting with the complainant (to be recorded using Complaints Meeting Template), outcome of which, including agreed actions to be included in response letter.	Team Co-ordinator / Ward Manager
By Day 15	Quality and Safety Team to receive a draft response letter from Team Co-ordinator / Ward Manager for feedback. Services to ensure draft response letter is copied to sent to Quality Improvement and Assurance Lead / Service Manager for information.	Team Co-ordinator / Ward Manager
	If response letter is not received on day 15, Quality and Safety Team to send a reminder email to appropriate Service Manager / Allocated Investigator (cc Quality Improvement and Assurance Lead).	Quality and Safety Team
	Should Operational Services be experiencing any difficulties responding within the 15 days to contact Quality and Safety Team as soon as possible to seek appropriate support and if required organise an extension of time for completing the draft response letter.	Team Co-ordinator / Ward Manager

Service Resolution		
Timeline	**Action required**	**By whom**
By Day 16 – 20	Upon receipt of draft response letter, a quality check is undertaken by Patient Experience Lead / Quality and Safety Team Leader and feedback offered to the author (including Quality Improvement and Assurance Lead if necessary) .	Quality and Safety Team
	Quality and Safety Team to send an update / holding letter if required to complainant advising that the investigation is still ongoing and confirming the date to expect a response by.	Quality and Safety Team
Day 20	If a response letter has not been received on day 20, the Quality and Safety Team to send a reminder email to appropriate Service / Allocated Investigator (cc Quality Improvement and Assurance Lead) advising of timeframes (including that if the complainant has not received a final response by day 25 the complaint will be non-compliant). Quality and Safety team will offer appropriate support to ensure timeframe achieved.	Quality and Safety Team
By Day 21 – 23	The final letter to the complainant is sent by the Team Co-ordinator / Ward Manager A signed copy letter should be sent to the Quality and Safety Team for records.	Team Co-ordinator / Ward Manager
By Day 25	Copy of letter uploaded to DATIX.	Quality and Safety Team
	Quality and Safety Team to update DATIX and a communication is sent via DATIX to Service/ Allocated Investigator to advise that the complaint has been closed down.	

Note:

- When consent form is received back the Investigating Manager will be informed as to whether consent has been given or not.
- If timeframe is extended – support will be offered and completion of response will be monitored by Quality and Safety Team.

Service Resolution (Medics)		
Timeline	**Action required**	**By whom**
Within 1 – 3 working days (from receipt of complaint)	Check clinical systems for information, for example, who is responsible for care relevant to complaint and any other supporting information.	Quality and Safety Team
	Register complaint on DATIX, including risk registering (see appendix 1).	
	Send acknowledgement letter to complainant (using standardised template)	
	If required, send consent forms to patient – (consent to share outcome of complaint with complainant / third party). See Appendix 2	
	Complaints regarding medical staff are sent to the Clinical Director who will identify an appropriate investigator.	
Day 15	A draft response due from named investigating Doctor to their Clinical Director within 15 working days (see appendix 3).	Named Investigating Doctor
Day 16	Quality and Safety Team to send an update / holding letter if required to complainant advising that the investigation is still ongoing and confirming the date to expect a response by.	Quality and Safety Team
By Day 15 – 20	Clinical Director to review/update draft response letter.	Clinical Director
By Day 21 – 23	Patient Experience Lead to review draft letter and offer any feedback.	Quality and Safety Team
By Day 23	Clinical Director to send final response to Quality and Safety Team who will send response to complainant.	Clinical Director
By Day 25	Quality and Safety Team to update DATIX and a communication is sent via DATIX to Clinical Director / Investigating Doctor to advise that the complaint has been closed down.	Quality and Safety Team
	Copy of letter uploaded to DATIX.	Quality and Safety Team
	Note:	

	• When consent form is received back the Investigating Manager will be informed as to whether consent has been given or not. • If timeframe is extended – support will be offered and completion of response will be monitored by Quality and Safety team.	

Formal Resolution		
Timeline	**Action required**	**By whom**
Within 1 – 3 working days (from receipt of complaint)	Check clinical systems for information on who is in charge of care relevant to complaint and any other supporting information.	Quality and Safety Team
	Register complaint on DATIX, including risk registering (see appendix 1).	
	Send acknowledgement letter to complainant.	
	If required, send consent forms to patient (consent to share outcome of complaint with complainant / third party). See Appendix 2.	
	Identify which Service Manager the complaint should be sent to (cc Quality Improvement and Assurance Lead / Divisional Manager).	
	If the complaint involves multiple services the relevant Quality Improvement and Assurance Leads to decide on Lead Investigator and inform Quality and Safety Team.	Quality Improvement and Assurance Lead
Day 1- 25	Investigation to take place within service area. This may include a face to face meeting with the complainant (which can be recorded using the template), outcome of which, including agreed actions to be addressed in response letter.	Service Manager/Allocated Investigator
By Day 25	Service Manager / allocated investigator to send draft response letter to Quality Improvement and Assurance Lead / Divisional Manager for approval. Quality and Safety Team to be copied in to email from Service Manager / Allocated Investigator.	Service Manager/Allocated Investigator

Day 26	If a response has not been received by day 25, the Quality and Safety Team to send a reminder email to appropriate Service Manager / Allocated Investigator (cc Quality Improvement and Assurance Lead) advising of timeframes (including that if the complainant has not received a final response by day 45 the complaint will be non-compliant). Quality and Safety team will offer appropriate support to ensure timeframe achieved.	Quality and Safety Team
	Quality and Safety Team to send an update / holding letter if required to complainant advising that the investigation is still ongoing and confirming the date to expect a response by.	

Formal Resolution		
Timeline	**Action required**	**By whom**
By Day 30 – 35	Quality Improvement and Assurance Lead to provide approved draft letter to Patient Experience Lead.	Quality Improvement and Assurance Lead
	Review / support by Patient Experience Lead, liaising with Quality Improvement and Assurance Lead if required. Final approved draft response sent to Director of Operations.	Patient Experience Lead / Quality and Safety Team Leader
Day 35 - 40	Director of Operations to review complaint response. Final amendments agreed between Director of Operations, Patient Experience Lead, Quality Improvement and Assurance Lead and Service/Investigating Manager.	Director of Operations
Day 40 - 45	Final approval by CEO or Deputy and response letter sent to complainant – may include offering a meeting with the complainant. Division to nominate most appropriate person to undertake meeting. This will be supported by the Patient Experience Lead.	CEO or Deputy
	Complaint closed down on DATIX and notification sent to Divisional management team.	Quality and Safety Team
	Note: If a formal complaint is linked with an SI then then timeframes will match those of the SI.	

Formal Resolution (Medics)		
Timeline	**Action required**	**By whom**
Within 1 – 3 working days (from receipt of complaint)	Check clinical systems for information on who is in charge of care relevant to complaint and any other supporting information.	Quality and Safety Team
	Register complaint on DATIX, including risk registering (see appendix 1).	
	Send acknowledgement letter to complainant.	
	If required, send consent forms to patient (consent to share outcome of complaint with complainant / third party). See Appendix 2.	
	Identify which Service Manager the complaint should be sent to (cc Quality Improvement and Assurance Lead).	
	Complaints regarding medical staff are sent to the Clinical Director who will identify an appropriate investigator.	
Day 1 - 25	Investigation to take place by Named doctor. This may include a face to face meeting with the complainant. Outcome of which including agreed actions to be addressed in the response letter.	Named Investigating Doctor
By Day 25	Named Doctor to send draft response letter to Clinical Director for approval. Quality and Safety Team to be copied in to email.	Named Investigating Doctor
Day 26	If a response has not been received by day 25, the Quality and Safety Team to send a reminder email to appropriate Named Doctor (cc Clinical Director) advising of timeframes (including that if the complainant has not received a final response by day 45 the complaint will be non-compliant). Quality and Safety team will offer appropriate support to ensure timeframe achieved.	Quality and Safety Team
	Quality and Safety Team to send an update / holding letter if required to complainant advising that the investigation is still ongoing and confirming the date to expect a response by.	Quality and Safety Team

Day 30 - 35	Clinical Director to provide approved draft letter to Patient Experience Lead. Quality review by Patient Experience Lead, liaising with Clinical Director if required. Final approved draft response sent to Director of Operations.	Clinical Director
Day 35- 40	Director of Operations to review complaint response. Final amendments agreed between Director of Operations, Patient Experience Lead ,.Clinical Director	Director of Operations
	Final approval by Medical Director / CEO and response letter sent to complainant – may include offering a meeting with the complainant. Clinical Director to nominate most appropriate person to undertake meeting. This will be supported by the Patient Experience Lead.	Medical Director / CEO
	Complaint closed down on DATIX and notification sent to Divisional management team. Note: If a formal complaint is linked with an SI then then timeframes will match those of the SI.	Quality and Safety Team

MP Enquiries		
Timeline	**Action required**	**By whom**
Within 1 – 3 working days (from receipt of complaint)	Enquiry letter received into the office of the CEO, acknowledged by CEO and forwarded to Quality and Safety Team to process.	Quality and Safety Team
	Preliminary enquiries with the services, including checking capacity.	
	Check clinical systems for information, for example, who is in charge of care relevant to complaint and any other supporting information.	
	Register complaint on DATIX, including risk registering (see appendix 1).	
	Send acknowledgement letter to MP.	
	Identify which Service Manager / Quality Improvement and Assurance Lead the complaint should be sent to. Service Manager and requesting a draft response is due to the Quality and Safety Team within 15 working days.	
	Complaints regarding medical staff are sent to the Clinical Director Doctor who allocates an investigator.	
Day 1-15	Investigation to take place within service area	Service Manager
Day 15	Service Manager / allocated investigator to send draft response letter to Quality Improvement and Assurance Lead / Divisional Manager for approval. Quality and Safety Team to be copied in to email from Service Manager / Allocated Investigator. If response letter is not received on day 15, Quality and Safety Team to send a reminder email to appropriate Service Manager / Allocated Investigator (cc Quality Improvement and Assurance Lead) advising of timeframes (including that if the complainant has not received a final response by day 25 the complaint will be non-compliant). Quality and Safety team will offer appropriate support to ensure timeframe achieved. Should Operational Services be experiencing any difficulties responding within the 15 days to contact Quality and Safety Team as soon as possible to seek appropriate support and if required organise an extension of time for completing the draft response letter. Quality and Safety Team send a holding letter to MP advising that the investigation is still ongoing and confirming the date to expect a response by.	Quality and Safety Team

Day 16 -20	Upon receipt of draft response letter, a quality check is undertaken by Patient Experience Lead / Quality and Safety Team Leader and feedback offered to the author.	Quality and Safety Team
Day 20	If a response letter has not been received on day 20, the Quality and Safety Team to send a reminder email to appropriate Service / Allocated Investigator (cc Quality Improvement and Assurance Lead) advising of timeframes (including that if the complainant has not received a final response by day 25 the complaint will be non-compliant). Quality and Safety team will offer appropriate support to ensure timeframe achieved.	Quality and Safety Team
By Day **21 – 25**	Director of Operations to review complaint response. Final amendments agreed between Director of Operations, Patient Experience Lead, Quality Improvement and Assurance Lead and Service/Investigating Manager. Final response letter to be signed by CEO and sent to MP. Copy of letter sent to Quality and Safety Team.	Director of Operations CEO or Deputy
Day 25	Quality and Safety Team update DATIX and a communication is sent via DATIX to Service/Investigating Manager and divisional management team to advise that the complaint has been closed down.	Quality and Safety Team

The risk assessment tool adopts the three step process which firstly categorises the consequences of a complaint, then assesses the likelihood of a recurrence of the incidents or events giving rise to the complaint and then finally, a risk level is assigned to the complaint. This is compatible with the Trust's Incident Reporting Policy and Risk Register.

Step One: Consequence Categorisation Table

Category	Description
Negligible	• No impact or risk to provision of healthcare.
Minor	• Minimal impact and relative minimal risk to the provision of healthcare or the Organisation. • No real risk of litigation.
Moderate	• Potential impact on service provision and delivery. • Legitimate consumer concern but not causing lasting detriment. • Slight potential of litigation.
Major	• Significant issues of standards, quality of care or denial of rights. • Complaints with clear quality assurance or risk management implications, or issues causing lasting detriment that requires investigation. • Possibility of litigation.
Catastrophic	• Issues regarding serious, adverse events, long-term damage, grossly substandard care, professional misconduct or death that require investigation. • Serious patient safety issues. • High probability of litigation.

Step Two: Likelihood Categorisation Table

Category	Description
Rare	• Isolated or one off. • A slight or vague connection to healthcare provision.
Unlikely	• Rare. • Unusual but may have happened before.
Possible	• Happening from time to time. • Irregular but not constant.
Likely	• Will probably occur several times a year.
Almost Certain	• Recurring. • Found or experienced often.

Step Three: Risk Assessment Matrix

	Consequence				
Likelihood of Recurrence	**1 Negligible***	**2 Minor***	**3 Moderate***	**4 Major***	**5 Catastrophic***
1 Rare*	**1**	**2**	**3**	**4**	**5**
2 Unlikely*	**2**	**4**	**6**	**8**	**10**
3 Possible*	**3**	**6**	**9**	**12**	**15**
4 Likely*	**4**	**8**	**12**	**16**	**20**
5 Almost Certain*	**5**	**10**	**15**	**20**	**25**

*National Patient Safety Agency (NPSA) definitions.

1 – 3	Low risk
4 – 6	Moderate risk
8 – 12	High risk
15 - 25	Extreme Risk

STATEMENT OF CONSENT FOR THE DISCLOSURE OF PERSONAL RECORDS AND INFORMATION WITH SOMEONE RAISING A COMPLAINT ON THE BEHALF OF A PATIENT/SERVICE USER

Complaint Reference No:	
Complainant's Name:	
Complainant's Address:	
Complainant's Telephone Number:	
Complainant's Email Address:	
Relationship to Service User:	
Service User's Name:	
Service User's Date of Birth:	
Service User's Address:	
Today's Date:	

Please tick the relevant box below.

I **give my consent** for Lincolnshire Partnership NHS Foundation Trust to share any relevant information with the complainant listed above so that the investigation into the complaint can be completed. I understand that this is likely to include my personal records. ☐

I **do not give my consent** for Lincolnshire Partnership NHS Foundation Trust to share any information with the complainant listed above. ☐

Signed: _____

Dated: _____

If you wish to disclose your personal records, the investigation into the complaint made will be coordinated by:

Cathy Hobbs –Patient Experience Lead

Once you have completed this form, please return in the Freepost envelope provided. Please could return this to us within 10 working days to enable us to respond to the concerns that have been raised by the complainant

Appendix 3

PROTOCOL FOR COMPLAINTS INVOLVING NAMED MEDICAL STAFF

1. The Corporate function for managing complaints is based within the Trust's Quality & Safety Department and managed by the Patient Experience Lead.

2. If a complaint is made regarding a named doctor, the Patient Experience Lead will share the details of the complaint with the relevant divisional Clinical Director who will identify an appropriate investigator based on the circumstances. In some instances this may be the Clinical Director but will be determined on an individual basis.

3. If the named doctor is a speciality doctor or other non-consultant doctor, then the supervising Consultant will be made aware of the complaint and its outcome by the Clinical Director. It may be more appropriate for the supervising Consultant to undertake the investigation, but this will be decided on an individual basis.

4. If the named doctor is a trainee, the Clinical Director will inform the supervising Consultant and Director of Medical Education (DME). The DME will advise the relevant Training Programme Director for information and regarding the outcome as appropriate. The Clinical Director will decide upon the appropriate investigation in conjunction with the DME.

5. If a Clinical Director is complained about in either their clinical capacity or managerial capacity the Medical Director will oversee the process and identity the appropriate investigator.

6. If the Medical Director is complained about in their clinical capacity, the appropriate Clinical Director will identify an investigator. If it is in their managerial capacity, this will be passed to the Chief Executive.

7. The doctor named in the complaint is responsible for providing any required information to the investigator/Clinical Director in a timely manner. Depending upon the complexity and/or the seriousness of the complaint, the required information may take the form of a response letter or may involve direct meetings with the investigator/Clinical Director.

8. The investigator/Clinical Director will provide a response letter within 25 days of the complaint being received by the Quality and Safety Team for Service Resolution and within 45 days for Formal Resolution. In the eventuality of absence or unavailability, the timescales may need to be reviewed in discussion with the Quality and Safety Team.

9. It may be that, in considering the complaint, the Clinical Director, and / or the doctor concerned, propose a meeting with the complainant in an effort to resolve the complaint. In this case, Duty of Candour will be observed where the Trust must act in an open and transparent way with relevant persons in relation to care and treatment provided to services users.

10. The Clinical Director will liaise with the Medical Director as needed regarding the complaint and will share the outcome to support Revalidation.

Dr Sue Elcock
Medical Director

5. PROCEDURE FOR THE MANAGEMENT OF EXTERNAL VISITS, REPORTS AND RECOMMENDATIONS

There are a range of external visits, reports, investigations and policies that the Trust may learn from. These include investigations and reports into other organisations which may have lessons for LPFT, National Enquiries which produce actions or examples of good practice, National Policy to do with Risk Management or Patient Safety, or recommendations that arise from external visits to LPFT.

This can be broadly split into two areas of work: recommendations and lessons from reports on other Trusts; and recommendations for LPFT arising from visits and inspections.

Lessons from other Trusts

In the case of best practice as identified in National Confidential Enquiries/Inquiries, and other external reports:

National Confidential Enquiries/Inquiries may come into LPFT through a variety of routes. These will be managed through the Quality Committee meeting.

Through the Quality Committee, the Director of Nursing, AHPs and Quality will be responsible for:

- Liaising with the Deputy Director of Informatics to ensure that LPFT responds to any National requests for data.
- Identifying relevant reports through discussion. If a document is felt not to be relevant then this will be documented through the minutes of the Quality Committee meeting.
- Disseminating relevant documents. Quality Committee will decide on the relevant group or committee to manage the report/ inquiry.

The nominated group will conduct a gap analysis by drawing together any recommendations, and disseminating through group members into the organisation.

Where recommendations need to be acted upon, this will be done through a process of action planning, managed through the nominated group.

The above process will be monitored through the action planning process at the nominated group, and the submission of a quarterly report to the appropriate parent committee.

This process ensures that external enquiries are incorporated into the Trust's Risk Management systems, and are reported on quarterly.

Any lessons to be shared across the Health Community will be via the Lincolnshire Quality Review Committee.

External visits and inspections to LPFT

With regard to recommendations arising from external agency visits and inspections:

Notification of an external visit may come into the organisation from a variety of sources. However, these should be raised at the next Executive Team meeting (ET) where a co-ordinating individual will be identified.

The nominated individual will liaise with the Trust Secretary to ensure that any information on forthcoming/regular review is entered onto a schedule of dates.

The nominated individual will be responsible for forwarding any action plans regarding recommendations to the appropriate group. It will be the responsibility of the chair of the appropriate group to ensure that the action plan is addressed, and to report to the appropriate committee on the maintenance and progress of the action plan

It will be the responsibility of both the nominated individual and group chair to populate the

organisational risk register with any identified risks. This will be done through the ET and completion of a risk assessment form.

Compliance with this process will be monitored by relevant reports to appropriate committees, and the regular update of the Risk Register

This policy aims to provide a framework for the co-ordination and evaluation of recommendations arising from external agency visits, inspections and accreditations. The framework includes a process for disseminating and performance managing the implementation of actions arising from the recommendations and providing assurance to the Board of Directors.

The Director of is responsible for ensuring that there is a centrally held, internally audited record of all external agency visits, inspections and accreditations together with their reports which is kept updated and monitored within specified timescales, including review dates.

Once a visit is announced the Chief Executive will identify a lead Director to oversee the visit and ensure that arrangements are in place and details of the visit are communicated as appropriate.

The lead Director will identify an employee to manage all aspects of the visit (Project Manager) and support front-line employees. The lead Director will have overall responsibility for overseeing the project, setting a schedule of dates, co-ordinating information requirements and communicating to the organisation.

The project manager will ensure that any identified risks are included on the risk register together with the mitigating actions.

Following the visit, the lead Director will be responsible for receiving, and responding to, the report and evaluating the recommendations. An action plan will be developed to ensure that all relevant and appropriate recommendations are implemented using the template at Appendix A.

The report will be received and the action plan approved by the Strategic Delivery Team.

The lead Director will be responsible for identifying the relevant service areas and for performance managing the implementation through the appropriate committee.

The lead Director will present regular progress reports to the Board of Directors / Board Committee(s) as appropriate.

Any report which affects the Terms of Authorisation will be presented to the Council of Governors.

6. PROCEDURE FOR IMPLEMENTING AND MONITORING SERVICE AND PRACTICE IMPROVEMENTS