Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Mr. Ahmed Khan
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Sir,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal information redacted by USI

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 28 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Mr. Ahmed Khan
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th April 2022

Signed 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 28 of 2022]

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, Associate Medical Director, the Head of Service, the Clinical Lead, urology consultants or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern

catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected,

can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

26. What, if any role did you have in staff performance reviews?

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37. Did those systems or processes change over time? If so, how, by whom and why?

38. How did you ensure that you were appraised of any concerns generally within the unit?

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

40. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you liaised with, involved, and had meetings with the following staff (please name the individual/s who held each role during your tenure):

    (i) The Chief Executive(s);
    (ii) the Director(s) of Acute Services;
    (iii) the Assistant Director(s);
    (iv) the Clinical Director
    (v) the Associate Medical Director;
    (vi) the Head of Service;
    (vii) the Clinical Lead;
    (viii) the consultant urologists.

    When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

    (a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and

detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding

concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were

those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text

communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.28 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Ahmed Faraz Khan

I, Ahmed Faraz Khan, will say as follows:-

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1.1 I believe that a full account of my involvement in and knowledge of all matters falling within the scope of the Inquiry Terms of Reference is set out in my answers to Questions 4 to 72 below and in my response to Questions 1 to 25 of the other Section 21 Notice served upon me, namely, No.31 of 2022. I rely upon all of those answers.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

2.2 Please see attached documents.

Urology Services Inquiry

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

4.1 My qualifications are as follows:

a. Fellow of Faculty of Paediatrics -Royal College of Physicians in Ireland, 2017
b. Fellow of Royal College of Paediatrics & Child Health (FRCPCH), London - 2010
c. Masters in Medical Sciences - National University of Ireland Galway- 2007
d. Membership- Royal College of Physicians in Ireland (MRCPI Paediatrics) - 2002
e. Diploma in Child Health (DCH)- Royal College of Surgeons in Ireland- 1999
f. Bachelor of Medicine & Bachelor of Surgery (MBBS)- LUMS, Pakistan- 1993 .

4.2 My occupational history prior to commencing employment in SHSCT was as follows:

a. Locum Consultant Paediatrician, Ulster Hospital, SEHSCT, March 2008 to May 2008
b. Locum Consultant Paediatrician, University College Hospital Galway, July 2006 to Feb 2008
c. Locum Consultant Paediatrician, Cork University Hospital, September 2005 to June 2006

d. Paediatric & neonatal specialist training, SHO & Registrar training, In Royal College of Physicians in Ireland training hospitals across Ireland, July 1997 to June 2005.

4.3 My CV is attached. *Relevant document can be located at S21 No 28 of 2022 Attachments, 1. CV – Dr Ahmed F Khan*

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 The posts I have held within SHSCT are as follows:

a. Locum Consultant Paediatrician - Daisy Hill Hospital, SHSCT, From June 2008 to 31st May 2009
b. Consultant General Paediatrician with special interest in Community Child Health - Daisy Hill Hospital & Community Paediatric Services – Southern Health & Social Care Trust - 1/6/2009 to date
c. Clinical Director- Community Paeds Services – SHSCT – 1st Nov 2012 till 31/5/2013
d. Associate Medical Director (AMD), Children & Young People Directorate (CYP) – 1st June 2013 till 31st April 2018, then from 1st Jan 2019 till 30th June 2021
e. Acting Medical Director – 1st April 2018 till Dec 2018
f. On career break from SHSCT - from July 2021 till 30th Sept 2022
g. Consultant Paediatrician with special interest in Community Child Health - Cork University Hospital - July 2021 to date

5.2 My Job Descriptions for the posts of Consultant Paediatrician, *can be located at S21 No 28 of 2022 Attachments, 2. CD CYP Community Paeds JD*, CD *can be located at S21 No 28 of 2022 Attachments, 2. CD CYP Community Paeds JD*, AMD *can be located at Relevant to HR/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description* & MD *relevant document can be located at Relevant to HR/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description*

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6.1 My Line management in each role is as follows:

a. During Locum Consultant Paediatrician: My line manager was Clinical Director Paediatrics, Daisy Hill Hospital (DHH) – Dr Bassam Aljarad.

b. During Consultant Paediatrician with special interest in Community Paediatrics: My Line manager was Clinical Director, DHH - Dr Bassam Aljarad.

c. During Clinical Director (CD) in Community Paediatric Services - My line manager was Associate Medical Director (AMD), Children & Young people Directorate (CYP) - Dr Bassam Aljarad.

d. During Associate Medical Director (AMD), CYP: I had two line managers: the Director of Services CYP, Mr Paul Morgan, and the Medical Director. My Medical Director line managers were:

i. From June 2013 till 2015 - Dr John Simpson
ii. From 2015 till 2018 -Dr Richard Wright
iii. From 1st Jan 2019 till 30th June 2021 - Dr Maria O'Kane

e. During Acting Medical Director (April 2018 - Dec 2018) - My line manager was the Chief Executive, Mr Shane Devlin.

6.2 My responsibilities in each role can be summarised as follows:

a. As Clinical Director (CD), Community Paediatric Services, I was the clinical line manager for medical staff in Community Paediatric Services, SHSCT. My Job Description is attached. *Relevant document can be located at S21 No 28 of 2022 Attachments, 2.vCD CYP Community Pediatric Job Description*

b. As AMD, Children & Young People Directorate (CYP), I was responsible for clinical line management of medical staff in the Children & Young People (CYP) Directorate. My Job Description is attached. R*elevant document can be located at Relevant to HR/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description*

c. As Acting Medical Director:

i. I had Corporate professional Governance responsibility for following :
   A. For the clinical outcomes and effectiveness of the Trust's services.
   B. To lead in the development of a framework to ensure a strong infrastructure of medical leadership.

ii. I was Trust's nominated Responsible Officer for General Medical Council (GMC):
   A. For referring concerns about a medical practitioner to the General Medical Council for addressing concerns about a medical practitioner's fitness to practice.
   B. For the effectiveness of medical appraisal of the medical workforce.
   C. For quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.

iii. I was the lead Director for strategic management of Patient Safety initiatives, and the link Director with the Patient Safety Forum and other regional Fora.

iv. I was responsible to ensuring an effective system of integrated governance within the Trust.

v. I was lead Director responsibility in a number of organisationally critical areas including:
   A. Health Care Acquired Infection (HCAI),
   B. Research & Development,
   C. Raising Concerns and
   D. Emergency Planning.

vi. I was lead Director for the Trust's Medical Negligence and other related committees.

vii. I was also responsible for Corporate Clinical Governance team through Assistant Director of Clinical Governance & Social Care (CGSC) - Ms Margaret Marshall.

6.3 I attach the following:

a. MD Job Description *can be located at Relevant to HR/ Reference No 15/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description*
b. Medical directorate structure chart -2018 *Relevant document can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

c. SHSCT organisation chart 2018 - *Relevant document can be located at S21 No 28 of 2022 Attachments, 4. SHSCT ORG CHART UPDATED09.02.18*

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

7.1 During my role as Consultant Paediatrician, Clinical Director & Associate Medical Director, in Children & Young People directorate (CYP) from 2013 till 2018 & then from 2019 till 2021, I have had no operational, governance & line management responsibilities of Urology services or staff.

7.2 During my role as Acting Medical Director (1st April 2018 till Dec 2018), I wasn't involved in operational or direct governance responsibilities of Urology services.

7.3 However, as an Acting Medical Director I had corporate professional governance responsibilities for the following:

a. For the clinical outcomes and effectiveness of the Trust's services.
b. To lead in the development of a framework to ensure a strong infrastructure of medical leadership within the Trust.
c. I was the Trust's nominated Responsible Officer for General Medical Council (GMC) for referring concerns about a medical practitioner to the General Medical Council to address any concerns about a medical practitioner's fitness to practice.
d. I was responsible for the effectiveness of medical appraisal of the medical workforce and for the quality and standard of CPD.
e. I was Lead Director for the Trust's Medical Negligence and other related committees.
f. I was the Lead, and managed, the Trust's Corporate Governance Team through the Assistant Director of Clinical Governance & Social Care (CGSC), Mrs Marshall. My key responsibilities were:

    i. Working with other operational Directors to inform, support and provide assurance on the systems for the effective identification and management of clinical governance concerns, ensuring that any learning is incorporated into professional practice and systems;
    ii. As a member of the Senior Management Team and Trust Board, as Medical Director I had corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a

safe working environment for staff, and appropriate and efficient use of public funds.

7.4 I refer to the Medical Director Job Description attached above. I also attach the SMT structure - 2018. *Relevant document can be located at S21 No 28 of 2022 Attachments, 4. SHSCT Org CHART UPDATED 09.02.18*

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, Associate Medical Director, the Head of Service, the Clinical Lead, urology consultants or with any other role which had governance responsibility.

8.1 The operational team in the Acute Directorate (including the Director, Assistant Director, Head of Services & other related staff mentioned in the question) were responsible for the operation and governance of Urology services. Acute Directorate clinical & professional governance was managed clinically by the Clinical Director & Associate Medical Director and operationally by the Director of Acute Services, Ms Esther Gishkori & Mrs Anita Carroll.

8.2 As Acting Medical Director (April to December 2018), I had the responsibilities mentioned in Question 7 above.

8.3 The main differences in my role compared to above mentioned roles were as follows:

a. I had a corporate professional governance role through the medical line management structure, i.e., Clinical Director and Associate Medical Director.
b. I was the Trust's nominated Responsible Officer for the General Medical Council (GMC) for referring concerns about a medical practitioner to the General Medical Council for addressing concerns about a medical practitioner's fitness to practice.
c. I was responsible for the effectiveness of medical appraisal of the medical workforce and for the quality and standard of Continuous Professional Development (CPD).
d. I was responsible for Trust Corporate Governance through Assistant Director of Clinical Governance & Social Care (CGSC), Mrs Margaret Marshall. My responsibilities mentioned in Question 7 above.

8.4 During my tenure as Acting Medical Director, I submitted number of reports to trust board including Medical Appraisal and Job Planning of medical staff. **See attached**.

Evidences:

- **Medical Appraisal report to Trust Board** *Relevant document can be located at S21 No 28 of 2022 Attachments, 5. item11ii. Medical Appraisal and Revalidation Annual Report 2017-2018 Final*
- **Job Planning report to Trust Board** *Relevant document can be located at S21 No 28 of 2022 Attachments, 6. Job PLANNING – ONE DIRECTION Version 3*

Urology services/Urology unit - staffing:

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

9.1 I had no involvement in that review or setting up southern trust urology services. Director of Acute Services at the time was Dr Gillian Rankin and the Medical Director was Dr Patrick Loughran, both of whom would be able to provide this information.

10. What, if any, performance indicators were used within the urology unit at its inception?

10.1 I had no involvement in this and was not aware of any performance indicators used. Director of Acute Services at the time was Dr Gillian Rankin and the Medical Director was Dr Patrick Loughran, both of whom would be able to provide this information.

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

11.1 I had no involvement in or knowledge of this. Director of Acute Services at the time was Dr Gillian Rankin and the Medical Director was Dr Patrick Loughran, both of whom would be able to provide this information.

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

12.1 I had no involvement in or knowledge of this. Director of Acute Services at the time was Dr Gillian Rankin and the Medical Director was Dr Patrick Loughran, both of whom would be able to provide this information.

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement with this plan?

II. How was it implemented, reviewed and its effectiveness assessed?

III. What was your role in that process?

IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

13.1 I have had no knowledge of or involvement in, the Implementation Plan. I wasn't aware of these challenges and issues during my tenure as Acting Medical Director. I understand this was managed by the Director of Acute Services at the time, Dr Gillian Rankin, and the Medical Director, Dr Patrick Loughran, both of whom would be able to provide this information.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role

was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

14.1 I refer to and repeat my answer to Question 13.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

15.1 I refer to and repeat my answer to Question 13.

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

16.1 I had no involvement or knowledge of this issue. I understand the Director of Acute Services at the time was Dr Gillian Rankin and the Medical Director was Dr Patrick Loughran, both of whom would be able to provide this information.

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

17.1 I refer to and rely upon my answer to Question 16.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

18.1 I had no knowledge of specific staffing shortages in the Urology unit. I wasn't responsible for or involved in Urology staff recruitment processes.

18.2 During my tenure as acting Medical Director, the general shortage of medical staff in several specialties across the Trust was discussed at the Senior Management Team meetings. Director of HR & her team (Zoe Parks) also presented update report of recruitment & selection. However, to the best of my recollection specific Urology service staffing wasn't brought to attention by the Director of Acute services.

18.3 The shortage of medical staff was already on the Corporate Risk Register as Medium risk since July 2015. However, this risk was discussed again between the Medical Director's Office & the HR Directorate. This risk was re-categorized as High in August 2018 and entered in the Corporate Risk Register.

Evidence: Corporate Risk Register October 2018 *can be located at S21 No 28 of 2022 Attachments, 7. 20180906 CRR*

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

19.1 I am not sure if I can usefully answer this question as I wasn't aware of any specific staffing issues in Urology services. The persons who occupied the Director of Acute Services role, Clinical Director role, and Associate Medical Director role over the relevant period would likely be able to provide the information sought in this question. From my previous experience as Associate Medical Director in Children and Young People Services, I am aware that staff shortage can lead to ineffective and unsafe services, however, this may not necessarily be the case.

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

20.1 During my tenure as Acting Medical Director (From April- Dec 2018), I wasn't involved in managing Urology Services posts, roles & responsibilities. This was managed by Director of Acute Services (Mrs Esther Gishkori) with the CD (Colin Weir) and AMD (Mr Mark Haynes).

20.2 I wasn't aware of any changes of posts, roles, duties or responsibilities.

20.3 The Director of Acute Services, Mrs Esther Gishkori, was off [Personal Information redacted by USI] July and September 2018 and Mrs Anita Carroll was covering her duties during this period. The

persons who occupied the Director of Acute Services roles over the relevant period would likely be able to provide the information sought in this question.

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

21.1 I was appointed as Acting Medical Director from April to December 2018. During this time, my roles and responsibilities remained the same and did not change. My Acting Medical Director role and responsibilities are explained earlier in response to Question 6.

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1 During my tenure as Acting Medical Director, I wasn't managing Urology services and had no knowledge of non-medical staff support to urology services. This information would be best provided by Director of the Acute Directorate at that time, Mrs Esther Gishkori (and Mrs Anita Carroll for the period between July and September 2018).

22.2 However, as part of my role as MHPS Case Manager in respect of Mr O'Brien, and through reading the MHPS investigation report from the case investigator, Dr Chada, I obtained some understanding of the challenges in Urology services.

22.3 In my MHPS Case Manager's Determination, I therefore made the following recommendation (at pages 10-11 of the Determination) that is potentially relevant here:

> *"In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."*

22.4 In July 2020, I was contacted by Mr Stephen Wallace, Project Manager by email from the Medical Director's office, regarding any comments on proposed Terms of Reference (TOR) for the Admin review as recommended in my MHPS report. My response was that during this investigations there was evidence of system wide failure within Acute directorate therefore my MHPS recommendation was to complete an the independent admin review in the acute Directorate to learn from this case & not to just focus in urology department. I wasn't approached afterwards regarding final Terms of Reference of this review. **See attached email of my comments for Admin review TOR** which *can be located at S21 No 28 of 2022 Attachments, 8. 20200804 - Email – RE Administration Review Terms of Reference 1.*

22.5 Then in October 2020, Mrs Siobhan Hynds shared some initial findings of the independent admin review however; this was to be completed in more detail at later stage. To the best of my recollection, I wasn't shared the final report of this review.

22.6 The current Director of Acute Services, Ms Melanie McClements, and/or the most recent Medical Director (and current Chief Executive), Dr Maria O'Kane, might be able to provide details of the findings of this review.

22.7 My knowledge is limited to an understanding that the admin review has been completed.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

23.1 I had no involvement in managing Urology Services and cannot answer this question. This information would be best obtained from Director of the Acute Directorate, Mrs Esther Gishkori (and/or by Mrs Anita Carroll for the period between April and December 2018).

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

24.1 As indicated above, I had no involvement in managing Urology Services. I don't remember any such concern being raised with me as Acting Medical Director between April and

December 2018. This information would be best obtained from the persons mentioned in my previous answer.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

25.1 During the time of my tenure as Acting Medical Director, from April to December 2018, the following were the arrangements:

a) Operationally:

i. I believe that the person who was in overall charge of the day to day running of the Urology Unit was the Head of Service (Martina Corrigan, now Wendy Clayton) who reported to the Assistant Director and the Director of Acute Services.

b) Clinically/ Professionally:

i. The professional medical lines of management were from consultant up to Clinical Director (Mr Colin Weir), up to Associate Medical Director (Mr Mark Haynes), and up to Medical Director.

ii. The clinical line management was from Clinical Director (Mr Colin Weir) to Associate Medical Director (Mr Mark Hynes), who reported to the Director of Acute Services (Mrs Esther Gishkori and Mrs Anita Carroll) and Medical Director.

iii. During my role as acting Medical Director, my line manager was the Chief Executive, Mr Shane Devlin.

26. What, if any role did you have in staff performance reviews?

26.1 From 2011- 2013, I was Clinical Director in Community Paediatric service therefore I was responsible for medical staff performance in that team only. **CD JD already attached**

above *and can be located at S21 No 28 of 2022 Attachments, 2. CD CYP Community Paeds JD*

26.2 From 2013 - 2018, I was Associate Medical Director of the Children & Young People's Directorate (CYP). During that period, I was responsible for medical staff performance in that directorate only.

26.3 AMD JD *can be located at Relevant to HR/ 20180300-REF 15- Dr A Khan – Acting Medical Director Job Description*. **CYP Directorate structure in 2013-2018 attached and** *can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

26.4 From April 2018 - December 2018, I was Acting Medical Director. During this period, I was responsible for staff performance within the Medical Directorate. However, there were no medical staff in that Directorate at that time.

26.5 As Acting Medical Director I had corporate professional Governance responsibility for all medical staff, once it had been escalated through the medical line management structure, i.e., through Clinical Director to Associate Medical Director to Medical Director.

26.6 Trust Guidelines for handling concerns about doctors' and dentists' performance from 2010 (replaced in late 2017 / early 2018 with revised Guidelines), provided guidance as per the principle of MHPS Framework

26.7 As per this policy issues of concerns about the doctors' and dentists' conduct, health and/or clinical performance were managed with specific role and responsibilities of clinical and operational managers. All medical staff conduct, health and /or clinical performance related matters were initially raised with the relevant Clinical Manager. The Clinical Manager and HR case manager undertake preliminary enquiries to identify the nature of concerns and perform an assessment of the seriousness of the issue. If indicated, they notify the medical staff performance oversight committee for their assessment and decision.

26.8 The medical staff performance oversight committee was comprised of the Medical Director (or nominated person from the Medical Director's office), the Director of Human Resources (Ms Vivienne Toal) or a nominated person from the HR team, and the relevant Director of Service. I was part of this committee during my tenure as Acting Medical Director from April to Dec 2018.

26.9 As Acting Medical Director, I was also responsible for medical staff education, Continuous Professional Development (CPD), appraisal & revalidation as mentioned in detail in question 7.

Evidence:

a. **Medical Directorate in 2018 structure attached** and *can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*
b. **Trust guidelines for handling concerns about Doctor and dentists' performance- September 2010** *can be located at S21 No 28 of 2022 Attachments, 9. 20100915 Guidelines for Handling Concerns about Doctors*

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

27.1 Yes; I was subject to annual performance appraisal and performance review. I had regular supervision meetings with my line manager, the Chief Executive, Mr Shane Devlin.
As part of this process, Medical Director's Directorate performance matrix / score card was developed as per the responsibilities of Medical Director and his team.

27.2 The performance matrix / score card was a live document which was updated throughout my tenure. This performance matrix / score card became the basis of regular performance review during 1:1 supervision meetings with Shane Devlin throughout my tenure.

Evidence: Combined Accountability Scorecard. final signed off version (Signed off- 28/06/18) *can be located at S21 No 28 of 2022 Attachments, 10. Combined Accountability Scorecard final signed off version*

<u>Engagement with unit staff</u>

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week

to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

28.1 As Acting Medical Director, I started a process of staff engagement with medical staff throughout the Trust. This included:

a. Attendance in regular medical staff meetings where large numbers of medical staff from various specialties used to attend, from trainees to senior consultants. I used to attend to engage in medical staff discussion regarding topics of interest. This was also an important opportunity for me, as medical director, to inform and update medical staff regarding current challenges and upcoming issues.

b. I also started The Clinical Director's Forum, where all CDs were invited to meet with the Medical Director and discuss issues of their respective areas / interests. I, as Medical Director, used to Chair this Forum. The agenda items, discussion points and the meeting dates were set in advance to allow maximum attendance.

c. The monthly Associate Medical Director (AMD) Forum was streamlined to have more proactive discussion for current issues and future strategic planning. The agenda and dates were set in advance with sufficient time to allow discussion for important topics.

d. A new M&M Chairs forum was established where I, as acting medical director used to meet with M&M Chairs. This forum was also to build peer to peer support and learning among the M&M Chairs.

e. I also attended most of M&M meetings across the Trust services. I used to attend a number of these monthly. I shared my reflection with M&M Chairs after my initial attendance of M&M meetings. See attached **Acting Medical Director's Walk-around M&Ms, 16 April 2018 which** *can be located at S21 No 28 of 2022 Attachments, 11. Dr Khan MM Walkaround 17 Apr 2018*

28.2 To best of my recollection, as acting medical director, I had no direct engagement / meetings with the urology staff. However, they may have attended as part of General or M&M meetings with wider medical staff groups.

Evidence:

- **Medical Director M&M senor leadership walk around summary,** *can be located at S21 No 28 of 2022 Attachments, 11. Dr Khan MM Walkaround 17 Apr 2018*
- **CD Forum details- 2018** *can be located at S21 No 28 of 2022 Attachments, 12. Clinical Director meeting 24th August 2018 – action notes*
- **CD meetings minutes – 2018** *can be located at S21 No 28 of 2022 Attachments, 12. Clinical Director meeting 24th August 2018 – action notes*
- **AMD meeting details- 2018** *can be located at S21 No 28 of 2022 Attachments, 13. AMD meeting Schedule without Medical Forum REVISED*
- **20180410 AMD Minutes.pdf** *can be located at S21 No 28 of 2022 Attachments, 14. 20180410 AMD Minutes*
-

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

29.1 I had no direct engagement with the urology service or its staff.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

30.1 During my tenure as Acting Medical Director, I wasn't aware of any conflict or poor working relationships among medical and professional managers in the Acute Directorate nor was I informed of any such issues.

30.2 A more detailed answer on this might be best provided by Director of the Acute Directorate, Mrs Esther Gishkori (and/or Mrs Anita Carroll for the period between April and December 2018).

Governance – generally:

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

31.1 As acting medical director (between April- Dec 2018), I had Corporate professional governance responsibility for the medical staff's professional medical standards. The professional medical lines of management were from consultant up to clinical director up to Associate Medical Director up to Medical Director.

31.2 As the designated Responsible Officer for the Trust to GMC, I was responsible for:-

a. The effectiveness of medical appraisal of the medical workforce, for quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.
b. The provision of expert advice and assurance to the organisation in relation to the Trust's processes for addressing concerns about a medical practitioner's fitness to practice (as set out in the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance).

31.3 I was responsible for working with other Directors to inform, support and provide assurance on the systems for the effective identification and management of clinical governance concerns, & ensuring that any learning was incorporated into professional practice and systems.

31.4 I had no direct staff management role for medical staff in the Urology Unit in the Acute Directorate unless there was a serious conduct and/or clinical performance concern raised. In that case, trust policy for dealing with a doctor's performance was initiated by the Clinical Director or AMD. This was then monitored by the performance monitoring oversight committee, of which I was a member along with the Director of HR and relevant Director (e.g., in the case of Urology, the Director of Acute Services).

31.5 If there was a serious adverse incident (SAI) in any service across the Trust then it had to be reported to Corporate Governance team as per the SAI Policy. The outcome of these SAI investigations was reviewed by the Medical Director's Office team, usually through the Assistant Director of Clinical Governance & Social Care.

31.6 Another way of alerting the Medical Director was through the appraisal system if there was any significant finding from review of appraisal by the Appraisal/ revalidation team.

31.7 The M&M meetings were well established across all teams. As indicated above, I used to attend a number of monthly M&M meetings across the Trust.

31.8 As also stated above, during my tenure we established a new forum called the M&M Chairs Forum, where I as acting Medical Director used to meet with M&M Chairs. This forum was also to build peer-to-peer support & shared learning among the M&M Chairs. For me as the Medical Director, it was vital meetings to know about current patient safety challenges, what measures has been implemented to mitigate the safety risks at the clinical teams level & how this learning has been disseminating among the staff.

31.9 A new Lessons Learned Forum was established during my tenure to encourage & spread the learning from complaints, clinical incidents and serious adverse incidents (SAIs) across all clinical team in all directorates and services across the Trust. The membership of this forum was the AMDs, CDs, M&M Chairs, SAI chairs, clinical governance leads, governance coordinators and a nominated non-executive Director from the Trust Board.

Evidences:

- **Clinical incident management policy** *can be located at S21 No 28 of 2022 Attachments, 15. 20141106_WorkingDraft_ SHSCTIncidentMgmtProcedure_CGO_Nov2014*
- **SAI management policy** *can be located at S21 No 28 of 2022 Attachments, 16. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1.Nov 2016*
- **Appraisal policy** *Relevant document can be located at S21 No 28 of 2022 Attachments, Relevant to MDO/ reference no 2t/ 20140701 Policy – Southern Trust Appraisal Scheme for Medical Staff*
- **M&M chairs forum minutes** *Relevant document can be located at Ongoing Discovery March 2022 / MDO/ No 75 M and M Files/ M and M Charis meetings/ MM Chair Meeting Minutes/ 20180924_MM Chairs Minutes*
- **Lessons Learned forum paper to Governance committee** *can be located at S21 No 28 of 2022 Attachments*, 17. Lessons Learned forum – Update to Gov Committee
- **Lessons Learned forum minutes** *be located at S21 No 28 of 2022 Attachments, 18. 20181206 Approved Governance Committee Minutes 06.12.28*

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

32.1 The Director of the Acute Services Directorate oversaw the clinical governance of Urology services. This Director provided an assurance report through the Acute Directorate clinical governance team.

32.2 The following systems and process were providing assurance to me:

a. Clinical incidents were managed as per the policy of management of clinical incidents which provides guidance for risk assessment and risk management.
b. If there was a Serious Adverse Incident (SAI) in any service then it was managed as per the trust SAI management policy & reported to the Corporate Clinical Governance team. If the outcome of SAI investigations indicated medical staff performance or clinical competency issues then it was to be highlighted through medical professional line management i.e. Clinical Director and/or Associate Medical Director to Medical Director.
c. If any serious conduct and/or clinical performance concern arose / was raised as a result (or led to) a clinical incident then the Trust policy for dealing with a doctor's performance (the 2010 Guidelines) was initiated by the Clinical Director or Associate Medical Director. As per this policy, escalation to the medical staff performance monitoring oversight committee could lead to involvement of the Medical Director along with the Director of HR and relevant Director of Services.
d. The appraisal system was another way of alert to the Medical Director as, if there was any significant finding from review of appraisals by the Appraisal/Revalidation team, then this would be escalated to the Medical Director.
e. M&M meetings were well established across all teams. These meetings were discussing Mortality & Morbidity in their teams. I attended M&M meetings across the Trust.
f. A new M&M Chairs Forum was established to build peer to peer support and learning among the M&M chairs. As acting Medical Director, I met with M&M chairs. It was an important forum for me to know current safety standards and challenges, and what measures were being implemented to mitigate safety risks. **M&M chairs forum minutes- 2018** *Relevant document can be located at, Ongoing Discovery March 2022 / MDO/ No 75 M and M Files/ M and M Charis meetings/ MM Chair Meeting Minutes/ 20180924_MM Chairs Minutes*

g. A newly established Lessons Learned Forum was also providing assurance. This forum was established to encourage and spread learnings from the complaints, clinical incidents, and serious adverse incidents across all Trust. Lessons Learned Forum paper presented to the Governance committee. *Relevant document can be located at S21 No 28 of 2022 Attachments, 17. Lessons Learned forum – Update to Gov Committee*

h. If Job planning processes highlighted any concerns/ potential concerns then this was escalated to the Medical Director.

i. A complaints management process was also in place. **See attached Policy for the Management of Complaints Version: 2- July 2018** *which can be located at S21 No 28 of 2022 Attachments, 19. 2018 Policy for the Management of Complaints*

j. There was a Risk Register management process in each directorate and at corporate level and escalation of a risk from directorate governance team to corporate governance team could occur where appropriate.

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

33.1 I wasn't directly overseeing and managing the quality of services in the urology unit. However, as Acting Medical Director I was indirectly involved in this through the clinical / medical line management structure i.e., through the Clinical Director (Mr Colin Weir) and Associate Medical Director (Mr Mark Haynes).

33.2 The Director of Acute Services provided assurance of the quality of services through the clinical governance team to the corporate clinical governance team.

33.3 All AMDs provided assurance reports in the monthly AMD meeting. The agenda and dates were set in advance with sufficient time to allow discussion for important topics.

33.4 I also started the Clinical Directors' Forum, where all CDs were invited to meet with the Medical Director and discuss issues in their respected areas/ interests. I, as Medical Director, used to Chair this Forum. There were set agenda items and discussion points. The meeting dates were set in advance to allow maximum attendance.

33.5 As Acting Medical Director I was providing assurance to the Trust Board for the Trust. These assurance reports were based on information provided by the operational directorate governance teams to the corporate Clinical Governance team.

33.6 In the specific case of Mr O'Brien's return to work in February 2017, an action plan and monitoring arrangement were in place with regular assurance reports from Assistant Director (Mr Ronan Carroll) to me as MHPS Case Manager. In this specific case I therefore also had some involvement in ensuring the quality of service provided by one consultant.

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

34.1 I wasn't responsible for performance metrics in urology services. It was the Director of Acute Services (Mrs Esther Gishkori) and Director of Performance, (Mrs Aldrina Magwood) who oversaw this.

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

35.1 As Acting Medical Director, I was assured on the basis of the process and systems as explained in my answer to Question 32.

35.2 In addition, during my tenure as Acting Medical Director, there were number of Clinical Governance policies and strategies reviewed and updated to improve assurance process. For example:

a. **Policy of management of Complaints** - July 2018: This updated policy enables service users to raise any concerns they may have at an early stage and in the right way. Complaints management process was providing assurance. **See attached Policy for the Management of Complaints Version:2- July 2018** *which can be located at S21 No 28 of 2022 Attachments, 19. 2018 Policy for the Management of Complaints*

b. **Clinical Audit Strategy** - June 2018: This strategy outlines the arrangements for defining, prioritising, approving, supporting, monitoring and reporting on the Trust's annual national, regional, and local clinical audit work programme. The strategy also

strengthens the assurance processes. **Clinical Audit Strategy- June 2018 attached** *and can be located at S21 No 28 of 2022 Attachments, 20. '3b. Clinical audit Strategy V3 June 2018*

c. **Health Care Acquired Infection** / Infection Prevention Control Strategy – December 2018: This 3 years strategy was co-produced with staff and service users. The aim was to deliver the highest safety standards for patients, visitors, and staff. This is also explained in Q 46.8. **HCAI strategy 2018 attached** *and can be located at S21 No 28 of 2022, 21. IPC Strategy 2018-21 TB Paper 27.9.18 FINAL*

d. **Medical Leadership review & development paper**: This is explained in Q 46.8 **Medical Leadership Review 2018 Draft-V11-September 2018 attached** *and can be located at S21 No 28 of 2022 Attachments, 22.* Medical Leadership Review 2018 Draft-V11-September 10

35.3 The Clinical Governance report from Assistant Director for Clinical Governance and Social Care (CGSC) also went to the Governance Committee on a quarterly basis. **See attached CSCG reports, May18** *located at S21 No 28 of 2022 Attachments, 23. 20180511 Final Governance Report May 2018 FINAL 3***, Sept18** *can be located at S21 No 28 of 2022 Attachments, 24. 20180906 Final Governance Paper*, **Dec18** *can be located at S21 No 28 of 2022 Attachments, 25. 20181206 Clinical and Social Care Governance Report December 2018 FINAL after SMT*

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

36.1 Issues of concern could be brought to my attention in a number of ways during my tenure as Acting Medical Director:

a. Any issue of concerns could be brought to my attention through the Medical management line, i.e., through CD & AMD.
b. Director to director escalation of any potential significant clinical incident / performance related issue regarding medical staff.

c. Serious Adverse incident (SAI) notification to my office was another method (an SAI investigation was ongoing regarding Mr O'Brien).
d. Complaints were managed as per the Trust complaints policy. Recording and escalation were providing assurance for external concerns.
e. A whistleblowing policy was introduced and managed. Escalation as per Trust policy was providing assurance from internal concerns.
f. A Risk Register management process was in place at all levels including at Urology team, Corporate level. Risks were managed according to the Trust risk management policy. They were escalated or deescalated after regular Risk Assessment process.
g. Through performance related issues, i.e., MHPS and the related Trust Guidelines.

36.2 As for systems and processes, all medical staff conduct, health and /or clinical performance related matters would be initially be raised with the relevant clinical manager. The clinical manager and HR case manager would undertake preliminary enquiries to identify the nature of the concerns and assess the seriousness of the issue. If appropriate, they would notify the Medical staff performance oversight committee/ group for their assessment and decision. The Medical staff performance oversight committee was comprised of the Medical Director (or nominated person from the Medical Director's office), the Director of Human Resources (Ms Vivienne Toal) or a nominated person from the HR team, and Director of the relevant service. I was part of this committee during my tenure as acting medical director from April to December 2018.

36.3 In terms of the efficacy of those systems and process during my tenure as Acting Medical Director, I was provided with assurance from the relevant responsible professionals as described above (i.e., in this Question and Questions 33 and 35). Therefore, I believed the systems and processes were performing as expected.

37. Did those systems or processes change over time? If so, how, by whom and why?

37.1 During my tenure as Acting Medical Director (April - December 2018) they didn't change to the best of my knowledge.

38. How did you ensure that you were appraised of any concerns generally within the unit?

38.1 I relied on the various methods, processes, and systems set out in my responses to Questions 35 and 36 above.

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

39.1 Governance, including professional and clinical governance, in the Acute Directorate was managed within the Directorate's operational and clinical management teams. The Acute Director then provided assurance to the SMT.

39.2 After commencing my role as Acting Medical Director in April 2018, I had 1:1 meetings with the 2 Assistant Directors in the Medical Directorate; Ms Margaret Marshall and Mr Simon Gibson. Those discussions and updates from Mrs Margaret Marshall, Assistant Director for Clinical Governance and Social Care (CGSC), highlighted a perception at the Corporate Clinical Governance team that some clinical Governance related systems/process of SAI, Standards & guidelines, complaints & clinical Audits may not be robust in operational directorates resulting with possibly delay in disseminate system-wide learning across the Trust. I wasn't provided any specific examples (although Mrs Margaret Marshall might be able to provide further information).

39.3 Therefore, after discussion with the Chief Executive, I started an informal exercise to review the current governance arrangements in the Trust Operational Directorates including Acute Directorate, Children & Young People Directorate, Mental Health & Learning Disability Directorate, and Older People & Primary Care Directorate in May 2018. The exercise can be summarised as follows:

a. We started gathering information regarding clinical Governance arrangements / systems in place both at directorate level.
b. This exercise was specifically reviewing systems and processes for four elements of clinical governance;

    i. Serious Adverse Incident investigations;
    ii. Standards & guidelines compliance;
    iii. Complaints;

iv. Clinical Audit.

c. This exercise started with information gathering from all operational Directorates on a template under four headings: Strength, Weakness, Opportunity & Threat ('SWOT').

d. The initial information gathering was completed in July 2018.

e. The information received was then analysed on the SWOT template, which highlighted the strengths, weakness, opportunity & threat in each directorate clinical governance process/ system.
Evidence: SWOT analysis attached and *can be located at S21 No 28 of 2022 Attachments, 26. Directorate SWOT Analysis*

f. For Acute Directorate, the summary of main findings of this work as below:
   i. **Serious Adverse Incident investigations**: Acute Services have a robust system for screening of incident reports to determine whether an SEA/SAI is required but struggles with resource to complete activities in a timely manner. The process for final release of Acute SAI reports is well developed.
   Medical staff job plans don't have protected time for governance activity and time to chair or participate in SAI panels – this leads to long delays in getting investigations started and then completed. There is no protected time to follow up actions and learning following an SAI report, to ensure that learning is embedded and actioned consistently. Some cross Directorate SAIs would benefit from a 'corporate' approach and chairs often do each part in a 'silo'- which affects the continuity and standard of the resulting report.

   ii. **Standards & guidelines compliance**: The Acute team has good systems and processes in place to manage standards and guidelines. Acute receives the majority of S&G within the Trust, therefore resource remains an issue.
   Medical staff job plans do not allow time to take on the role of Change Leads for S&Gs. This has resulted in being unable to secure Change Leads for a number of new S&Gs. Some S&Gs that are applicable to more than one operational Directorate would benefit from a 'corporate' approach and appointment of a corporate Change Lead. Lack of audit activity to ensure S&Gs are embedded is also a challenge. Suggestion to strengthen the

Corporate database for S&G so it becomes a useful resource for all the Directorates.

iii. **Complaints:** Good systems in place to track and manage the complaints received by Acute. Governance resource to assist clinicians and ward managers in responding to and managing complaints received is a challenge. It can lead to a delay as a result of unavailability of clinician time to respond to complaints. A consistent Trust training in complaint management is needed. To implement the DATIX complaints management section of the system in Acute Directorate

iv. **Clinical Audit:** Apart from major national audits, results of other audits are often not shared. This could result in identified risks being hidden to management teams, however, there are pockets of good audit practice within clinical teams. There is no link between audits undertaken and the risks identified through SAIs and complaints**.** Un-Availability of resources is a threat. An Acute audit facilitator would allow collation of audit results and monitoring of implementation of associated action plans. A stronger link between audit and Quality Improvement teams within the Trust would allow for issues identified by audit to become QI projects of the future.

g. This SWOT analysis paper was presented to the Chief Executive in my 1:1 Meeting in August 2018.

h. Further face to face meeting with operational directorate governance leads and all director/ representatives occurred in October 2018 for feedback.

39.4 More detail on this governance review can be found in my answer to Question 46 below.

39.5 The actions taken by the Medical Directorate after this exercise through corporate governance team included the following:

a. Shared the findings of SWOT analysis with Chief Executive (Mr Shane Devlin).
b. Shared findings and feedback with operational directorate governance leads and all director/ representatives. The face to face meeting occurred in Oct 2018.
c. Incident Dashboards system for DATIX was provided to Acute Directorate clinical governance team to monitor and review clinical incidents in a timely manner.

d. SAI chairs training program commenced with first training organized during 2018;
e. Lessons Learned Forum was established after consultation with SMT & Governance committee.
f. Job Planning (JP) review paper produced with proposed changes in JP process.
g. M&M Chairs' Forum established.
h. Medical Director attendance in M&M meetings (senior safety rounds).
i. Medical Leadership review paper suggested 2 dedicated deputy Medical Directors - one with responsibilities for patient safety and quality and the other with responsibilities for medical workforce development and staff performance at corporate level within the Medical Director's office. This paper also proposed dedicated time in M&M Chairs' job plans.

Evidences:

- **See email of agenda of my 1:1 August meeting with Chief Executive** which *can be located at S21 No 28 of 2022 Attachments, 27. RE Re; 11 meeting discussions points*
- **See evidence SWOT analysis exercise July 2018** which *can be located at S21 No 28 of 2022 Attachments, 26. Directorate SWOT Analysis*
- **Governance review paper,** *Relevant documents can be located at S21 No 28 of 2022 Attachments, 28. 20180511 Final Governance Report May 2018 FINAL 3, 29. Final Governance Paper – August 2018 and 30. Clinical and Social Care Governance Report December 2018*

40. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

40.1 I understand the risks in the Urology unit were assessed Trust Risk Management policy and procedures. I wasn't involved in this process in the Acute Directorate, however, I was made aware of this process by the Director of Acute Services (Mrs Esther Giskhori). See an example of Acute Directorate Governance Action notes from Oct 2018. *Relevant document can be located at Relevant to Acute/ Document Number 2 L/ Acute Directorate Director's Office/ 2018/ Acute Governance Meetings/ 20181002 Acute Directorate Governance Action notes*

Evidence: 20181002 Acute Directorate Governance Action notes *Relevant document can be located at Relevant to Acute/ Document Number 2 L/ Acute Directorate Director's*

Office/ 2018/ Acute Governance Meetings/ 20181002 Acute Directorate Governance Action notes

40.2 At the Medical Director's office, a Risk Assessment was completed by Mrs Margaret Marshall (Assistant Director for Clinical Governance and Social Care) in April 2018 under the heading of To Improve Processes to Identify, Act on, and Disseminate Learning Across the Trust.

40.3 Subsequent to this risk assessment, the SWOT analysis started as described in detail Question 39.

Evidence:

- ***Medical director risk Assessment form*** *can be located at S21 No 28 of 2022 Attachments, 31. Risk Assessment_Governance 201017* ***& Corporate Risk register- 2018*** *can be located at S21 No 28 of 2022 Attachments, 7. 20180906 – CRR*

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

41.1 Collecting & monitoring of patient data in the unit was managed & monitored by operational team in the Directorate, including Head of Service, Assistant Director, and Director of Service, as per Trust operational policies including the Integrated Elective Access Protocol.

Evidence: Integrated Elective Access Protocol Executive Summary April 2008. Attached *Relevant document can be located at Relevant to Acute/ Document Number 6/ 20080430 No.6 Integrated Elective Access Protocol*

41.2 I am aware that clinical incidents were recorded on the trust DATIX system as per the trust guidelines.

41.3 The Clinical Audit Strategy outlines the arrangements for defining, prioritising, approving, supporting, monitoring and reporting on the Trust's annual national, regional, and local clinical audit work programme. Collection of patient data was done as part of any Audits in the unit.

41.4 The Directors of Acute Services, Mrs Esther Gishkori & Mrs Anita Carroll for the period between April and December 2018, would be able to provide this information.

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

42.1 I believe Acute Directorate was managing and monitoring the efficacy of operational systems and process. During my tenure as Acting Medical Director, I had little knowledge of the efficacy of these. I do not know if they changed. The persons mentioned at paragraph 41.3 above would be better placed to address this.

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

43.1 As part of Job Planning, all medical staff have set targets, i.e., number of clinics per year and/or theatre sessions per year and/or participation in on-call or consultant of the week rota, and so on. These performance targets are monitored by line management within the Division and by Clinical Directors and/or by AMDs in Directorate.

43.2 The operational team have monitoring responsibilities as to early identification and escalation if medical staff are deviating significantly from their monthly / annual targets.

43.3 During my tenure as Acting Medical Director, I wasn't managing performance objectives of any specific team (including the urology team) as it was a Divisional Clinical Director & Operational Head of Service responsibility. At the Directorate level, the Associate Medical Director and Director of Service were managing the performance objectives. I was, however, responsible for the performance of the Medical Director's Office team. I was line manger of two of the Assistant Directors (Mr Simon Gibson & Mrs Margaret Marshall) there.

43.4 In the circumstances, others (i.e., the relevant Clinical Director, Head of Service, Assistant Director, Associate Medical Director, and Director of Acute Services) might be better able to provide information regarding how well the performance objectives were set. However, my views on it are set out in my answer to the next question (Question 44).

43.5 All medical staff have also to go through an annual appraisal process, which includes:

a. Updated training passport & continuous professional development (CPD) information for the previous year.

b. Personal development Plan (PDP) for previous year is reviewed & PDP for next year is planned at every Appraisal.

c. Yearly clinical activity report supplied by the trust.

d. Consultant level information & performance (CLIP') report (the CLIP report provides comparative information with local consultants and regional colleagues);

43.6 In addition, all medical staff have to complete a separate 360-degree feedback from colleague and patients once every five years as part of General Medical Council revalidation requirements.

43.7 My opinion on the appraisal process is set out in my response to the next question (Question 44).

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

44.1 I think that, generally, the medical staff appraisal process worked well. It is mandated by the General Medical Council. It is a structured and standardized approach for all medical staff and the vast majority of medical staff have been engaged in this process. The Trust appraisal and revalidation team is supportive in guiding medical staff through for appraisal and revalidation. Over the last few years, a regionally developed appraisal process has been developed with a shift to an online system. This has eliminated the need to hold hard copies of appraisal folders. It has also helped getting annual appraisal completed online remotely. The Medical Directorate is mainly responsible for the appraisal process in the Trust. In the circumstances, I provided an assurance report to the Trust Board regarding Appraisal and Revalidation on 30th August 2018. **Attached** *Relevant document can be located at S21 No 28 of 2022 Attachments, 5. item11ii. Medical Appraisal and Revalidation Annual Report 2017-2018 Final*

44.2 On the other hand, the job planning process was cumbersome and complex with lots of steps. These have to be completed even if nothing is changed in the Job Plan for the following year with multiple signoff requirements. Medical staff were, in my experience, engaged but a lot of them complain about complex and unnecessary steps for annual Job

Planning process. Both Human Resource department and the Medical Director's office were responsible for job planning process.

44.3 During my tenure as Acting Medical Director, on the advice of the Chief Executive, Mr Devlin, my office started a project to review the current job planning process by engaging with staff to gain insight and propose improvements in the process. This project was led by Dr Richard Wright during the summer of 2018. Dr Richard Wright would be able to provide more information regarding this project but my understanding is that a paper was summited to Chief Executive in July 2018. In summary, its recommendations were:

a. The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal.
b. The Trust should continue to offer further training for the online Appraisal Portal;
c. Further simplification of the sign off and notification process should be implemented.
d. The Directorates should implement a systematic, timely prospective process;
e. A Medical Job Plan Consistency Committee should be established reporting to the job planning lead.
f. Move to a position where each new consultant receives 2.5 SPA and 1.5 SPA for SAS doctors at the time of appointment.
g. The Trust should offer the opportunity to every doctor to work 1 flexible SPA off site.
h. The Trust should facilitate senior doctors to come off the on call rota if requested.
i. A clinical job planning lead should be appointed for monitoring job planning status.
j. A Job planning strategic oversight committee should be established set strategic direction and review progress, receiving reports from the job planning lead and reporting to SMT.

Evidence:

- **JP paper (one direction) – attached** *and can be located at S21 No 28 of 2022 Attachments, 6. Job PLANNING – ONE DIRECTION Version 3*
- **Appraisal policy attached.** *Relevant document can be located at Relevant to MDO/ Reference no 2t/ 20140701 Policy – Southern Trust Appraisal Scheme for Medical Staff*

- **Appraisal and Job Plan report to Trust Board** *can be located at S21 No 28 of 2022 Attachments, 5. Item 11ii, Medical Appraisal & Revalidation Annual Report 2017-2018 final*

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1 There were a number of different processes relevant to this issue. They were as follows.

45.2 Any concerns about a doctor's performance were managed according to the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance of 23 September 2010. **Attached here** and *can be located at S21 No 28 of 2022 Attachments, 9. 20100915 Guidelines for Handling Concerns about Doctors.* This provided guidance as per the principles of the MHPS Framework. As per this policy, issues of concerns could include conduct, health and/or clinical performance. The Guidelines set out how these were to be managed, with specific roles and responsibilities being given to different managers.

45.3 The Southern Health and Social Care Trust Incident Management Procedure of October 2014 was also relevant. The purpose of the Procedure is to guide all employees of the Trust in the following:

a. Identification, reporting, review, monitoring and learning from all incidents which have resulted in, or had the potential to result in, injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure;
b. Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimise exposure to associated risks;

c. Enable staff to participate in and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice

45.4 Risk Registers could also be used in response to governance concerns with potential impact on patient safety. There was a Risk Register in each directorate recording clinical risks. There was, for example, an Acute Directorate Risk Register recording risk pertaining to the Acute Directorate. There was also a Corporate Risk Register, recording corporate risks.

Evidences:

- **Southern Health and Social Care Trust Incident Management Procedure, Oct 2014 attached** and *can be located at S21 No 28 of 2022 Attachments, 16. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1.Nov 2016*
- **Medical directorate structure chart attached** *and can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*
- **Corporate Risk Register -2018** *Relevant document can be located at S21 No 28 of 2022 Attachments, 7. 20180906 CRR*
- **Governance structure/ team in Acute directorate and corporate Governance.**
- **Clinical Incident guidance documents** *can be located at S21 No 28 of 2022 Attachments, 32. 20180810 Acute Clinical Governance Action notes, 33. 20181110 Acute Clinical Governance Action notes, 34. 20180907 Acute Clinical Governance Action notes*
- **SAI guidance document** *can be located at S21 No 28 of 2022 Attachments, 16. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1.Nov 2016*
- **MHPS Framework guidance document** *can be located at S21 No 28 of 2022 Attachments, 35. MHPS guidelines*

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

46.1 I was appointed as Acting Medical Director from 1st April 2018 until December 2018. The previous Medical Director (Dr Richard Wright) had been off [redacted] for some time. At commencement as Acting Medical Director, I therefore had no formal handover.

Evidence: See Medical director office structure during 2018 *can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

46.2 Most of the outstanding issues/ matters brought to my attention by Medical Director's Office staff, by Assistant Director Mr Simon Gibson, were matters on which Dr Wright had been working prior to Personal Information redacted by USI leave. There was no deputy medical director post (indeed, Deputy Medical Directors were not appointed until 2020). There was a significant amount of outstanding work that was on hold due to Dr Wright's Personal Information redacted by USI unexpected leave. Some of these matters were on the Medical Director's desk to progress urgently.

46.3 I had no formal induction to the Medical Director Job for another couple of months.

46.4 The corporate governance lead, Ms Margaret Marshall was also leaving the medical directorate in few months.

46.5 In the circumstances, I felt overwhelmed and not adequately supported when I began in this role

46.6 Once I familiarised myself with my own responsibilities and staff within the Medical Directorate, and after careful consideration of all my responsibilities and current challenges, I decided to set my **3 key priorities** for the 1st year. I then discussed these with my line manager, Mr Shane Devlin. They were as follows:

a. Review to Improve Corporate Clinical Governance & Social Care arrangements in the Trust (mentioned already at Questions 8 and 39).
b. Review current Medical leadership structure and to propose improved medical leadership structure with specific roles and responsibilities, including roles in patient safety, Quality and staff management & performance. **Medical Leadership paper attached here.** *Relevant document can be located at S21 No 28 of 2022 Attachments, 22. Medical Leadership Review 2018 Draft-V11- September 10*
c. Healthcare Acquired Infection (HCAI) / Infection prevention & Control (IPC) improvements.

46.7 The details of action taken under each of the priority as below:

(1) Review of Corporate Social & Clinical Governance: In order to understand & propose improvement changes at corporate level and at directorate level:

a. We planned this informal review by starting information gathering and reviewing governance arrangements with in each of the operational

directorates. The detail of this review has been set out in response to Question 39 above.

(2) Medical leadership Review: I was aware of the importance of strong medical leadership in improving patient care and safety. Therefore within the Medical Directorate we started an exercise to gather feedback from current Trust senior leaders including AMDs, CDs, and service Directors.

a. The Feedback report indicated a lack of focus in developing medical leadership in the Trust.
b. Therefore, a Medical Leadership Development Paper was developed and shared at SMT meetings. This paper proposed a revised medical leadership structure. Apart from other proposed changes it suggested 2 dedicated Deputy Medical Directors, one with responsibilities of patient safety and quality and the other with responsibilities for medical workforce development and staff performance at corporate level within the Medical Director's office. This paper also proposed dedicated time in M&M chairs' job plans.
c. It was presented to SMT meeting in September 2018. I handed over to the new Medical Director (Dr Maria O'Kane) after her appointment to progress. **Medical leadership paper attached** *and can be located at S21 No 28 of 2022 Attachments, 22. Medical Leadership Review 2018 Draft-V11- September 10*

(3) Health Care Acquired Infection / Infection prevention control (IPC): Healthcare Acquired Infection / Infection prevention control (HCAI/IPC) was another priority as the Trust was facing challenges in this regard. I led a small working group to engage with staff and draft an IPC strategy. The IPC Strategy was presented at SMT and Trust Board before I completed my tenure in December 2018.

Evidences:

- **IPC Strategy attached** and *can be located at S21 No 28 of 2022 Attachments, 21. IPC Strategy 2018-21 TB Paper 27.9.18 final*
- **Medical directorate structure** *can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you liaised with, involved, and had meetings with the following staff (please name the individual/s who held each role during your tenure):

(i) The Chief Executive(s);

(ii) the Director(s) of Acute Services;

(iii) the Assistant Director(s);

(iv) the Clinical Director

(v) the Associate Medical Director;

(vi) the Head of Service;

(vii) the Clinical Lead;

(viii) the consultant urologists.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

(i) Chief Executive(s)

47.1 I had no meetings with the previous Chief Executives (Mr Rice and Mr McNally). However, I had regular meetings with the new Chief Executive (Mr Shane Devlin) as acting Medical Director. I informed Chief Executive (CE) regarding the progress update of Mr O'Brien's MHPS investigations.

47.2 Then, as part of MHPS case manager determination process, I discussed my draft recommendations and sought advices from the Chief Executive (CE).

47.3 After the MHPS report was ready I shared this with the Chief Executive.

Evidences:

- **CE Meeting agenda email attached** *and can be located at S21 No 28 of 2022 Attachments, 27. RE RE; 11 meeting discussions points*
- **Email to CE with MHPS report attached** *Relevant document can be located at S21 No 28 of 2022 Attachments, 20180928 Email FW Case Manager Determination AO'B FINAL*

(ii) Director(s) of Acute Services

47.4 Acting Medical Director in April 2018, there were no set meeting dates with the Director of Acute Services or Assistant Director, HOS, Clinical Lead, and consultants.

47.5 Therefore I requested to set up regular 1:1 meetings with the Director of Acute Services. This meeting was started in May 2018 with informal discussions. In these meetings I discussed governance related issues in Acute Directorate. We also discussed Return to Work Action Plan monitoring arrangements in the Urology services (re Mr O'Brien).

47.6 I had number of 1:1 meetings with Director of Acute services.

(iii) Assistant Director(s)

47.7 I had regular 1:1 meetings with 2 Assistant Directors in the Medical Director's office, Mr Simon Gibson & Mrs Margaret Marshall. These meetings were around the responsibilities of each Assistant Director. My discussions related to medical staff and professional governance was discussed with Mr Simon Gibson. I had several meetings with him in relation to Urology services professional governance and for specific MHPS investigation issues related to Mr O'Brien.

See attached Medical director office structure in 2018. *Relevant document can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

(iv) Clinical Director

47.8 When I started as Medical Director, there were no set meetings with the Clinical Director with no specific forum to discuss matters or issues of concern with the Clinical Director. Therefore, I established a new Clinical Directors' Forum which was chaired by myself. This was a useful forum to engage and interact with all the CDs and lead clinicians.

Evidence:

- **CD forum meeting details,** located at S21 28 of 2022, Attachments 12. *Clinical Director meeting 24th August 2018 – action notes*

47.9 I discussed specific Urology governance with the Associate Medical Director (Mr Mark Haynes).

47.10 All AMDs provided governance reports in AMD forum meetings including the AMD for Urology, Mr Mark Haynes.

(vi) Head of Service

47.11 I had no direct contact with Head of Service in the urology unit.

47.12 I had number of Lead of Services in the Medical Directorate office including Project Lead, Appraisal Lead, Audit lead, and Research & Development Lead. I had regular meetings and communication with them but it was regarding their roles and responsibilities across the Trust and not specifically about the urology unit.

Evidence: See medical director's office structure. *Relevant document can be located at S21 No 28 of 2022 Attachments, 3. Medical Directors ORG CHART – April 2018 updated*

(vii) Clinical Lead

47.13 I had meetings with Clinical Director in Urology who was clinical lead in the unit. This contact/ engagement was as part of CDs' forum.

(viii) Consultant Urologists

47.14 As an acting MD I had no direct interaction / engagement with the Urology team.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those

concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

48.1 I wasn't involved at the time of the inception of the urology unit and I wasn't aware of any specific concerns regarding the urology unit since that time.

48.2 During my tenure, the only concern I was aware of in the urology unit was Mr O'Brien's one. I will deal with these particular concerns from Question 52 onwards and in my response to Section 21 Notice No.31 of 2022.

48.3 The Director of Acute Services at the time and the Medical Director at the time might be able to provide this information. I believe the former role was occupied by Dr Gillian Rankin or Dr Esther Giskhori and the latter by Dr Simpson or Dr Wright.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,

(b) their extent and impact assessed,

(c) and the potential risk to patients properly considered?

49.1 I refer to my answer to Question 48.

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

50.1 I refer to my answer to Question 48.

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

51.1 I refer to my answer to Question 48.

<u>Mr. O'Brien</u>

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

52.1 I had no contact with Mr O'Brien prior to my involvement in the MHPS process. The first time I met him was in the MHPS meeting as a Case Manager in February 2017. My role and

responsibilities in respect of him, and my contact with him, are set out in my response to Section 21 Notice No.31 of 2022.

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

53.1 I was not involved in his job planning formulation and agreement. His CD and AMD would be able to provide this information.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

54.1 I first become aware of the issues of concern regarding Mr O'Brien as part of my role as MHPS Case Manager in January 2017. I wasn't aware how long the issues had been in existence.

Evidence: Email from Dr Wright regarding MHPS- Dec 2016 *Relevant document can be located at S21 No 28 of 2022 Attachments, 37. Confidential*

54.2 I was provided with some information in relation to concerns and the MHPS investigations started. In due course, I received the MHPS investigation report from the MHPS Case Investigator, Dr Chada, in June 2018.

54.3 All of these MHPS issues are addressed in more detail in my response to Section 21 Notice No.31 of 2022.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

55.1 I was only involved in discussion about Mr O'Brien arising out of my role as MHPS Case Manager in MHPS investigations. All involvement with him in this regard is addressed in more detail in my response to Section 21 Notice No.31 of 2022.

Evidences: MHPS meetings details have been provided by the trust.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

56.1 I acted as Case Manager in the MHPS investigation into Mr O'Brien, during which a Return to Work Action Plan was in place. Monitoring arrangements for the Plan were through the Acute Directorate operation team who provided assurance on a regular basis. All of this is addressed in detail in my response to Section 21 Notice No.31 of 2022.

Evidences: MHPS investigation report & Copy of action plan. *Relevant document can be located at Relevant to HR/ Reference no 1/ MHPS Investigation Report*

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

57.1 As part of my role as MHPS case manager, I considered concerns and evidence presented to me in the Preliminary Report from the original Case Investigator (Dr Colin Weir) in the case conference in January 2017. (Preliminary report by Mr Colin Weir attached) All of these issues, and those mentioned throughout the rest of this answer are addressed in more detail in my response to Section 21 Notice No.31 of 2022.

(i) what risk assessment did you undertake, and

57.2 As case manager, I reviewed the lookback exercise findings in the preliminary investigation report. There were 4 broad concerns identified as part of initial scoping exercise and presented at the case conference by case investigation:

1. Un-triaged Out-patient Referrals: 783 GP referrals had not been triaged in line with the agreed / known process for such referrals. Some of these dated back to 2015.

2. Patient letters and clinic letters: 668 patients had no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months.
3. Patient hospital charts at Mr O'Brien's home: 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes were located within Mr O'Brien's office, and 13 sets of notes, tracked to Mr O'Brien, were missing.
4. Private patients: The fourth issue of concern identified during the initial scoping exercise related to Mr O'Brien's private patients. A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients and then had their procedure within the NHS. The waiting times for these patients were significantly less than for other patients.

(ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

57.3 The Return to Work Action Plan was drafted and agreed with Mr O'Brien. Monitoring arrangements were agreed with the Acute Directorate team. An MHPS investigation was also started.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

58.1 A Return to Work Action Plan and monitoring arrangements were drafted after careful consideration and thorough discussions. These were then agreed with Mr O'Brien. They were also agreed with the Acute Directorate team, with regular assurance reports to be provided to me as MHPS Case Manager. (*Return to work action plan attached and can be located at S21 28 of 2022, Attachments 38. FW Return to Work Action Plan February 2017 FINAL.*) These issues are addressed in more detail in my response to Section 21 Notice No.31 of 2022.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

59.1 I refer to my answer to Question 58. I do not believe that a similar action plan or monitoring was in place prior to February 2017 (for example, during the period after similar concerns were raised with Mr O'Brien in a letter dated 23 March 2016).

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

60.1 As indicated above and in my response to Section 21 Notice No.31 of 2022, a Return to Work Action Plan was in place with monitoring arrangements. This action plan had been shared and agreed with Mr O'Brien. Monitoring assurance arrangements were agreed with the Director of Acute Services and a regular assurance report was to be provided by the Acute Directorate team.

60.2 Any issue of concern could also have been brought to my attention through the medical line management structure, i.e., the CD & AMD.

60.3 There were also other ways in which any concerns could be raised:

a. Operational Director to Medical Director escalation process of any potential significant clinical incident and / or performance-related issues.
b. Serious Adverse incident (SAI) notification to Medical Director's Office.
c. Clinical incident reporting, DATIX, was in place and actively managed by clinical governance team in the Acute Directorate.
d. Serious incident reporting and management processes were in place.
e. A complaints process was in place.
f. Risk Register management process in Acute Directorate, with escalation from the Directorate governance team to Corporate Governance Assistant Director, Mrs Margaret Marshall.

Evidence: Return to work Assurance report/ email from Ronan Carroll to Dr Khan-2017 *can be located at S21 No 28 of 2022 Attachment, 38. FW Return to Work Action Plan February 2017 FINAL*

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

61.1 Yes; the Return to Work plan with monitoring arrangements in place did address the concerns. However, in Oct 2018, some concerns were raised by the Clinical Director (Dr Colin Weir) regarding Work Action Plan.

61.2 Once I became aware of this situation, I took the following actions:

a. I sought assurance of a Return to Work Action Plan implementation report from the Assistant Director (Ronan Carroll) of the Acute Directorate on 20th October 2018.
b. I informed the Chief Executive (Mr Shane Devlin) and Director of Human Resources (Mrs Toal) for some possible deviation from the Action Plan on 22nd October 2018. **See email** *which can be located at S21 No 28 of 2022 Attachments, 39. AOB Action Plan 22.10.28*
c. Then I followed this issue up with the Acute Directorate to ensure monitoring arrangements were in place to identify any departure.
d. I was assured on 23rd October 2018 that there wasn't any significant departure from the Action Plan and it was only 16 clinic dictations awaiting completion from 28th September. I requested close monitoring of the Action Plan and its implementation **Evidence**: (from Ronan Carroll to Ahmed Khan, Siobhan Hynds & Simon Gibson). **See email FW AOB notes and dictation** *which can be located at S21 No 28 of 2022 Attachments, 40. FW AOB notes and dictation*
e. On 30th October 2018, I issued a letter to Mr O'Brien about his obligations regarding adherence to the Action Plan.

61.3 The return to work monitoring arrangements (including agreements and systems which were put in place in Urology services) did operate to remedy the concerns due to the fact that immediate identification and escalation to the case manager and the Medical Director led to involvement of both operational and professional governance teams working together to remedy this concern.

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in

what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

62.1 Mr O'Brien wrote a detailed letter to me as MHPS Case Manager on 30th July 2017. Apart from his dissatisfaction with the process of exclusion in December 2016 and the MHPS investigation process, he indicated that he had been informing his managers about service pressures on him, quality of care to patients, and other patient safety concerns for many years. Mr O'Brien indicated that there were large numbers of patients awaiting admission for surgery in November 2016, excluding those awaiting admission to the Day Surgical Unit. He further indicated that he had raised this issue previously on numerous times with all tiers of management. He also made a reference to the delivery of a letter to him on 23 March 2016 by members of Trust management, identifying concerns which they expected him to address and rectify, without remedial action and support. He made reference to meetings with the Assistant Director of Acute Services, the Clinical Director, the Head of Service, the Medical Director (Dr Wright), Mrs. Hynds, and others.
Evidence: Letter to Dr. Khan 30 July 2017 *can be located at S21 No 28 of 2022 Attachments, 41.* Letter to Dr. Khan 30 July 2017

62.2 I forwarded this letter to the Medical Director (Dr Richard Wright) and Mrs Siobhan Hynds for sharing with the oversight committee and Director of Acute Services, and to reply to Mr O'Brien regarding his concerns raised.

62.3 In my MHPS Case Manager role, I read Dr Chada's Investigation report and became aware that Mr O'Brien had also raised similar concerns with the Case Investigator during his statement and submission. By reading his MHPS statement/submissions, I understand he raised these concerns with others including his Clinical Director (Mr Colin Weir), Associate Medical Directors (Mr Eamon Mackle & Mr Mark Haynes), and operational managers including the Head of Service, Assistant Director, and Director of Acute Services.

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

63.1 As set out above and in my response to Section 21 Notice No.31 of 2022, I became aware of concerns regarding Mr O'Brien in December 2016 when the Medical Director (Dr Richard Wright) approached me to act as MHPS Case Manager. Then I received the

preliminary investigation / initial scoping exercise report for the 26th January 2017 case conference along with the Oversight Committee. This Preliminary report led me to be concerned about Mr O'Brien's conduct and performance.

(a) outline the nature of concerns you raised, and why it was raised;

63.2 The 4 broad concerns have been identified above (e.g., at Question 57) and in my response to No.31 of 2022.

(b) who did you raise it with and when?

63.3 I raised my concerns at the case conference in February 2017 with the Oversight Committee, which comprised the Medical Director (Dr Richard Wright,) Director of Acute Services (Mrs Esther Gishkori), and Director of Human Resources (Mrs Vivienne Toal).

(c) what action was taken by you and others, if any, after the issue was raised?

63.4 As part of my role as MHPS Case Manager, I considered these preliminary findings carefully and discussed possible options with the Oversight Committee members. Based on the evidence presented, the concerns were very serious and there was significant deviation from GMC Good Medical Practice and the agreed processes within the Trust. Therefore with the advice of the Oversight Committee, I concluded that Mr O'Brien had a case to answer.

(d) what was the outcome of raising the issue?

63.5 The decision was agreed by the Oversight Committee members and therefore a formal investigation commenced under MHPS.

63.6 In the Oversight Committee meeting of 26th January 2017, there was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

a. Protecting patients;
b. Protecting the integrity of the investigation; and
c. Protecting Mr O'Brien.

63.7 Mr Weir (CD and Case Investigator) reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

63.8 The members discussed whether Mr O'Brien could be brought back with either restrictive duties or robust monitoring arrangements which could provide satisfactory safeguards. Mr Weir outlined that he was of the view that Mr O'Brien could come back and be closely monitored, with supporting mechanisms, doing the full range of duties. The members considered what this monitoring would look like, to ensure the protection of the patient.

63.9 A Return to Work Action Plan / monitoring arrangement was drafted by the Acute Directorate management and agreed by the Oversight Committee meeting on 3rd February 2017. This Plan was shared with Mr O'Brien. He agreed to adhere to this plan during the MHPS investigation. The monitoring arrangements were agreed by the Director of Acute Services, Mrs Esther Gishkori

Evidences;

- **Return to work action plan attached** *Relevant document can be located at S21 No 28 of 2022 Attachments, 38. FW Return to Work Action Plan February 2017 FINAL*
- **Preliminary investigations findings report- Jan 2017** *Relevant document can be located at Relevant to PT/ Evidence Added or Renamed 19 01 2022/ Evidence No 77/ No 77 – Dr Neta Chada/ 20180523 – E – Report of Investigation*
- **Oversight committee meeting – 26th Jan 2017** *Relevant document can be located at S21 No 28 of 2022 Attachments, Relevant to HR/ Reference No 1/ Oversight Documentation Mr O'Brien Oversight Group Notes*
- **Return to work action plan – 2017** *Relevant document can be located at S21 No 28 of 2022 Attachments, 38. FW Return to Work Action Plan February 2017 FINAL*

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

63.9 Not applicable.

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1 In January 2017, Mr O'Brien returned to work after being excluded for 4 weeks from the end of December 2016. He also had period of sick leave. A Return to Work Action Plan was created and agreed with Mr O'Brien. This Plan supported Mr O'Brien to fulfil his required Trust clinical duties safely and effectively.

64.2 Mr O'Brien was also referred to and reviewed by the Occupational Health Department

64.3 He was also actively managed by his CD, AMD, and Director of Acute Services.

64.4 Assurance was provided by his CD and AMD that his Job Plan would be reviewed as per the Trust job plan policy.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

65.1 I wasn't involved in assessing and recording Risks in the Acute Directorate.

65.2 By discussing with Mr O'Brien and with relevant managers, I understand, Mr O'Brien's previously raised concerns were discussed at Urology team meetings and at urology service governance meetings. I wasn't part of those meetings, however, his CD and AMD, along with Head of Service, Assistant Director & Director of Acute Services, were managing those risks within the Acute Directorate.

65.3 The Clinical Director (Mr Colin Weir), AMD (Mr Hynes), Assistant Director (Ronan Carroll), Director of Acute Services (Esther Gishkori) would be able to provide this information.

Learning :

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

66.1 I was the Acting Medical Director between April and December 2018. I was also the Case Manager of MHPS investigations from January 2017. In September 2018 I made the MHPS determination and recommendations

66.2 After ceasing my Acting Medical Director role in January 2019, I went back to my previous role as Associate Medical Director in the Children & Young People Directorate with little or no contact with urology services. I am aware that Mr O'Brien was referred to GMC by The Medical Director (Dr O'Kane) for fitness to practice concerns in April 2019.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

67.1 My reflection is based on my knowledge, information and evidence provided through the MHPS investigation.

67.2 It appears to me that Mr O'Brien had been significantly deviating from GMC Good Medical Practice, agreed processes within the Trust, and the working practices of his peers.

67.3 However, it was also evident that his practices were known to his managers (both clinical & operational) for some time and that they were never addressed sufficiently. I outlined this concern in my MHPS Case Manager Determination as follows:

> "4.7 MHPS investigation findings:
>
> *"Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'Brien's practice dating back a number of years. There was no evidence available of actions taken to address the concerns."*

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

68.1 Whilst there was evidence of some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own failure to meet his individual professional responsibilities.

68.2 In terms of wider governance issues, I made a recommendation in my MHPS report which I think is an important piece of learning in this regard:

"MHPS: 6.0 Final Conclusions / Recommendations:

> *"The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate.*
> *The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients. Default processes were put in place to work around the deficiencies in practice rather than address them.*
> *I am therefore of the view there are wider issues of concern, to be considered and addressed."*

68.3 On reflection, the governance learning from the MHPS process are multifactorial. This includes lack of compliance with established trust policy, procedure and guidelines at many levels. There was also evidence of poor staff management, support and accountability in Urology Services. The MHPS process was ongoing from earlier in 2016, with some informal measures. However, there appears to have been no real focus on outcomes and follow-up with a number of missed opportunities.

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

69.1 Yes; in my view there was a failure to engage fully by clinicians and managers at many levels in Acute Services. This ranges from Consultants to Clinical Directors to Associate Medical Directors on the one side and, on the other, operational managers from Head of Service to Assistant Director to Director of Services. This failure includes non-compliance with established Trust policy and procedures and a lack of accountability.

69.2 Then there is the non-engagement of Mr O'Brien for many years. This seems to have been managed poorly by his clinical and operational line managers. I wasn't involved in any of these discussions and interventions however relevant managers would be able to provide this information. The non-engagement of Mr O'Brien during the period from March 2016 until December 2016 may have been avoided if this issue was escalated to the Medical Director earlier and if the Medical Director, who was his Responsible Officer, had intervened sooner. I believed Dr Wright had discussions with Mr O'Brien in the later part of 2016 but Dr Wright would be best able to provide this information.

69.3 I believe that the above views are broadly reflected in the paragraph from my MHPS Conclusions / Recommendations quoted in the previous answer.

69.4 I also think that the following part of my MHPS Determination is relevant:

> "MHPS: 6.0 Final Conclusions / Recommendations:
>
> *"The findings of the report should not solely focus on one individual, Mr O'Brien. In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."*

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please

explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

70.1 My reflection in response to this Question is again based on knowledge, information and evidence experience obtained through the MHPS investigation.

70.2 Personally as Case Manager, I tried my best to fulfil my duties as best I could. On reflection I could maybe have been more proactive in dealing with the non-engagement of Mr O'Brien during the MHPS formal investigation which started in January 2017, especially when he wasn't engaging between January and March 2018. In my view, there were some mitigating factors, listed below. However, I believe these factors did not damage the quality of the end product (my Case Manager's determination). They largely just caused the formal MHPS investigation process to be slower than I think it ought to have been.

a. In my view, most important factor was that I had no previous experience of conducting such a complex formal MHPS investigation as a Case Manager. I reviewed all the relevant Guidelines and the MHPS framework document. However, with no previous experience, I wasn't fully equipped to carry out such a complex case investigation. I received MHPS training after the investigation had commenced.

b. I also believe that having no dedicated / protected time for the Case Manager role in my job plan was also an important factor. Initially, it was meant to be for only a couple of months but ended up taking much longer. I was carrying out a very busy clinical and management job at the same time. Then I was appointed as the Acting Medical Director role in April 2018 after going through recruitment and selection process in previous couple of months.

c. The resources allocated to carry out such a complex investigation were inadequate.

70.3 I also refer in particular to the following part of my MHPS Determination in answer to Question 70:

> "4.7. Investigation findings:
> *"Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding*

Mr O'Brien's practice dating back a number of years. There was no evidence available of actions taken to address the concerns."

70.4 Considering the part of the question that focuses on existing governance arrangements, I have the following additional thoughts. Although I wasn't directly involved in urology services management, I am aware of some suggestion that the existing governance arrangements may not have been utilized sufficiently. In my view, by adherence to existing agreed trust policies and procedures by all staff would have resulted in improved outcomes.

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

71.1 As per my reply to Question 39, we reviewed and recommended change in respect of some governance arrangements.

71.2 There was a question mark about whether governance arrangements were fit for purpose. Therefore I recommended in my MHPS report the following:

"In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."

See MHPS report already provided by the Trust

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1 No, I have nothing to add.

Urology Services Inquiry

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: ___Ahmed Faraz Khan_____

Date: ____08/07/2022_____

S21 28 of 2022

Witness statement of: Ahmed Faraz Khan

Table of Attachments

Attachment	Document Name
1	CV- Dr Ahmed F Khan
2	CD CYP Community Paeds JD
3	Medical Directors ORG CHART - April 2018 updated
4	SHSCT ORG CHART UPDATED09.02.18
5	Item 11ii. Medical Appraisal and Revalidation Annual Report 2017-2018 Final
6	Job PLANNING- ONE DIRECTION Version 3
7	20180906 CRR
8	20200801 - Email - Administration Review Terms of Reference
9	20100915 Guidelines for Handling Concerns about Doctors
10	Combined Accountability Scorecard. final signedoff version
11	Dr Khan MM Walkaround 17 Apr 2018
12	Clinical Director meeting 24th August 2018 - action notes
13	AMD meeting schedule 2018 without Medical Forum REVISED
14	20180410 AMD Minutes
15	20141106_WorkingDraft_SHSCTIncidentMgmtProcedure_CGO_Nov2014
16	20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1. Nov 2016
17	Lesson Learned Forum - Update to Gov Committee
18	20181206 Approved Governance Committee Minutes 06.12.28
19	2018 Policy for the Management of Complaints
20	'3b. Clinical audit strategy V3 June 2018.pdf'
21	IPC Strategy 2018-21 TB Paper 27.9.18 FINAL
22	Medical Leadership Review 2018 Draft-V11-September 10
23	Final Governance Report May 2018 FINAL
24	20180906 Final Governance Paper

25	20181206 Clinical and Social Care Governance Report December 2018 FINAL after SMT
26	Directorate SWOT Analysis
27	RE Re; 11 meeting discussion points
28	20180511 Final Governance Report May 2018 FINAL 3
29	Final Governance Paper- August2018
30	Clinical and Social Care Governance Report December 2018
31	Risk Assessment- Governance201017
32	20180810 Acute Clinical Governance Action notes
33	20181110 Acute Clinical Governance Action notes
34	20180907 Acute Clinical Governance Action notes
35	MHPS Framework guidance document
36	20180928 Email FW Case Manager Determination AO'B FINAL 280918
37	Confidential
38	FW Return to Work Action Plan February 2017 FINAL
39	AOB Action Plan 22.10.18
40	FW AOB notes and dictation
41	Letter to Dr. Khan 30 July 2017

curriculum vitae

Ahmed Faraz Khan

Qualifications:

- Fellow of Faculty of Paediatrics (FFPaeds) - Royal College of Physicians in Ireland – 2017
- Fellow of Royal College of Paediatrics & Child Health (FRCPCH), RCPCH London- 2010
- Masters in Medical Sciences (MMSc.) - National University of Ireland Galway- 2007
- Membership of Royal College of Physicians in Ireland (MRCPI - Paediatrics) - 2002
- Diploma in Child Health (DCH)- Royal College of Surgeons in Ireland- 1999
- Bachelor of Medicine & Bachelor of Surgery (M.B;B.S)- Liaquat University of Medical Sciences (LUMS) Pakistan- 1993

Professional Registration:

- General Medical Council (GMC), UK - Full & Specialist Register- No. 6121249
- Irish Medical Council (IMC) - Full & Specialist Register -No. 021546

Employment History:

- Consultant Paediatrician with Special Interest in Community Paediatrics, Daisy Hill Hospital & Community Paediatric Services – Southern Trust (SHSCT)- June 2009 to date
- On carrier break from SHSCT- From July 2021 to Sept 2022
- Consultant Paediatrician with Special Interest in Community Paediatric Services, Cork University Hospital- from July 2021 to date
- Locum Consultant Paediatrician- Daisy Hill Hospital – From June 2008 to May 2009
- Locum Consultant Paediatrician, The Ulster Hospital, SEHSCT, March 2008 to May 2008
- Locum Consultant Paediatrician- University Hospital Galway- From July 2006 to Feb 2008
- Locum Consultant Paediatrician - Cork University Hospital- From Sept 2005 to June 2006
- Paediatric & Neonatal Specialist training- SHO & Registrar- From July 1997 to June 2005 - In RCPI training hospitals across Ireland

Duties & Commitments as Consultant:

1. Consultant Paediatrician/ Community Paediatrician – 1st June 2009 to date
Daisy Hill Hospital & Community Paediatric Services, SHSCT

- Inpatient & Out-patient care of general paediatric patients (0-16yrs)
- Participate in on-calls & consultant of the week rota in DHH
- Regular clinics in hospital & in Community Paeds services
- Teaching & training of Paediatric & GP trainees attached to the department

2. **Consultant Paediatrician/ Community Paediatrician – 1st July 2021 to date**
   Cork University Hospital & Community Paediatric Services

   - Inpatient & Out-patient care of general paediatric patients (0-16yrs)
   - Participate in on-calls & consultant of the day rota
   - Regular clinics in hospital & in Community Paeds services
   - Teaching & training of Paediatric & GP trainees attached to the department

Medical Leadership Roles:

1. **Acting Medical Director, SHSCT- April to Dec 2018**
   Duties / Responsibilities: I was responsible for:

   - Corporate professional governance for all medical staff:
   - For the clinical outcomes and effectiveness of the Trust's services
   - To lead in the development of a framework to ensure a strong infrastructure of medical leadership
   - Trust's nominated Responsible Officer for GMC
     A. For referring concerns about a medical practitioner to the General Medical Council for addressing concerns about a medical practitioner's fitness to practice
     B. For the effectiveness of medical appraisal of the medical workforce,
     C. For quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.
   - For the strategic management of Patient Safety initiatives, and the link Director with the Patient Safety Forum
   - To ensuring an effective system of integrated governance within the Trust
   - Responsibility in a number of organisationally critical areas including Health Care Acquired Infection (HCAI), Research & Development, Raising Concerns and Emergency Planning.
   - To Trust's Medical Negligence and other related committees
   - To Lead and manage Corporate Clinical Governance team

2. **Associate Medical Director –Children & Young People Services, SHSCT-** From 2013 to April 2018 then from Jan 2019 to June 2021
   Duties / Responsibilities: I was responsible for:
   - Providing Medical leadership to medical staff in CYP services
   - Ensuring Patient safety measures and quality standards are met
   - Enforcing Standards/ Guidelines
   - Implement Trust strategic
   - Involved in Medical workforce planning & recruitment & Section
   - Conducting consultants Appraisal and involved in Job planning

3. **Clinical Director- Community Paediatric Services-** Three years (2012-2013)
   Duties / Responsibilities: I was responsible for:

   - Team leader role in community paeds medical staff team
   - Involved in service development
   - Monitor & enforce standards & guidelines
   - Ensuring required service delivery targets are met
   - Improving interface with Primary care teams

Southern Health and Social Care Trust

Quality Care - for you, with you

73811112

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE	Clinical Director - Children &Young People- Community Paediatrics
DRIECTORATE	Children &Young People Directorate
INITIAL LOCATION	Southern Health and Social Care Trust
RESPONSIBLE TO	Director of Children and Young People's services
OPERATIONALY RESPOSNIBLE TO	Associate Medical Director C&YP
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of the Children &Young People's Division in community paediatrics.

He/She will:

- Participate as a member of the Children &Young People management Team.
- Be responsible for medical operational issues within Children &Young People in community paediatrics and provide professional advice to the Associate Medical Director and management team on professional medical issues of the site.
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY DUTIES/RESPONSIBILITIES

OPERATIONAL EFFECTIVENESS OF SERVICES

Operational Management

1. Support the Trust in the development of a high quality, responsive elective care service, ensuring that regional and local targets are achieved

2. Provide leadership and direction to consultants and other medical staff within community paediatrics.

3. Attend Directorate wide meetings with Service Director, AMD and Assistant Directors etc

4. Take such action as may be necessary in disciplinary matters in accordance with Trust procedures.

5. Chair a regular community paediatrics meeting for medical staff

6. Be first contact point for Assistant Directors for issues arising in community paediatrics.

Service Development:

1. Provide a medical perspective on protocols/ pathways relating to service improvements/ modernisation within the Division (community paediatrics)

2. Actively participate in discussions about service change and medical capacity

3. Work with the Divisional team to support and develop the modernisation of services.

4. Lead the medical aspects of service change at Divisional level and contribute to the implementation of multi disciplinary change

Budgetary Awareness

1. Work to deliver efficient and effective services within agreed financial budgets and provide advice and guidance on the costs and benefits of planned developments.

2. Take account of financial implications when making decisions in conjunction with Assistant Directors and with the support of Finance staff. This could include for example medical staffing/ locum costs

within service delivery and development, cost of sickness absence, approval of doctors expenses etc

GOVERNANCE AND PROFESSIONAL PRACTICE STANDARDS

Divisional Governance Forum

1. Participate in Divisional Governance activities/ meetings as agreed with the Associate Medical Director

2. Work with the Trust/ Directorate Governance manager to ensure effective clinical governance

3. Involvement in complaints investigation and resolution, critical incident reporting and follow up, risk management and audit

Standards

1. Providing advice to the Assistant Director and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc

2. Assisting in preparation for external inspections

3. Working with relevant managers and colleagues on implementation plans to address issues highlighted by external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) overseeing development and roll out of implementation plans in conjunction with the Director/ Assistant Director

Public Health and urgent operational issues

1. Support the Trust in planning a response to major incidents and outbreaks

2. Contribute to the roll out of contingency plans, working with identified leads and the Associate Medical Director (e.g. swine flu, hyponatraemia).

Education and Research

1. Work with the Associate Medical Director to support the development and delivery of Education and Research within the Division, ensuring the appropriate Governance arrangements are in place

2. Contribute to decisions to resolve tensions at specialty level between the demands of training and service delivery.

MEDICAL MANAGEMENT

Appraisal

1. Contribute to the appraisals for all grades of staff in line with regional guidance
2. Liaise with Associate Medical Director re completion of appraisals and reports on common issues

Job Planning

1. Undertake job planning role as agreed with Associate Medical Director

Application of Medical HR policies

2. Undertake a management role in the application of relevant medical HR policies and the provision of advice to medical colleagues in areas such as;

- Annual Leave
- Study Leave
- Performance
- Sickness absence

3. Support the Associate Medical Director in the effective implementation and monitoring of EWTD for junior doctors

4. Liaise with Human Resources for appropriate advice and support

5. May be the nominated person for the Directorate in specific HR policies

Communication

1. Facilitate good communication with medical staff, formally through meetings and informally through other opportunities

2. Liaise with other clinical managers in support of good multidisciplinary team working

3. Actively promote the development of clinical and professional networks between the Daisy Hill and Craigavon Area Hospital sites.

4. Act as a primary communication point within the Division for management and medical colleagues

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

9. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing

circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE Clinical Director - Children &Young People- Community Paediatrics

DIRECTORATE CYPS

Ref No: 73811112 **November 2011**

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

Knowledge, Skills & Experience

2. Hold a medical qualification, GMC registration and specialist accreditation (CCT)

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

Prior to interview all shortlisted applicants will be required to meet with Dr John Simpson, Medical Director to allow him to further discuss the role of Clinical Directors in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Dr Simpson directly on Personal information redacted by USI as soon as possible.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Seizing the future
- Leading Change through people
- Holding to Account
- Effective and Strategic Influencing
- Self Management
- Empowering Others
- Collaborative Working

In recognition that you may not have previously experienced the competency based interview process, to support you in preparation for your interview you are invited to contact Karyn Patterson, Head of Recruitment & Selection Services on Personal information redacted by USI or via email at Personal information redacted by USI who would be pleased to arrange a discussion with you on the competency based interview and provide you with general guidance in the context of the NHS Leadership Qualities Framework.

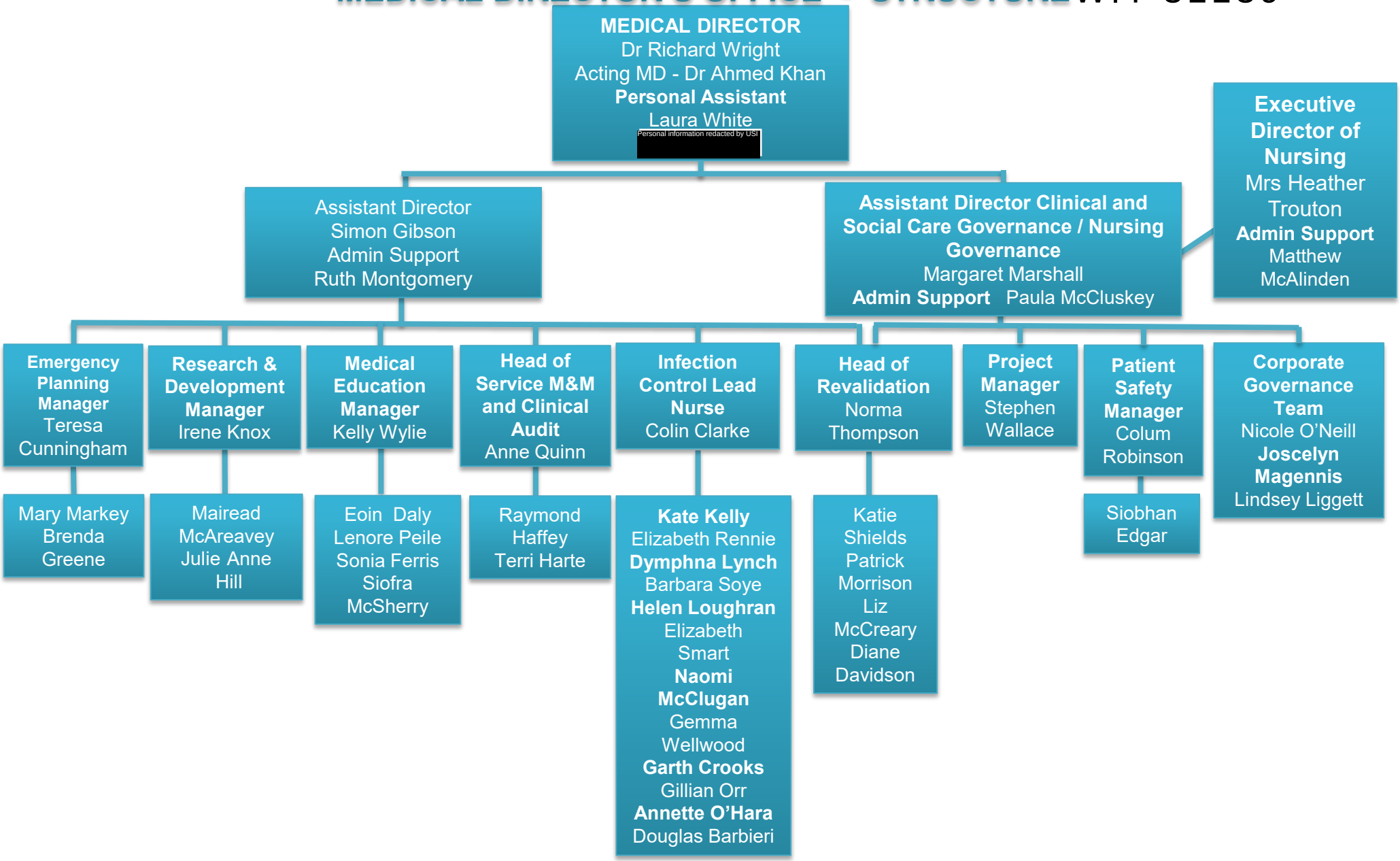
A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

The successful candidate will be appointed on a four year rolling contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

All staff are required to comply with the Trusts Smoke Free Policy

MEDICAL DIRECTOR'S OFFICE - STRUCTURE



Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

ORGANISATIONAL CHART

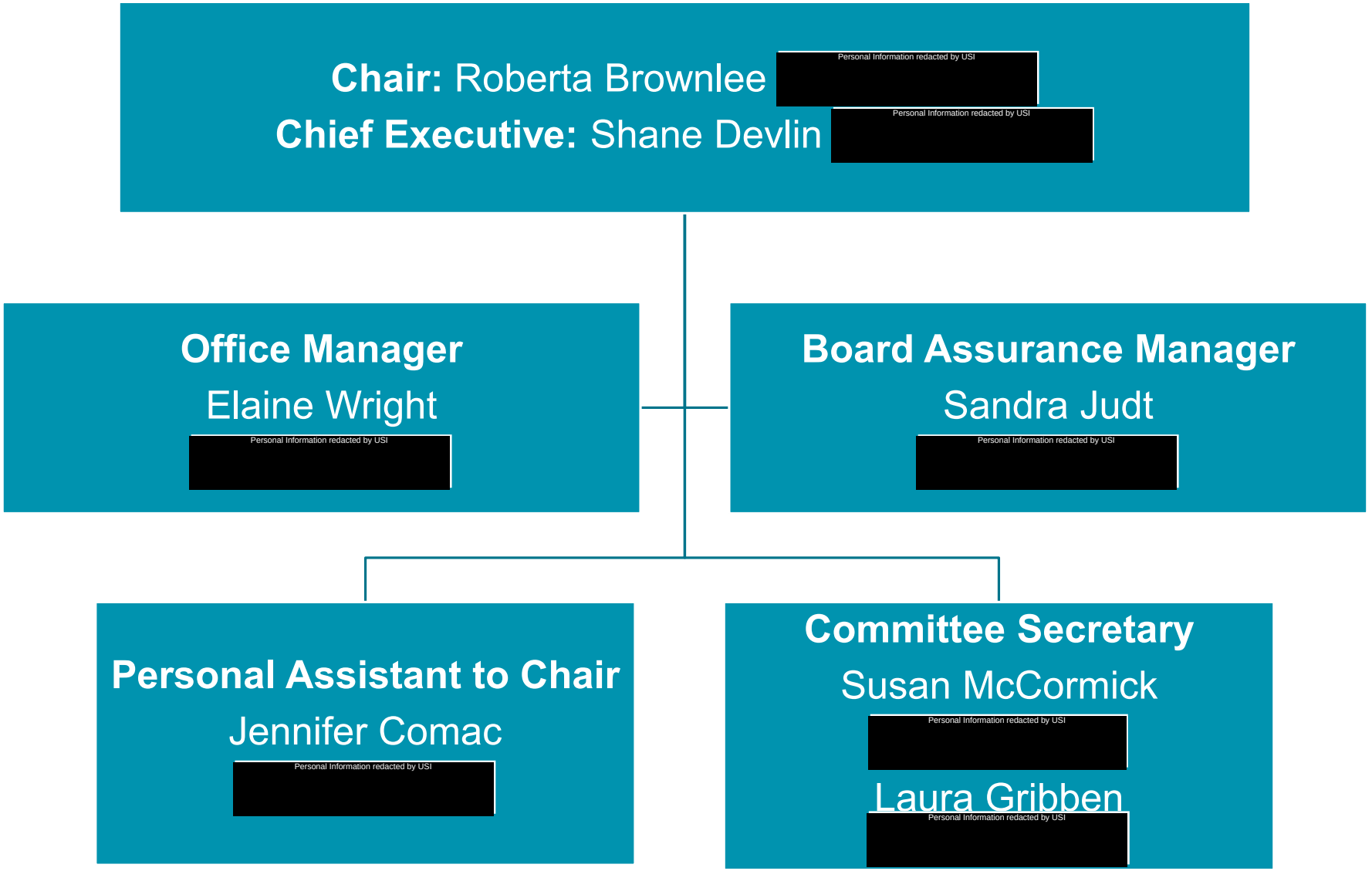
February 2018

Southern Health and Social Care Trust

Quality Care - for you, with you

Office of the Chair and Chief Executive

Chair and Chief Executive's Office SHSCT Headquarters



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Communications Team

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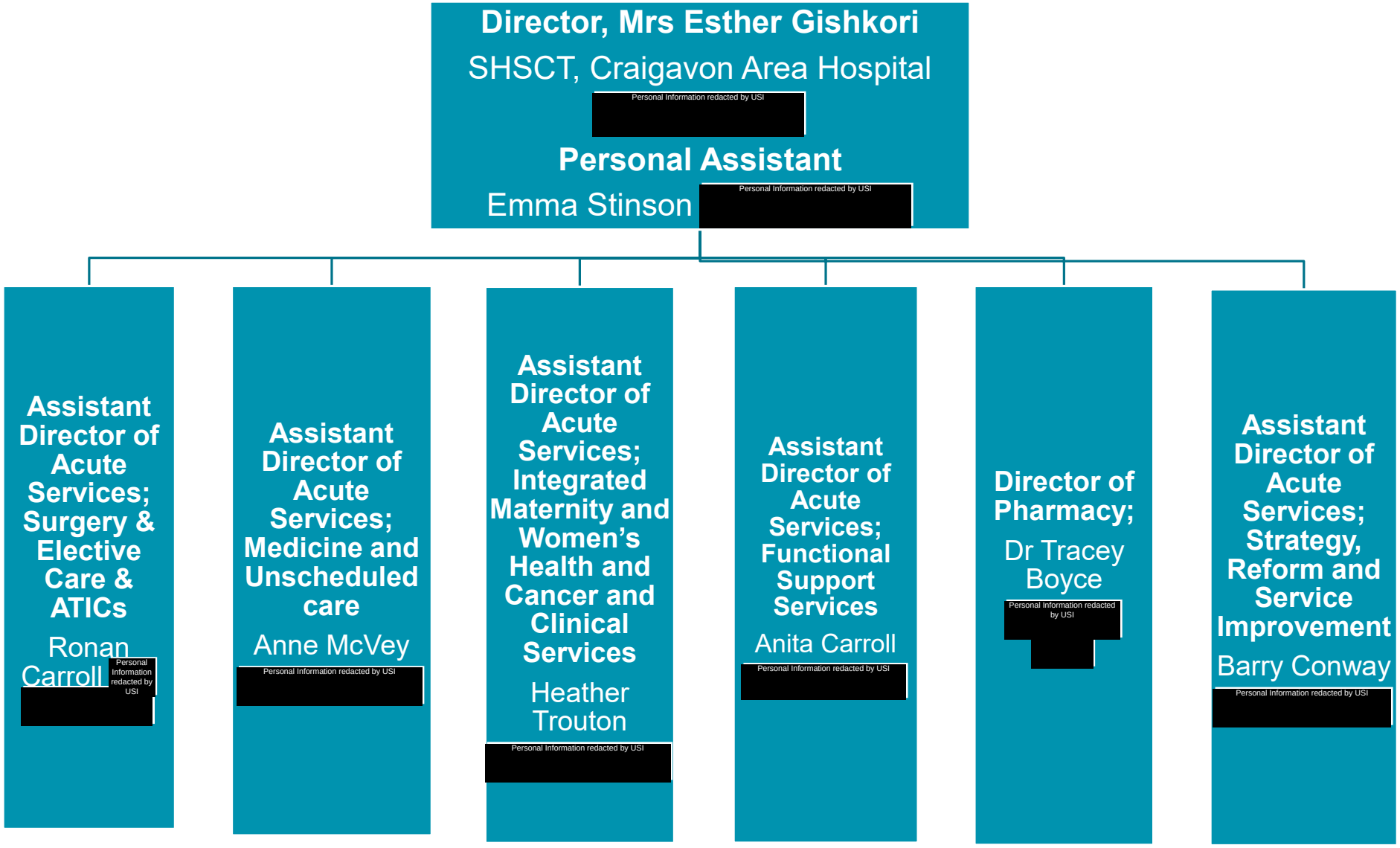
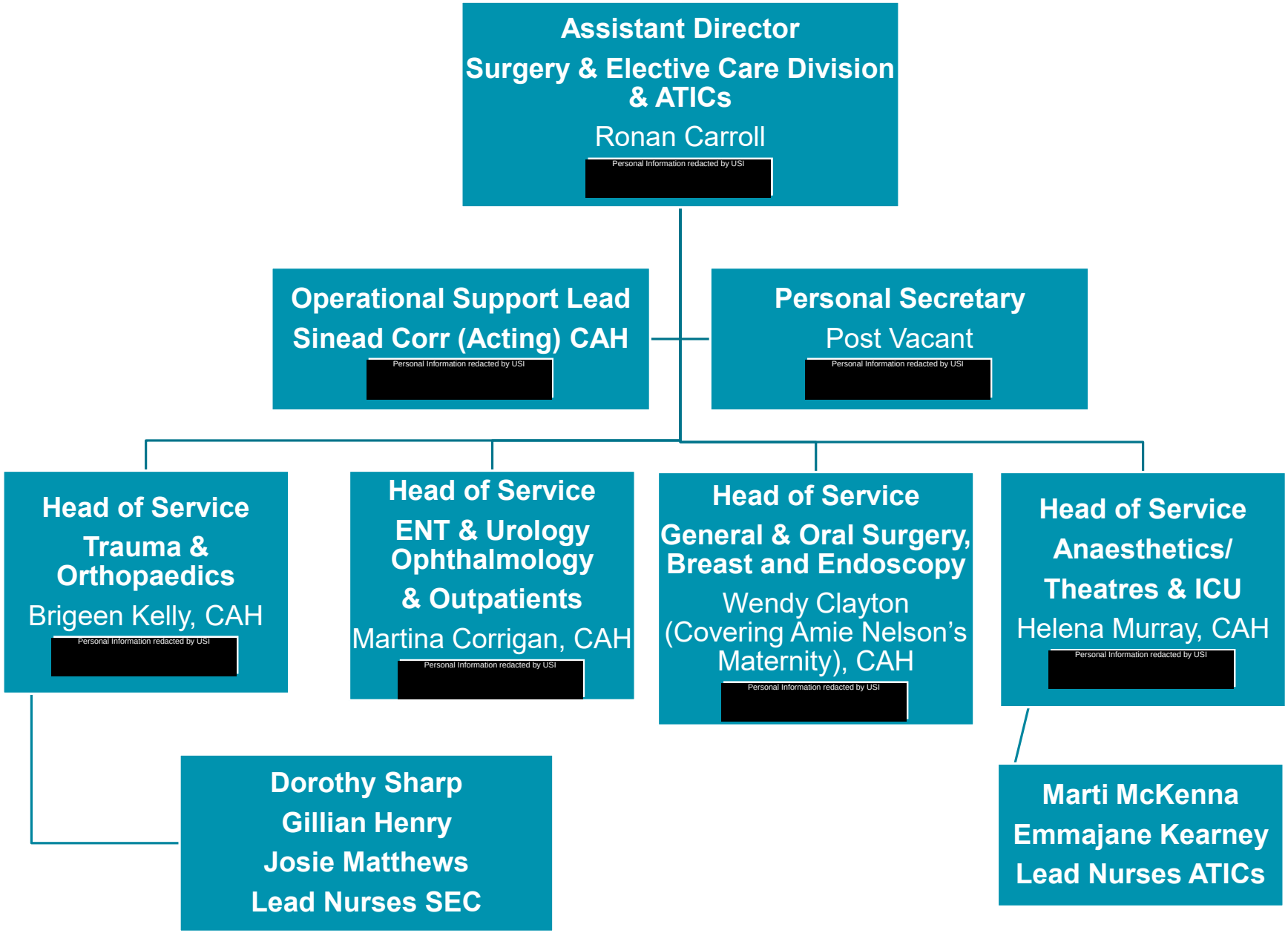
Directorate of Acute Services

Directorate of Acute Services



Directorate of Acute Services



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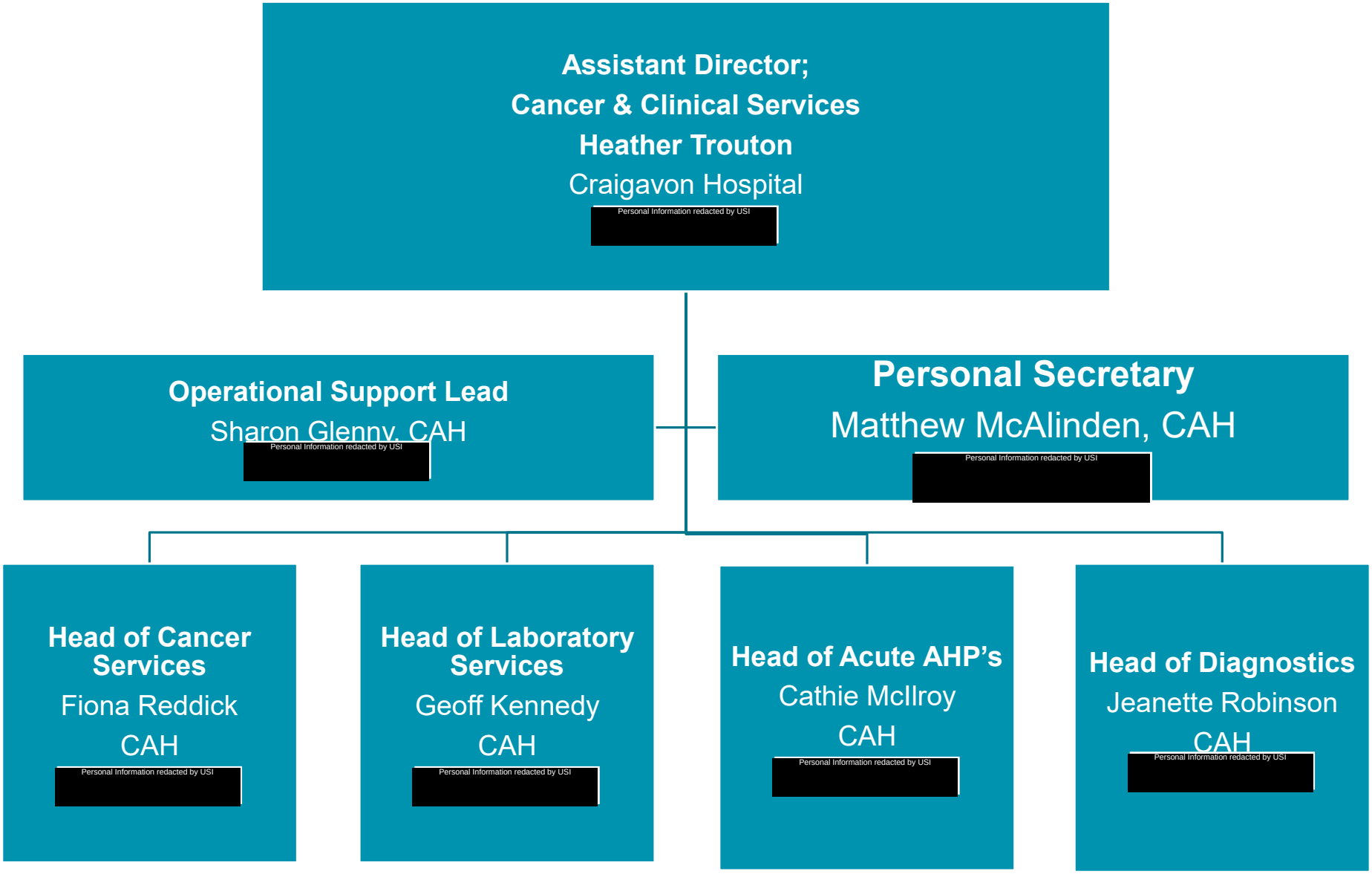

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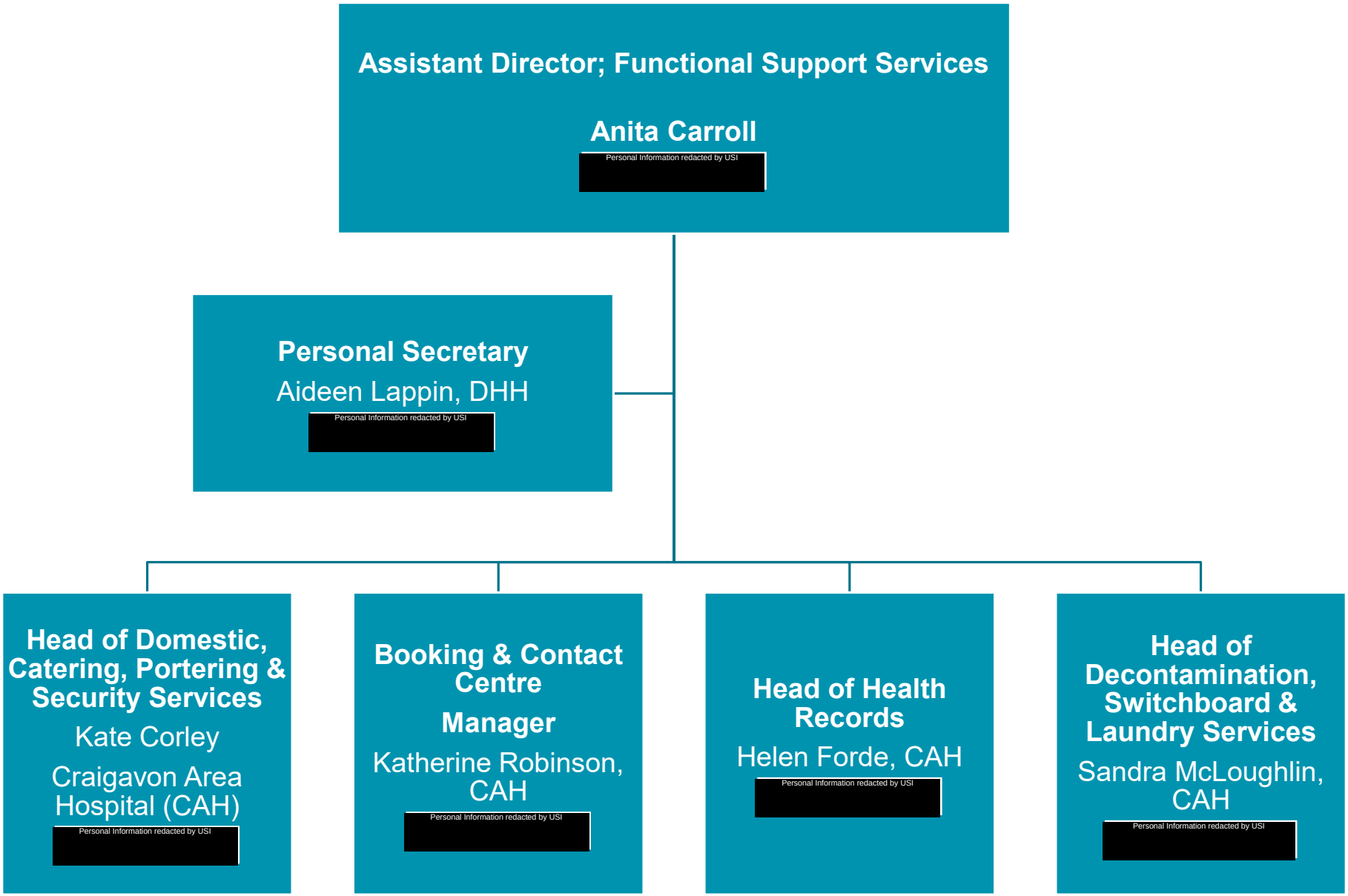

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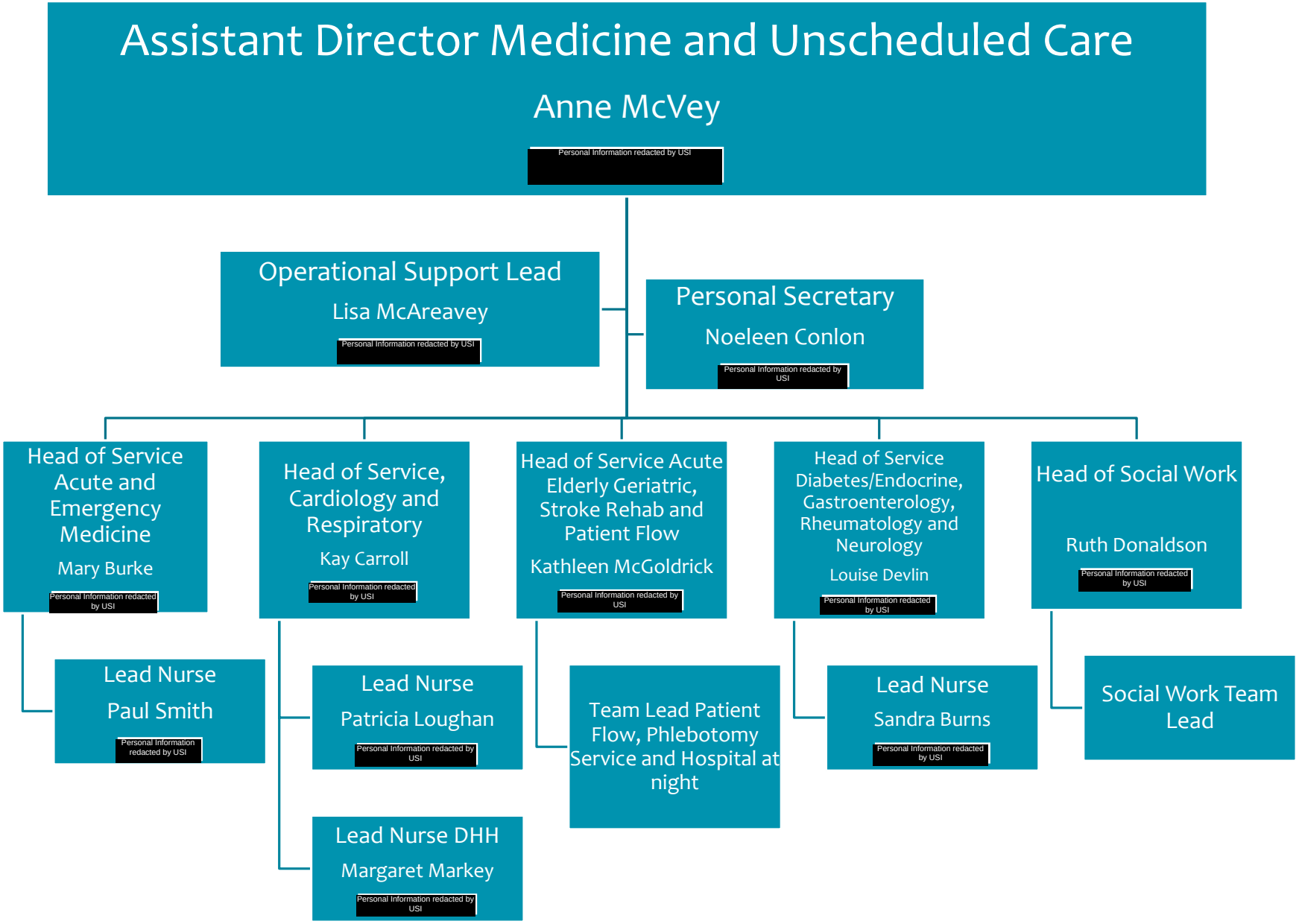

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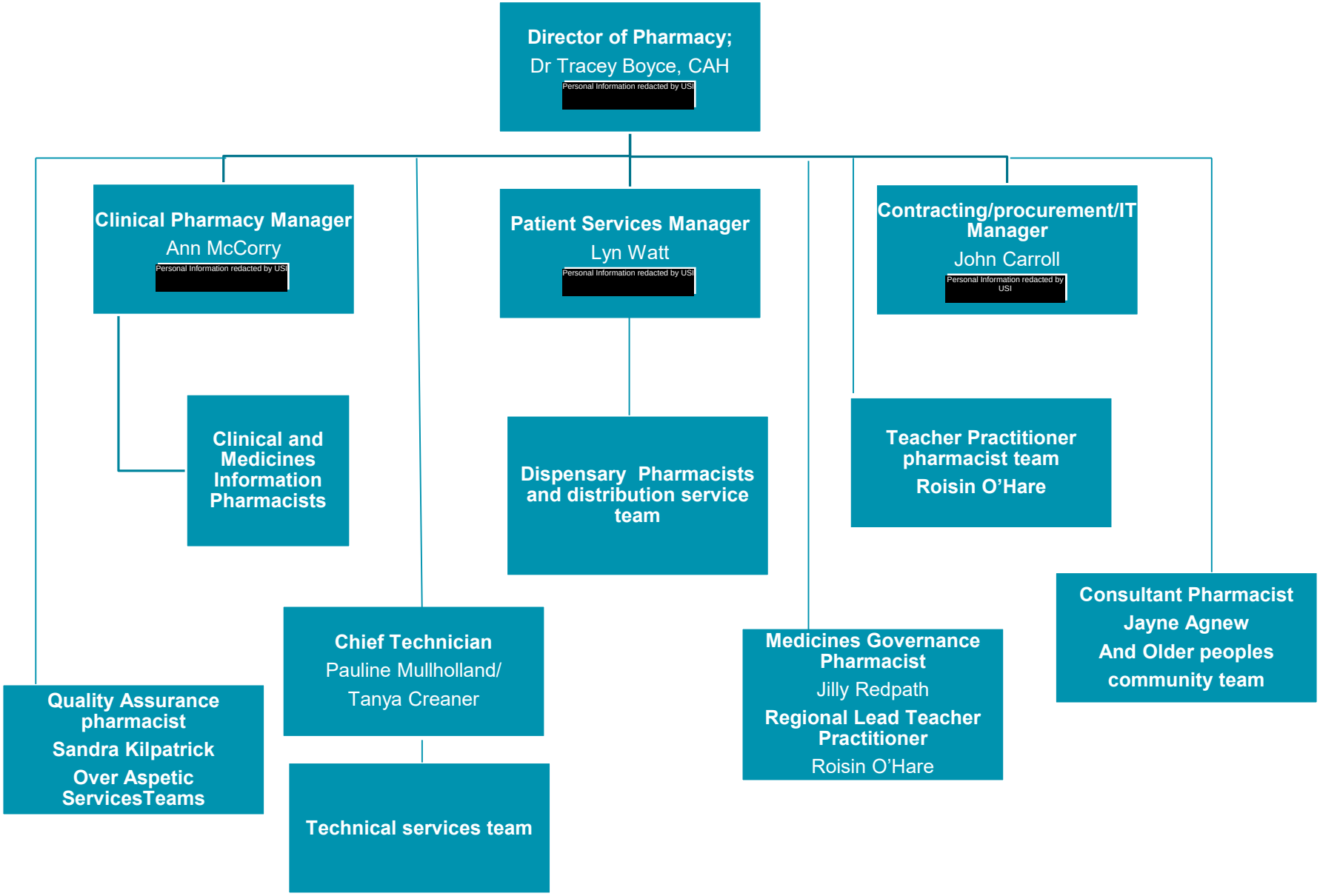

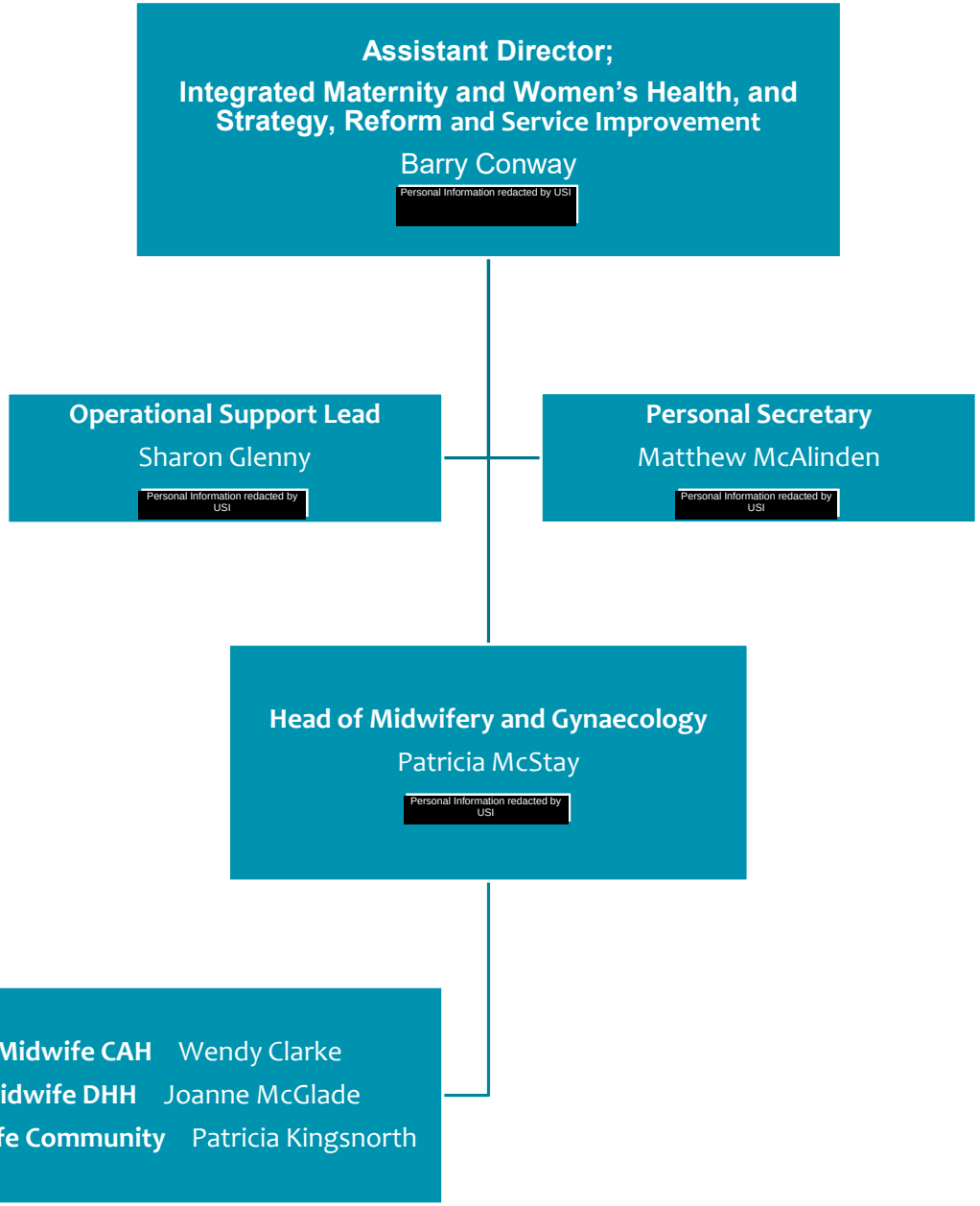

Interim Executive Director of Nursing, Midwifery and AHP's

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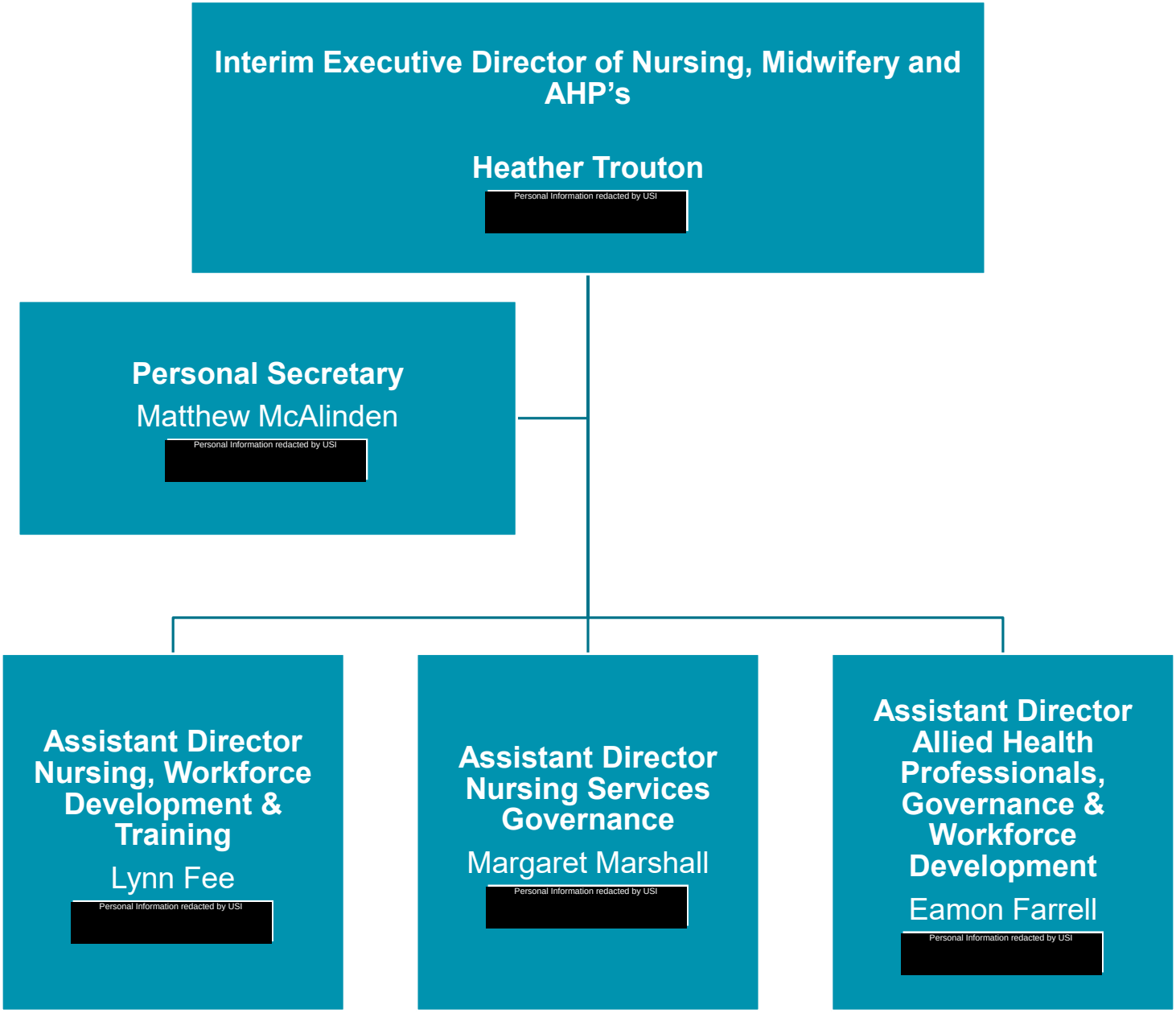


Directorate of Children and Young Peoples Services

Children & Young Peoples Services Directorate

WIT-31155

DIRECTOR Paul Morgan
Edenderry House, Portadown [redacted]
Personal Assistant Ruth Alexander [redacted]

Associate Medical Director
Dr A Khan
DHH, [redacted]

Assistant Director of Family Support & Safeguarding
David Douglas
Edenderry House [redacted]

Assistant Director of Specialist Child Health & Disability
Geraldine Maguire
Edenderry House [redacted]

Assistant Director of Corporate Parenting
Colm McCafferty
Lisanally House [redacted]

Assistant Director Social Work
(Governance, Workforce Development & Training)
Francesca Leyden
Edenderry House [redacted]

Head of Planning
Janet McConville, Rosedale, Gilford
[redacted]

Finance
Michael Gillespie, Financial Management Accountant
[redacted]

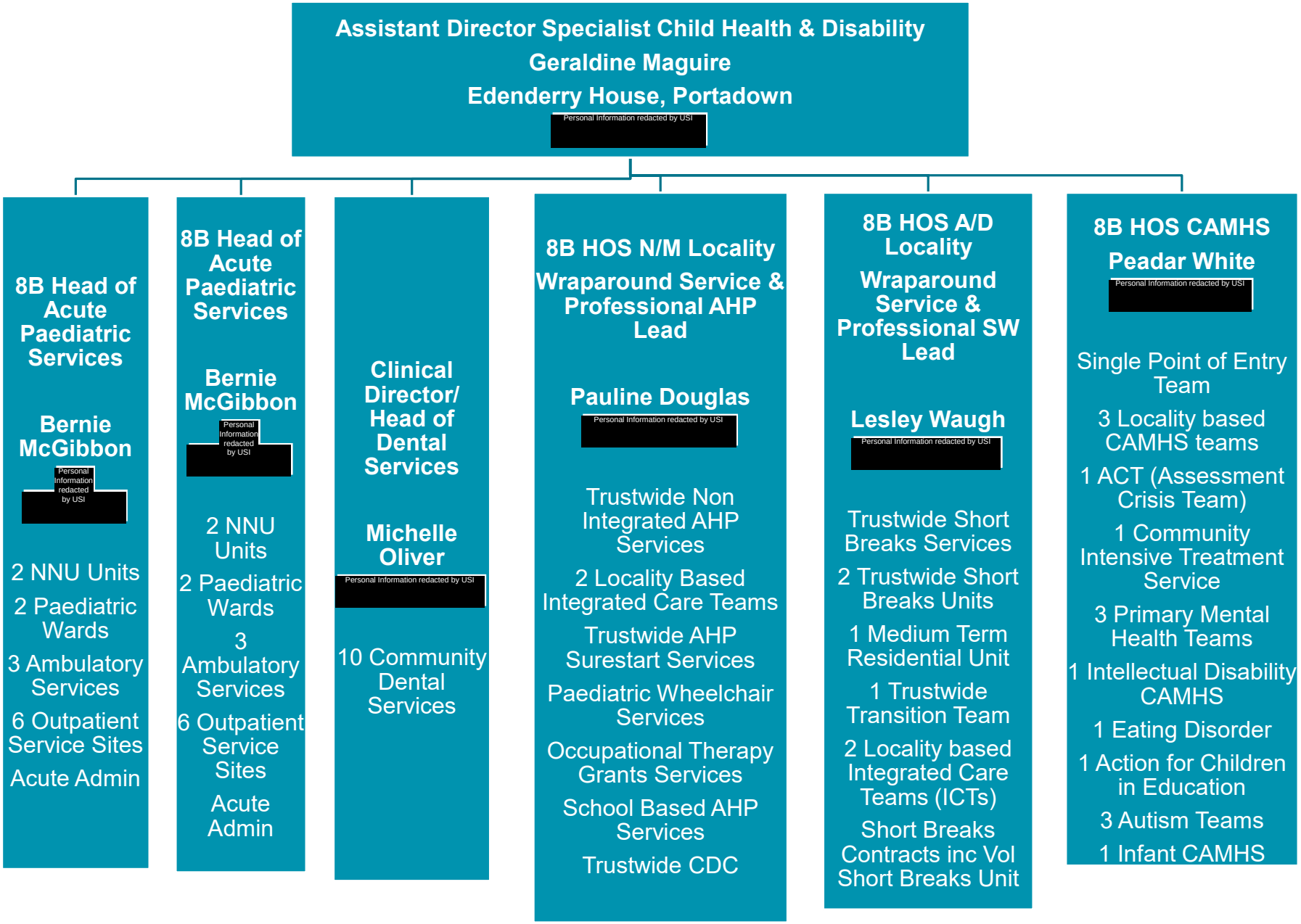
Assistant Director Human Resources
Lindsay McElrath
Edenderry House [redacted]

Informatics
Karen McCoy, Bannvale House
[redacted]

Performance & Reform
Paula Tally, BCBV Programme Manager
Trust HQ, CAH [redacted]

Governance Manager
Daphne Johnston
Edenderry House [redacted]

Children & Young Peoples Services Directorate



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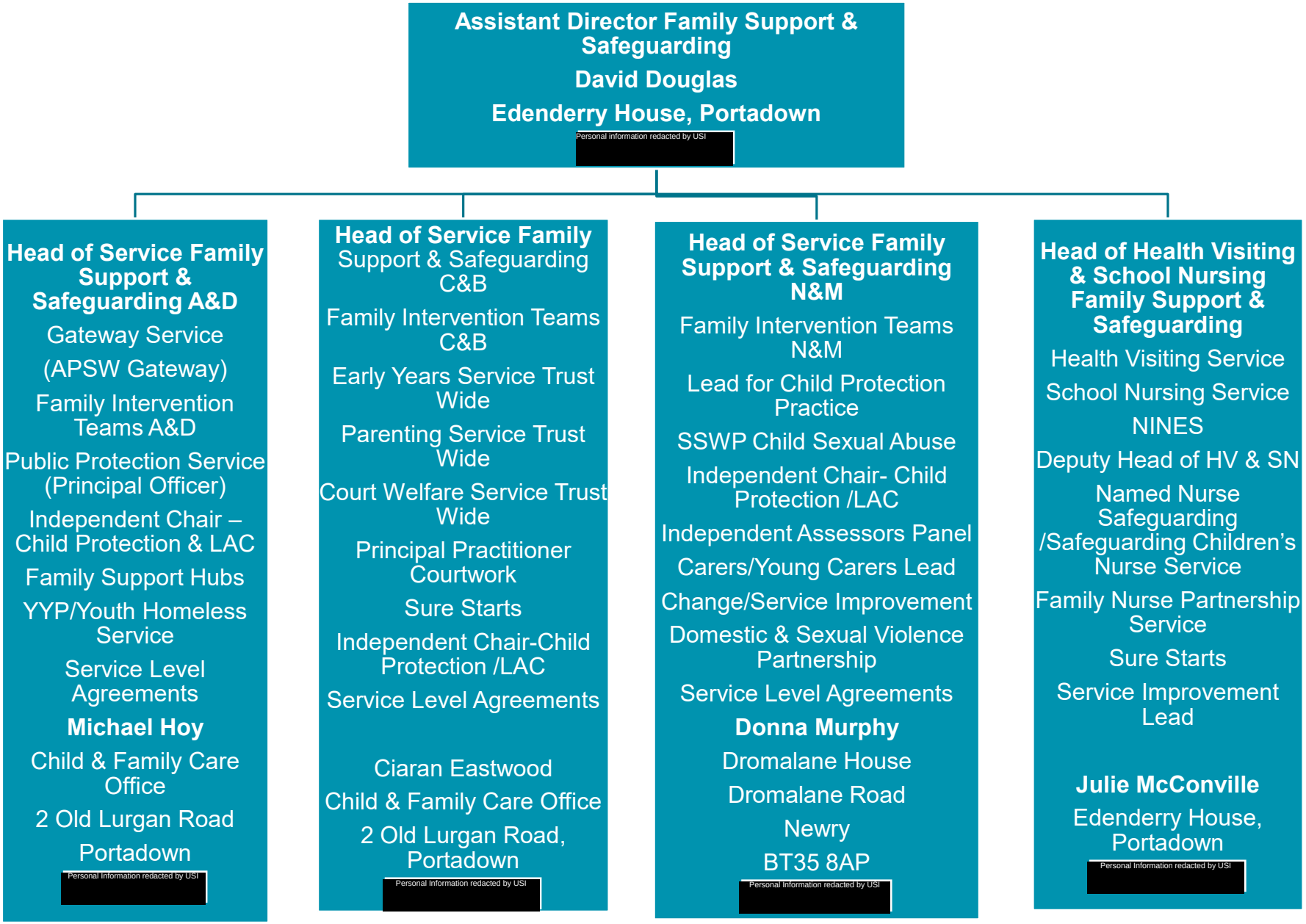
Children & Young Peoples Services Directorate



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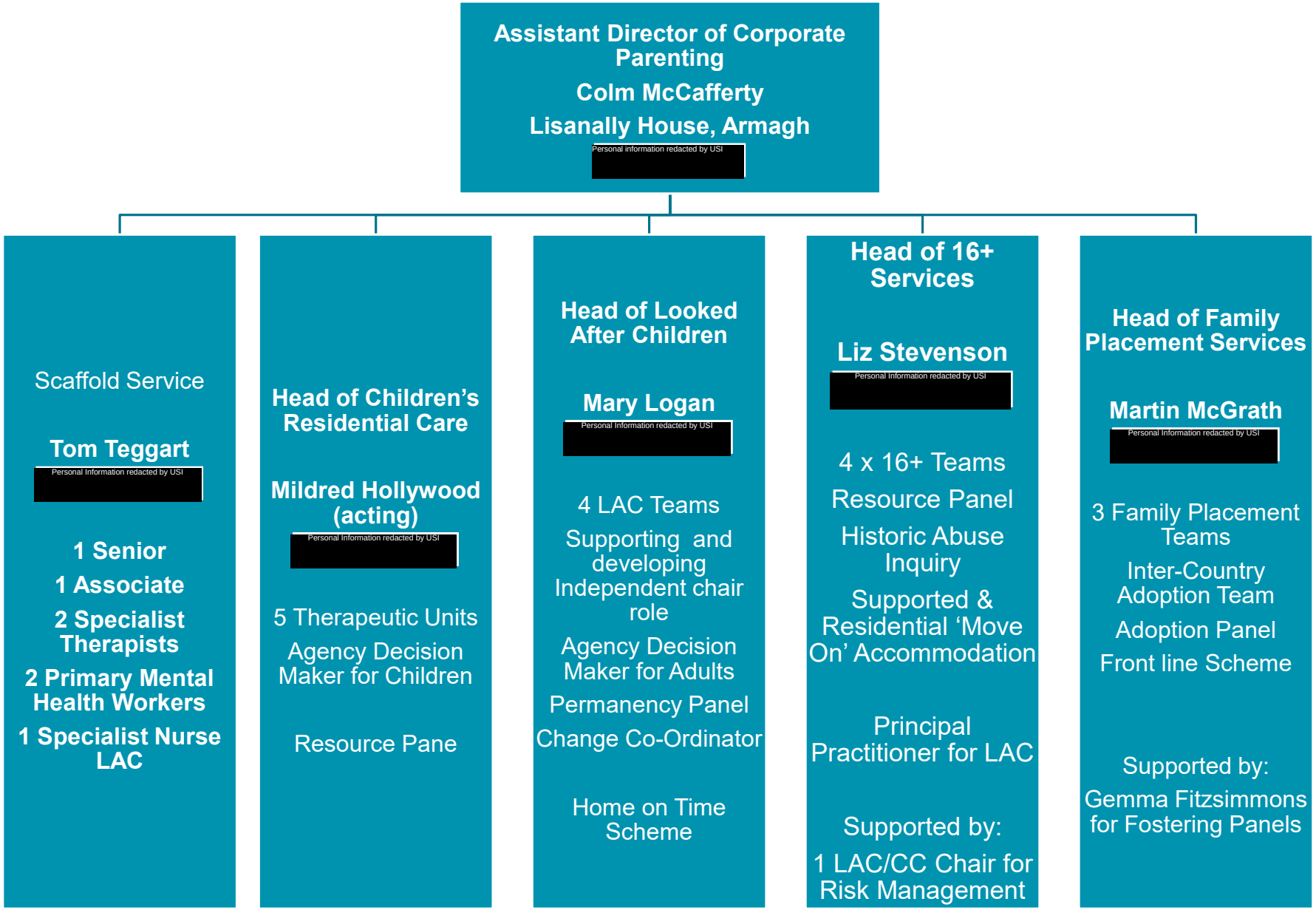

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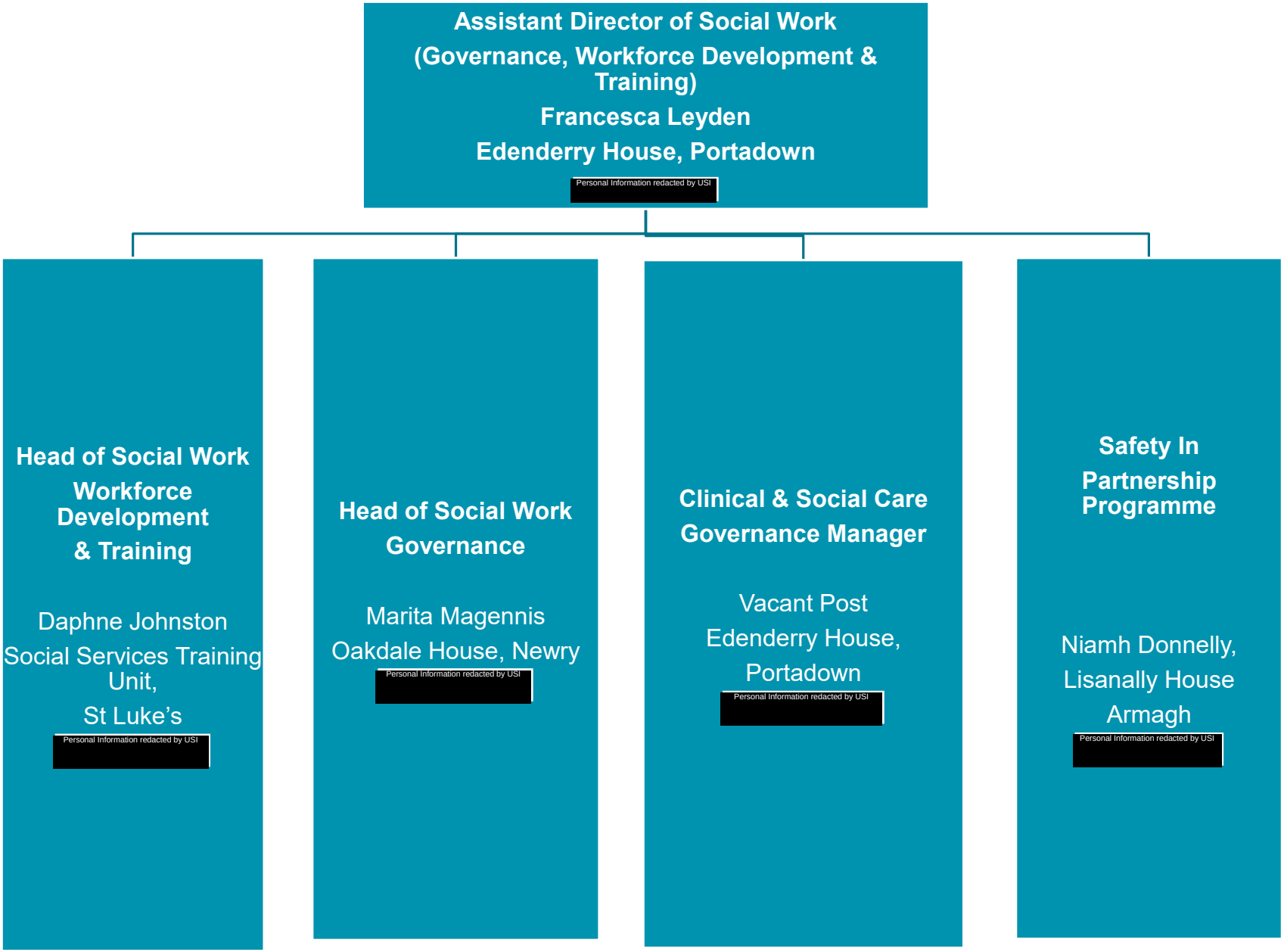
Children & Young Peoples Services Directorate



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Directorate of Mental Health and Disability

DIRECTORATE OF MENTAL HEALTH & DISABILITY

INTERIM DIRECTOR OF MENTAL HEALTH & DISABILITY SERVICES
Carmel Harney, Bannvale House
Personal Assistant: Mrs Tracy Griffin Personal Information redacted by USI

Assistant Director Mental Health Services (Acting)
Adrian Corrigan
Personal Information redacted by USI

Assistant Director Disability Services
Miceal Crilly
Personal Information redacted by USI

Head of Psychology
Dr Ivor Crothers
Personal Information redacted by USI

Associate Medical Director
Dr Neta Chada
Personal Information redacted by USI

Clinical Director General Adult Psychiatry
Dr Pat McMahon
Personal Information redacted by USI

Clinical Director Learning Disability and Physical/Sensory Disability
Dr Arun Subramanian
Personal Information redacted by USI

Assistant Dir Human Resources
Jenny Johnston
Personal Information redacted by USI

Senior Financial Management Accountant.
Johnny McMahon, Lurgan Hospital, Personal Information redacted by USI

Head of Planning
Janet McConville
Rosedale, Personal Information redacted by USI

Performance & Reform
Paula Tally
Personal Information redacted by USI

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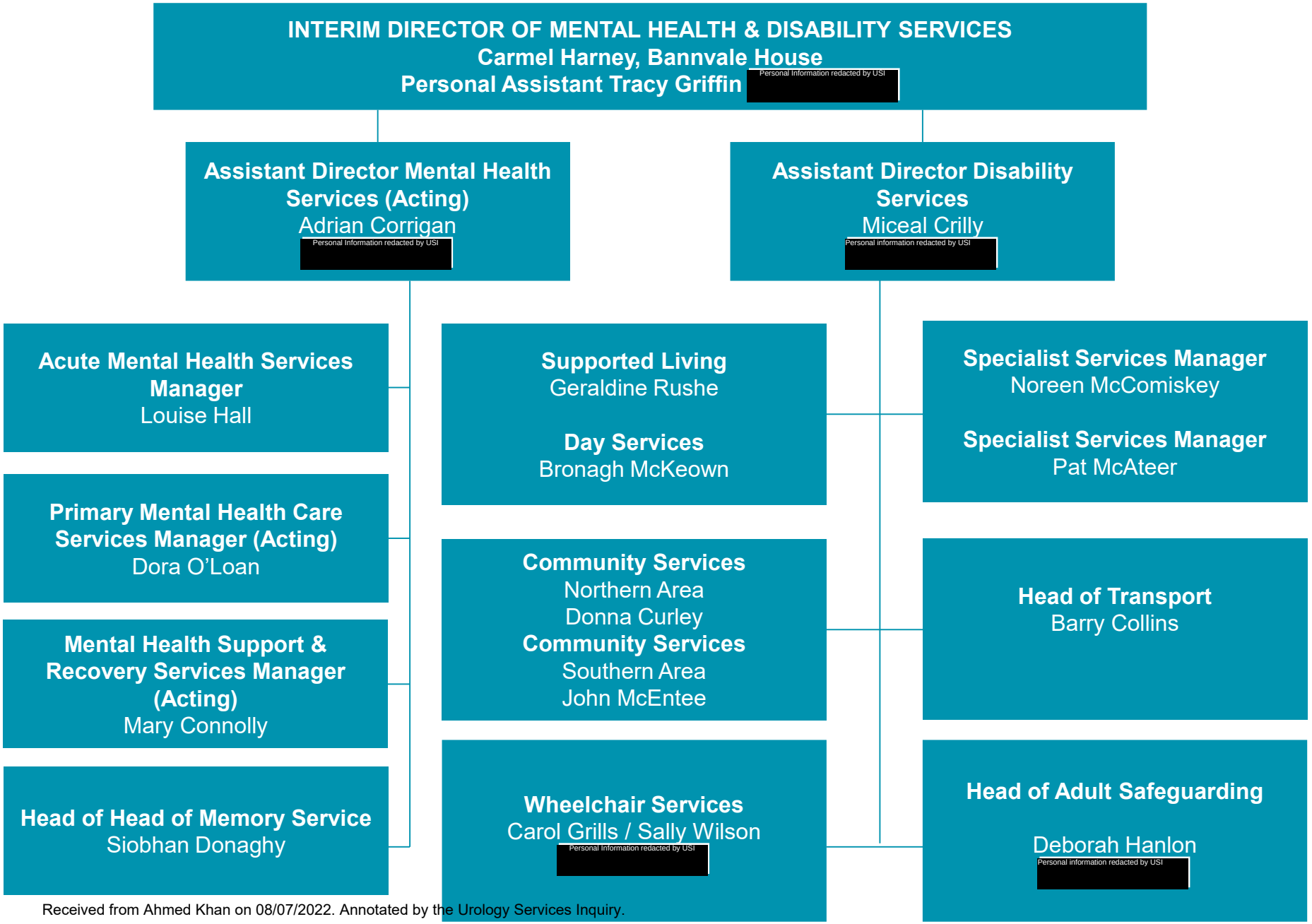

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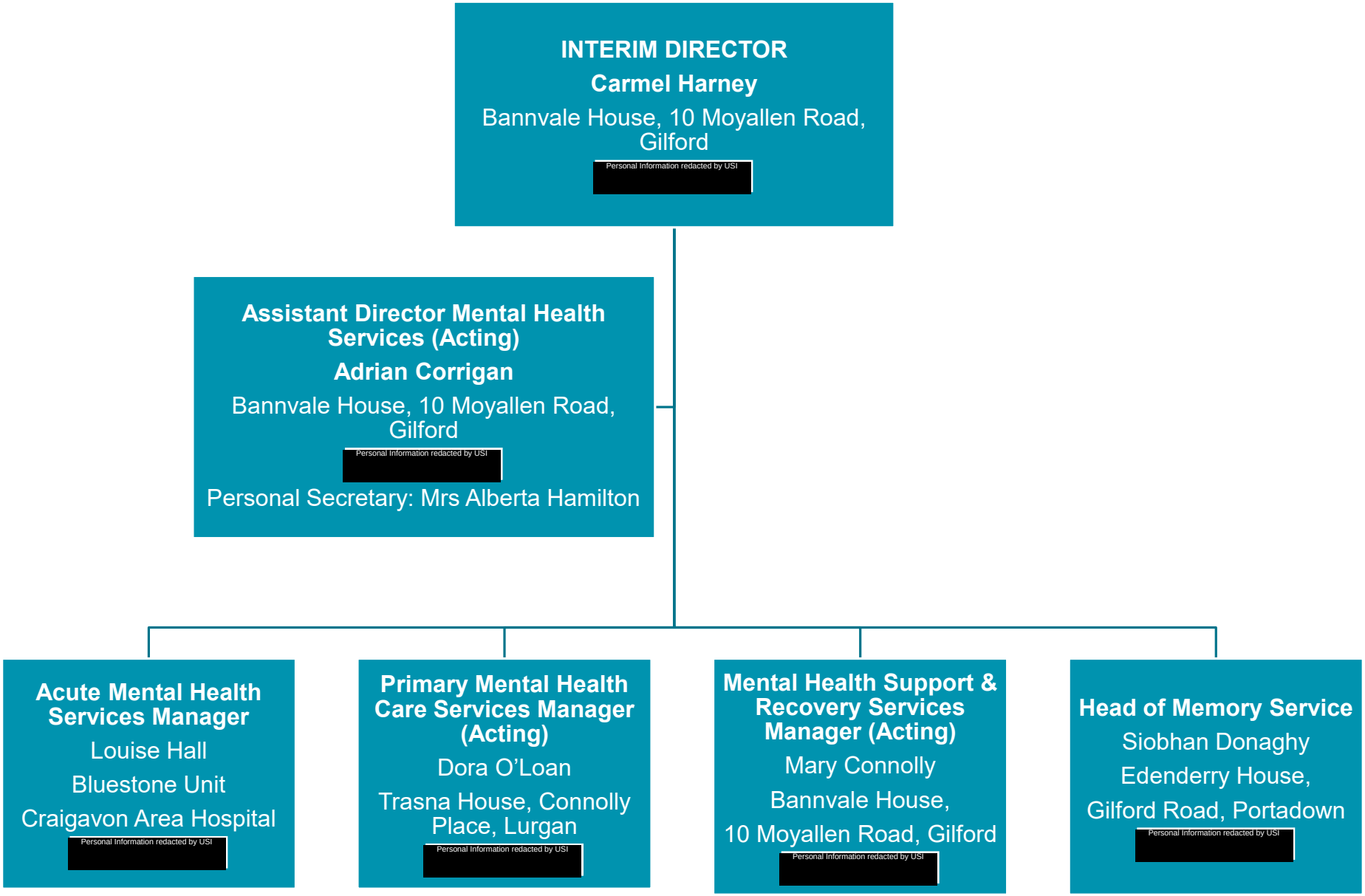
Mental Health Division



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DIRECTOR OF MENTAL HEALTH & DISABILITY SERVICES (ACTING)
Bryce McMurray, Bannvale House
Personal Assistant Tracy Griffin Personal Information redacted by USI

Assistant Director Disability Services
Miceal Crilly
Bannvale House, 10 Moyallen Road, Gilford
Personal Information redacted by USI
Personal Secretary: Mrs Jill Duffy

Supported Living
Geraldine Rushe
Personal Information redacted by USI

Day Services
Bronagh McKeown
Personal Information redacted by USI

Community Services
Northern Area
Donna Curley
Personal Information redacted by USI

Community Services
Southern Area
John McEntee
Personal Information redacted by USI

Wheelchair Services
Carol Grills / Sally Wilson
Personal Information redacted by USI

Specialist Services Manager
Noreen McComiskey
Personal Information redacted by USI

Specialist Services Manager
Pat McAteer
Personal Information redacted by USI

Head of Transport
Barry Collins
Personal Information redacted by USI

Head of Adult Safeguarding
Deborah Hanlon
Personal Information redacted by USI

Directorate of Finance and Procurement

Directorate of Finance and Procurement

Acting Director
Helen O'Neill
SHSCT HQ
Personal Information redacted by USI

Personal Assistant
Sandra Gilmore
SHSCT HQ
Personal Information redacted by USI

Assistant Director: Financial Services
Alison Rutherford
Lurgan Hospital
Personal Information redacted by USI

Secretary: Kim Anderson
Personal Information redacted by USI

Acting Assistant Director: Financial Management
Carol Cassells
Lurgan Hospital
Personal Information redacted by USI

Secretary: Kim Anderson
Personal Information redacted by USI

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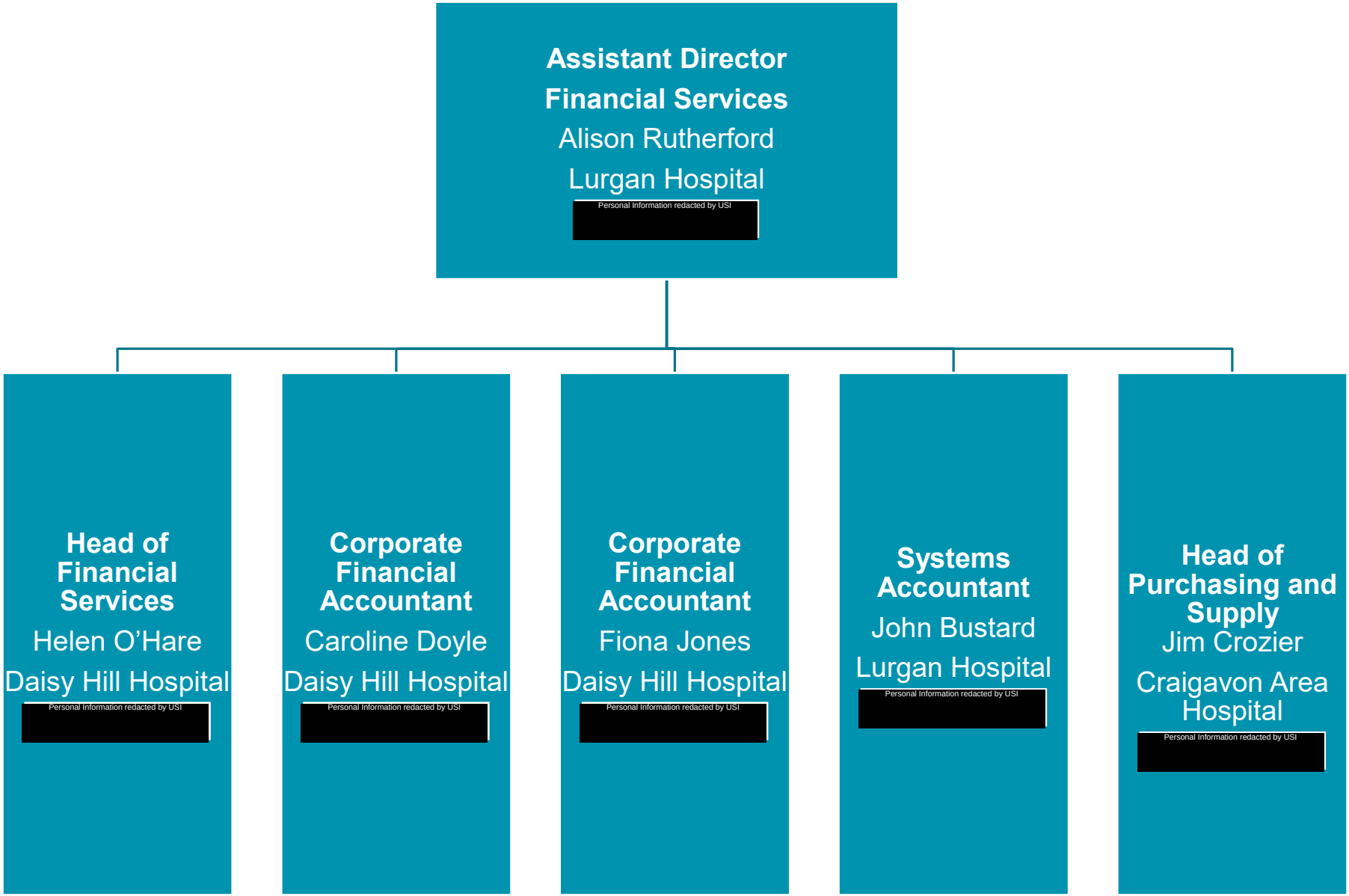
Directorate of Finance and Procurement



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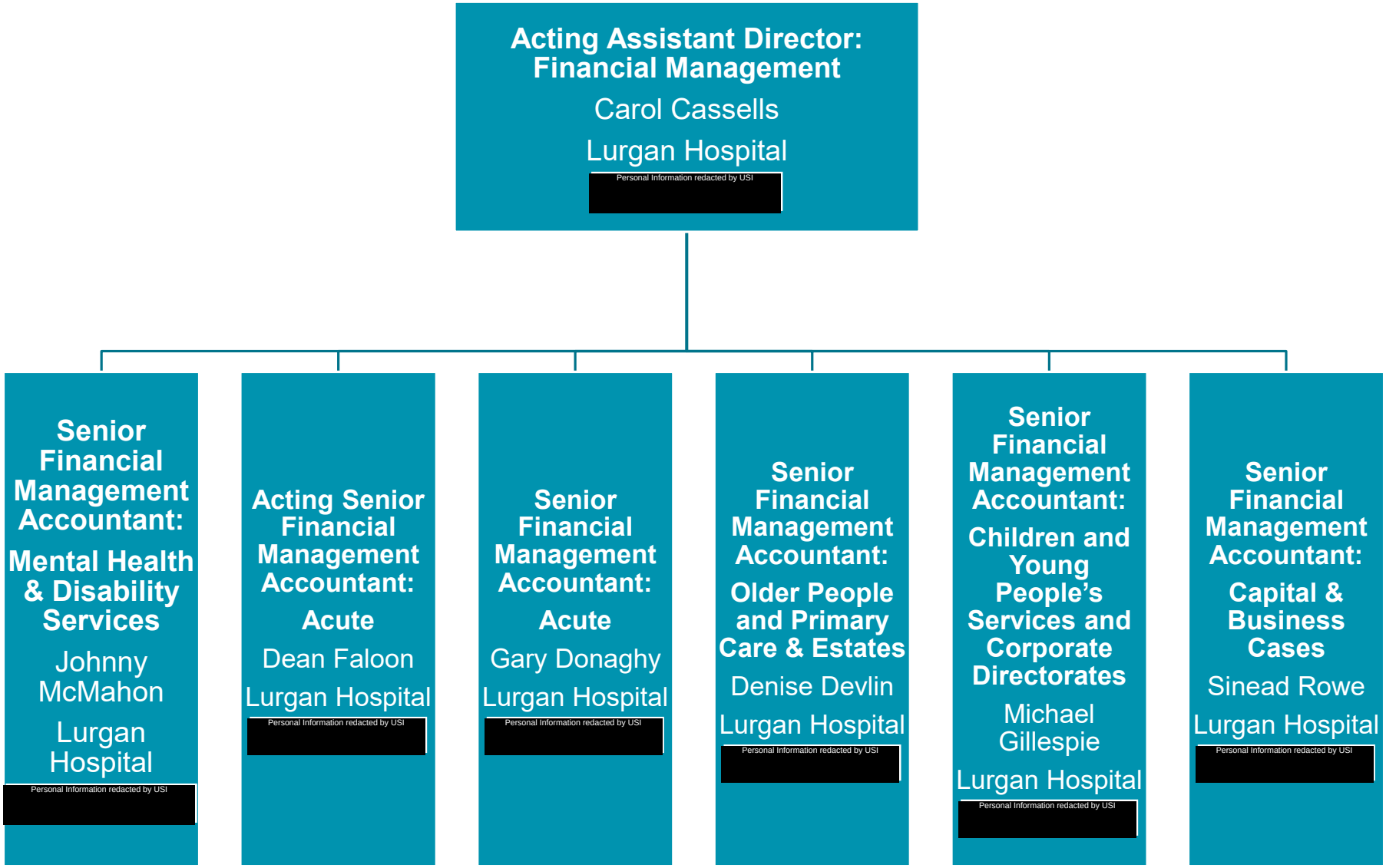
Directorate of Finance and Procurement



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Directorate of Performance and Reform

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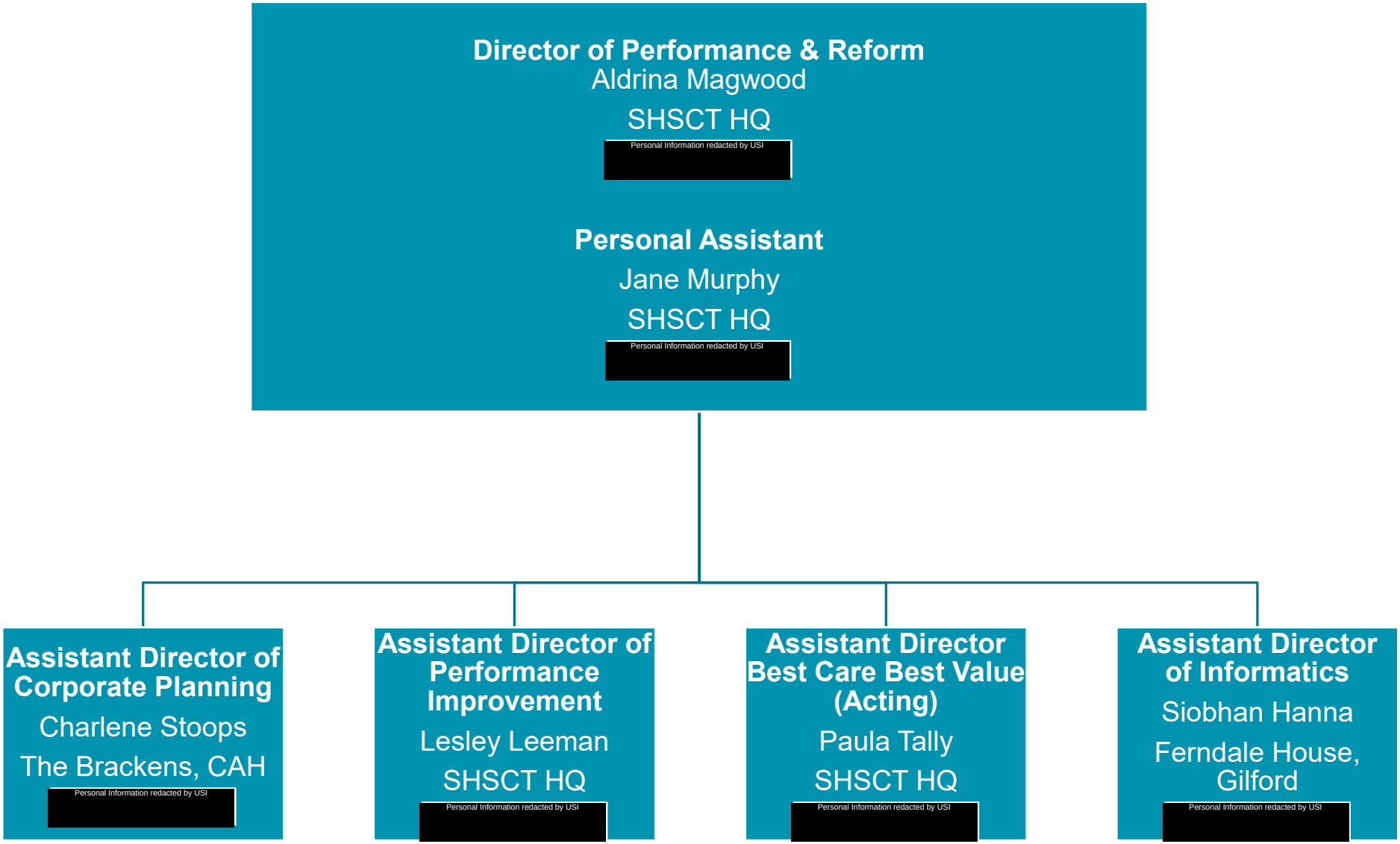

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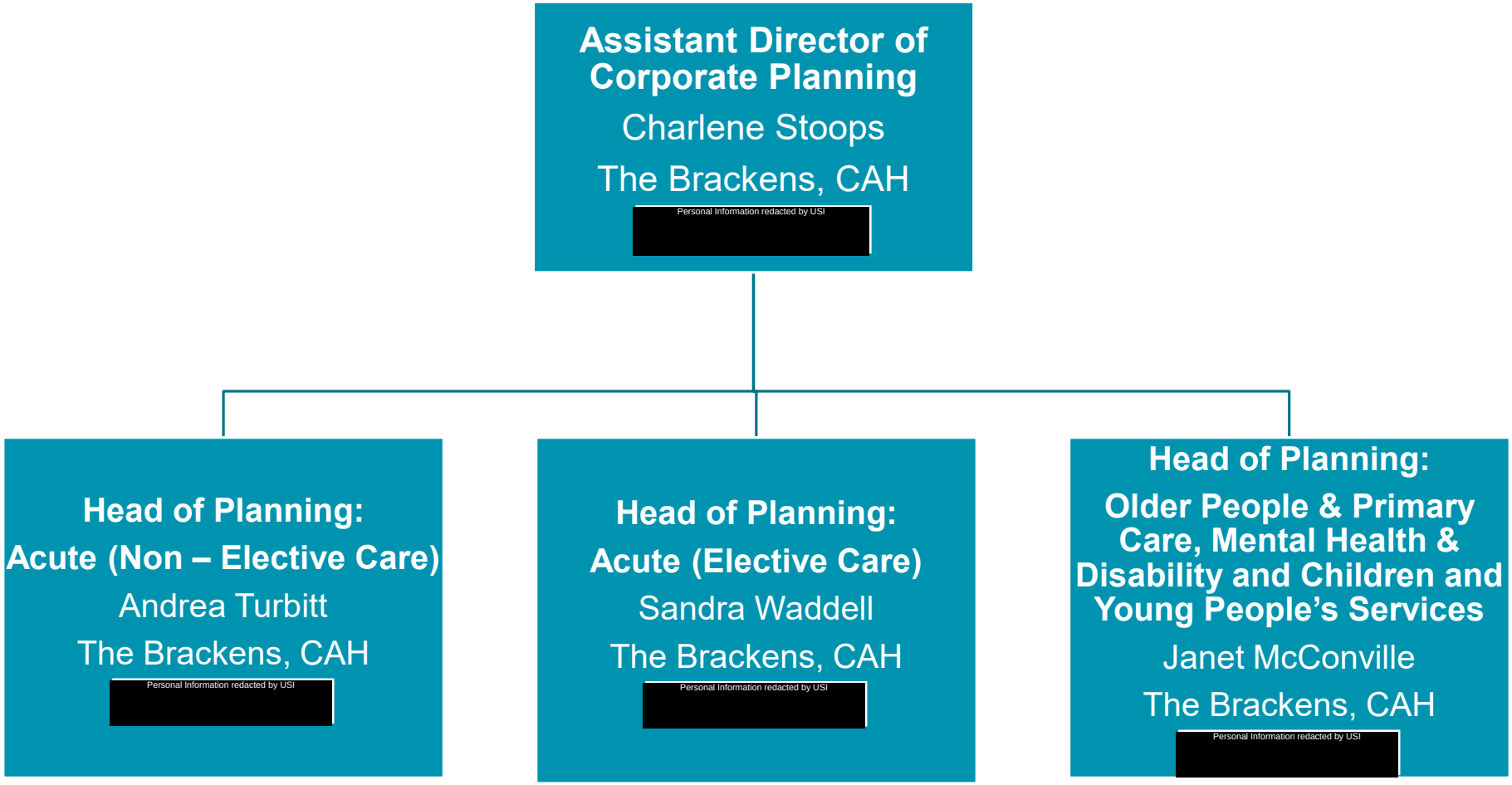

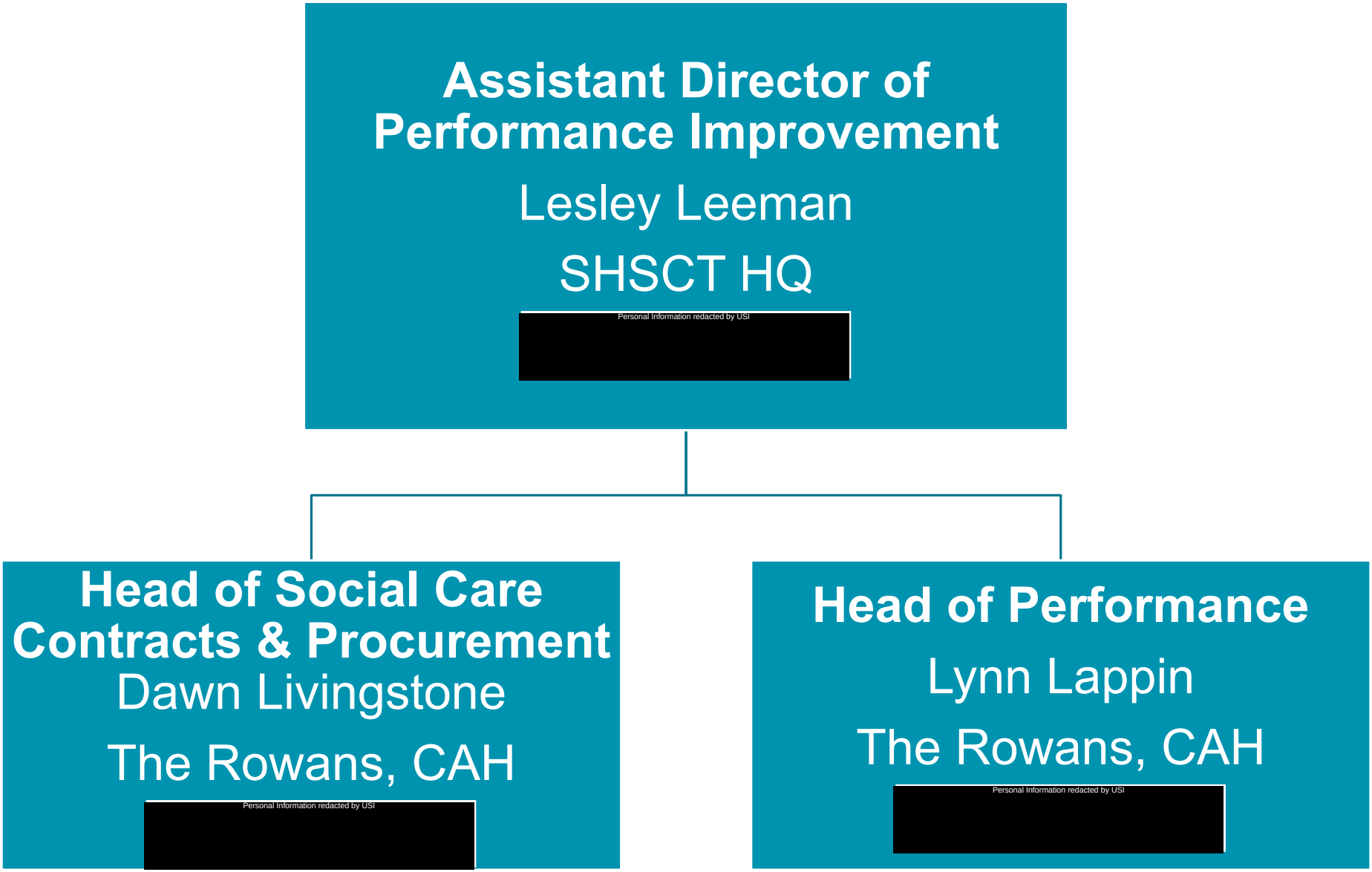

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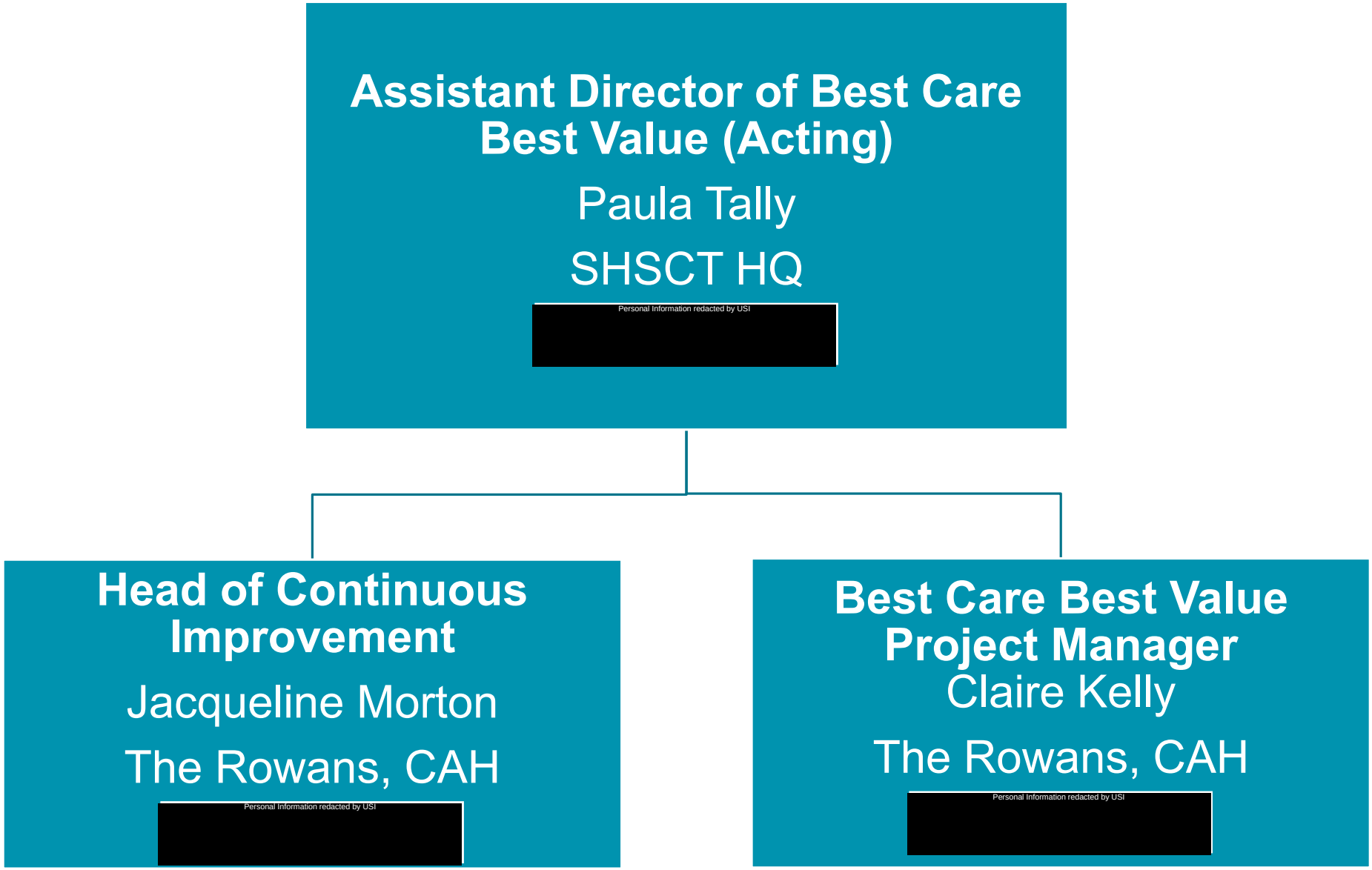

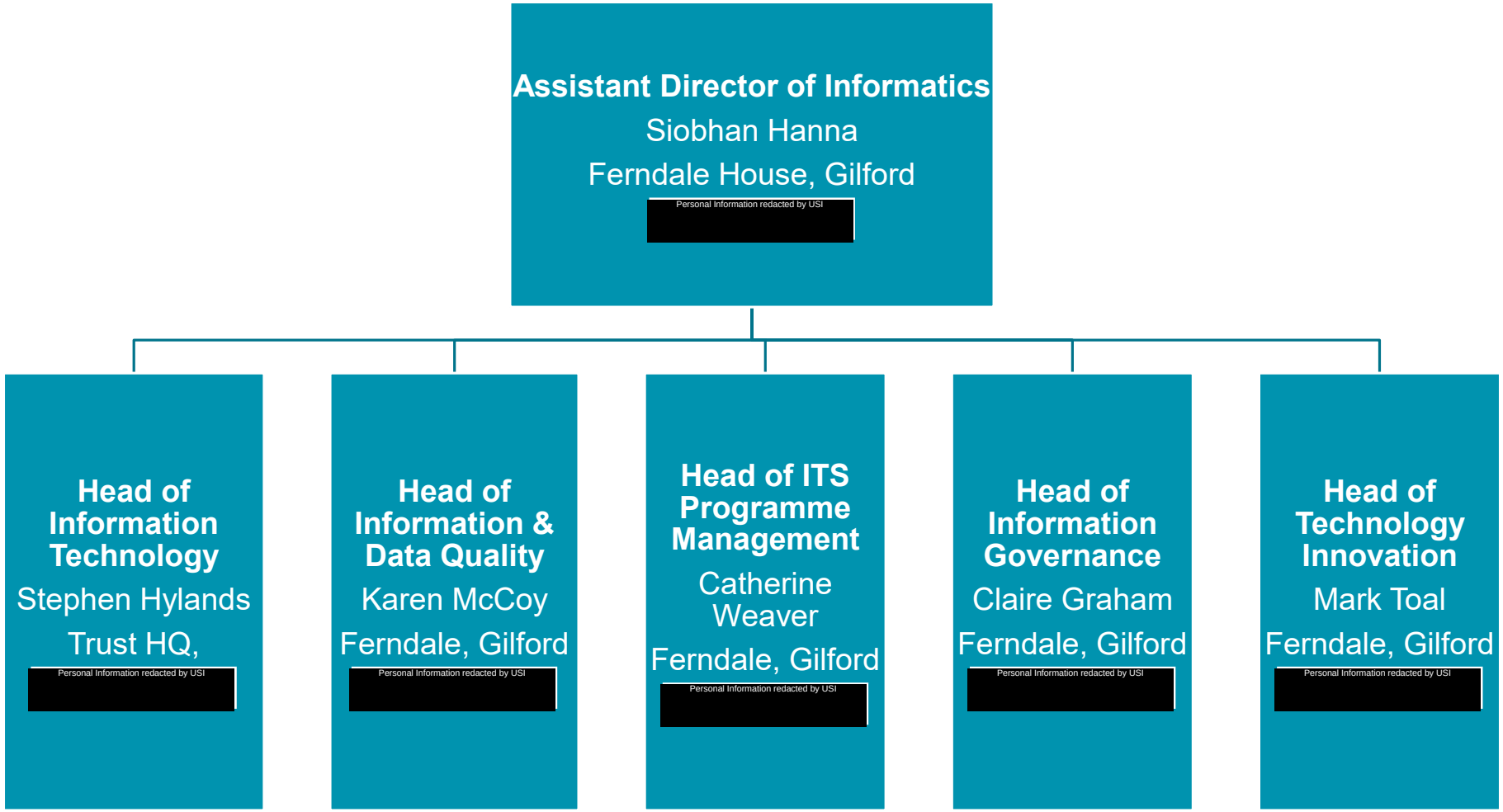

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Directorate of Human Resources and Organisational Development

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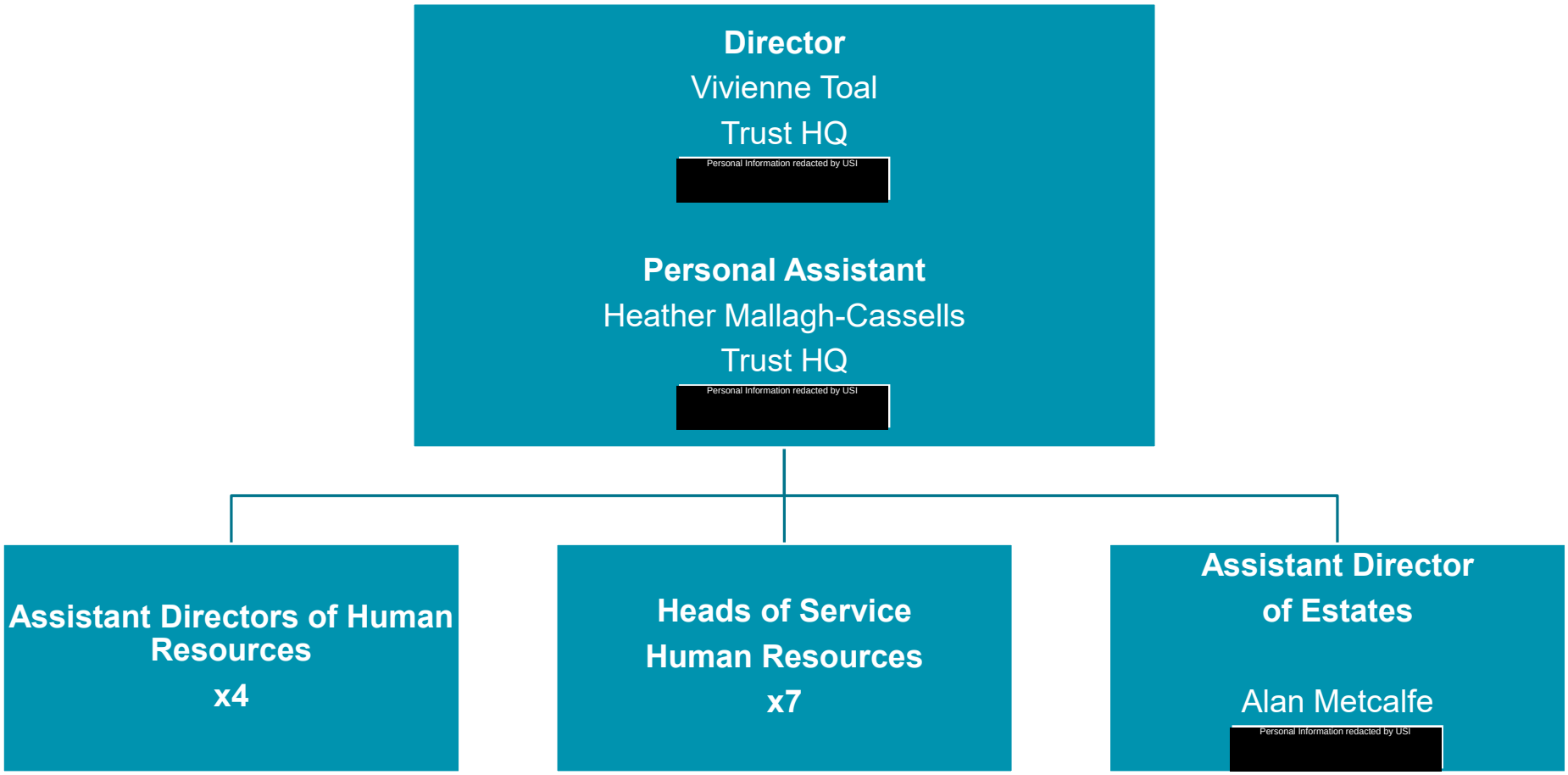

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Directorate of Human Resources and Organisational Development

Director
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Trust HQ

Assistant Director of Human Resources:
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Helen Walker
CAH
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Assistant Director of Human Resources:
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Assistant Director of Human Resources:
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Jenny Johnston
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Assistant Director of Human Resources:
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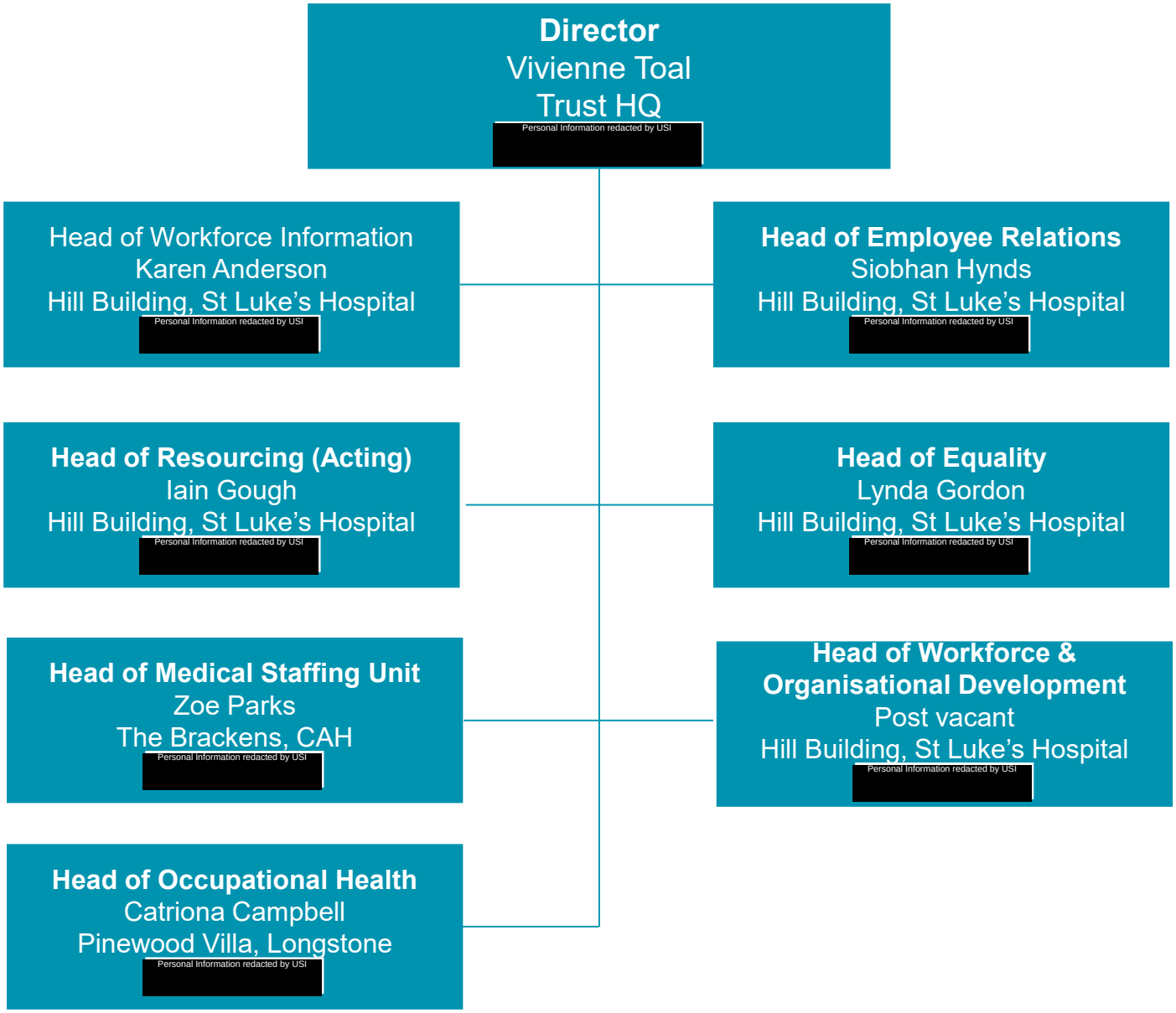
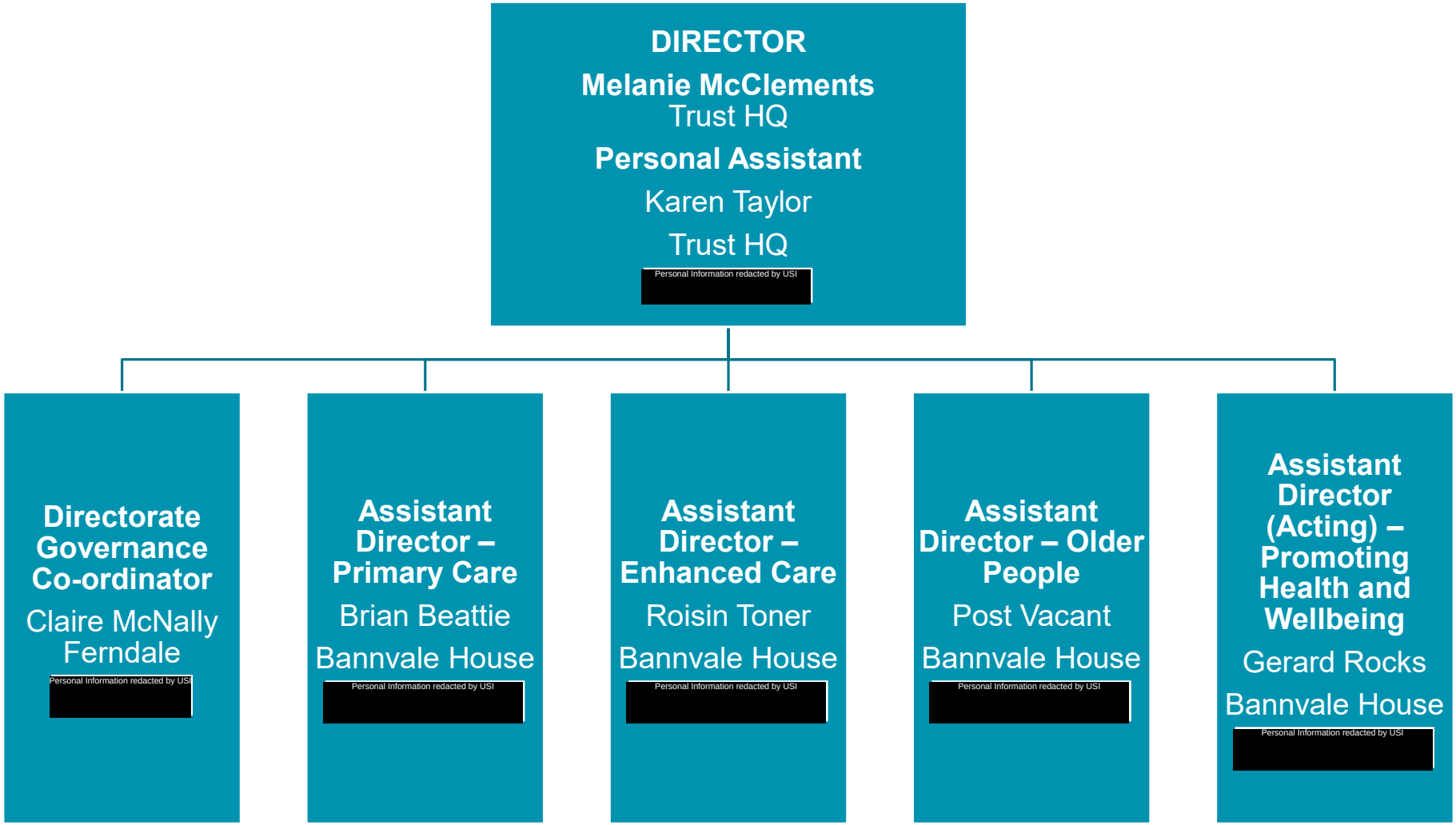
Directorate of Human Resources and Organisational Development



Directorate of Older People and Primary Care

Directorate of Older People & Primary Care



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Primary Care Division

ASSISTANT DIRECTOR
Brian Beattie
Bannvale House
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Head of Physiotherapy
Teresa Ross

Head of Podiatry
Denise Russell
(Acting)

Head of Occupational Therapy, Community Equipment Store & Re-ablement
Brenda Byrne

Head of Integrated Care Teams
Monica McAlister

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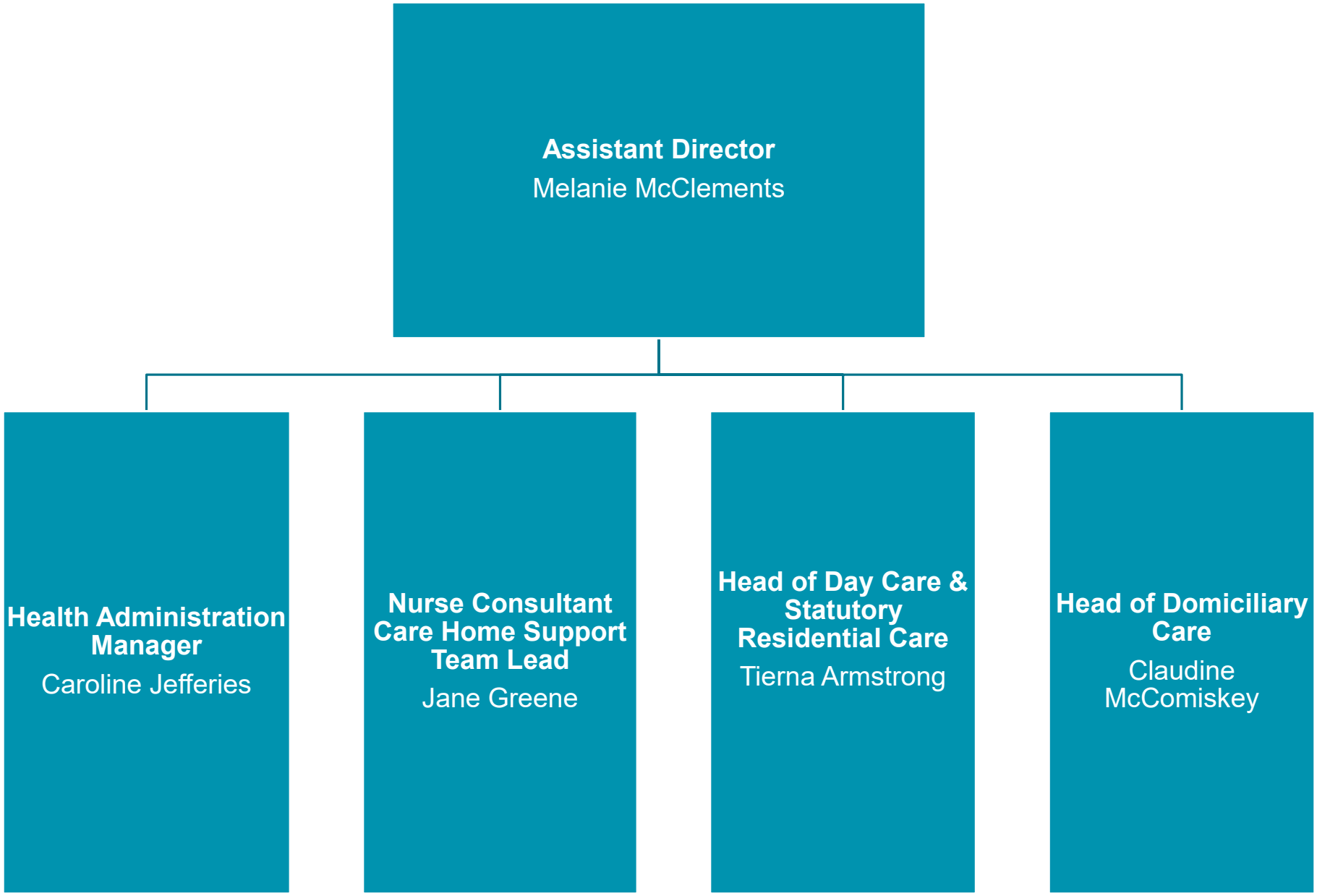
Older Peoples Division



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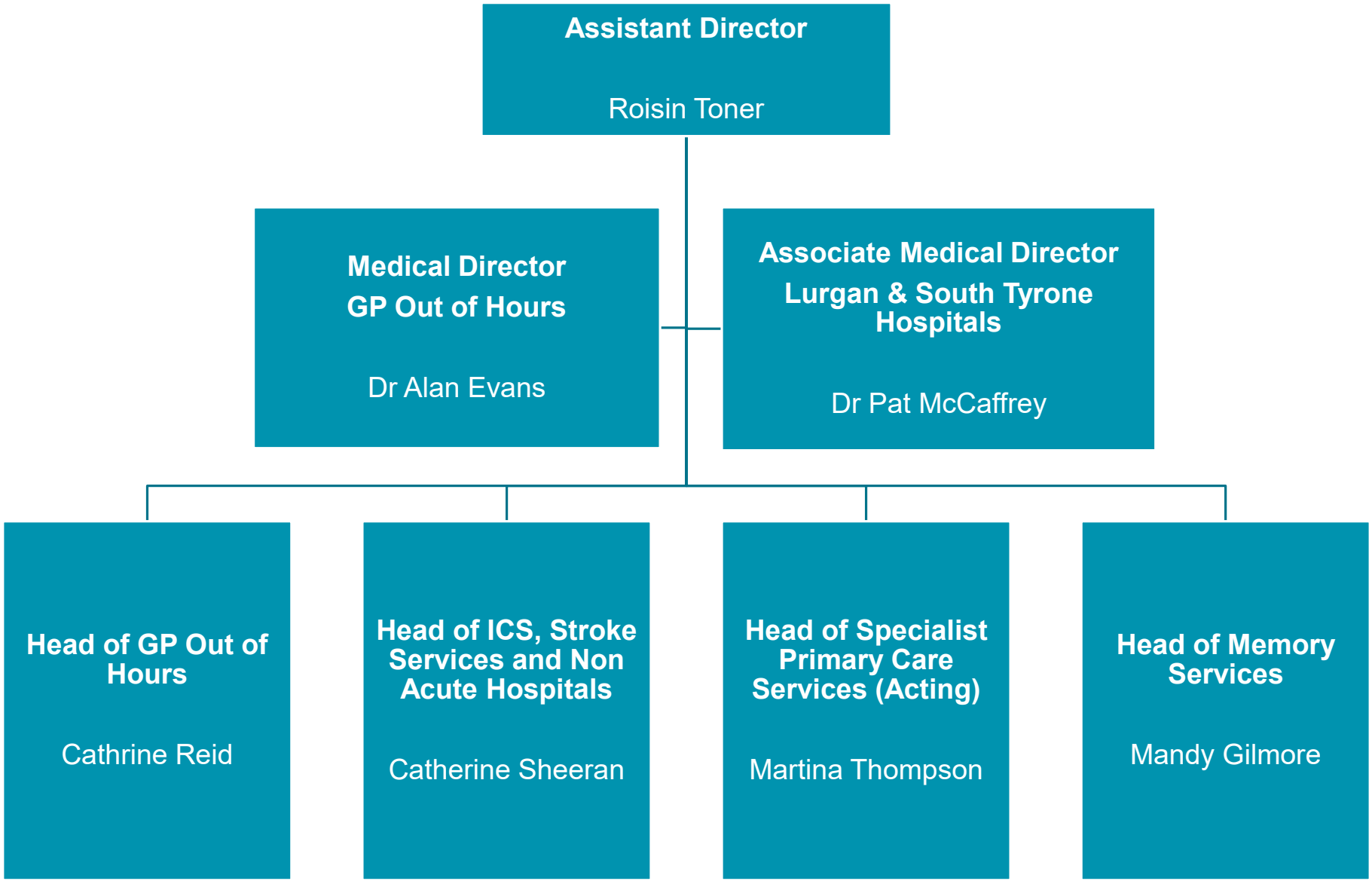
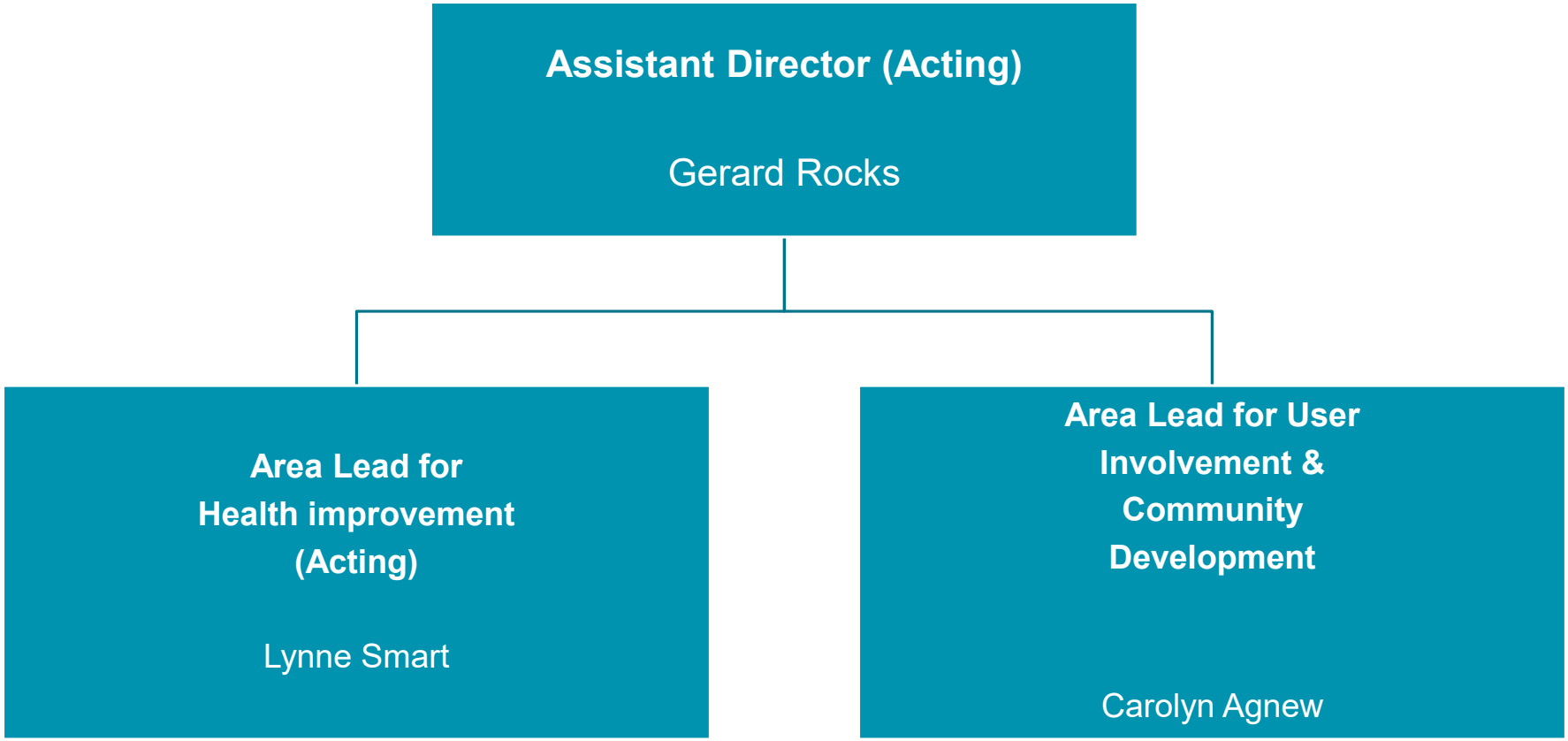
Enhanced Care Division





Medical Directorate

Medical Directorate

MEDICAL DIRECTOR
Dr Richard Wright
Personal Assistant
Laura White [redacted]

ASSISTANT DIRECTOR
Simon Gibson
Ruth Montgomery
Administrator [redacted]

Infection Control
Colin Clarke

- Dr Martin Brown
- Margaret Markey
- Josie Matthews
- Kate Kelly
- Annette O'Hara
- Barbara Soye
- Elizabeth Rennie
- Douglas Barbieri (in CAH)

Project Managers
Stephen Wallace

- Roisin Feely (DHH) (maternity leave)

Research & Development
Irene Knox

- Valerie Hamilton
- Mairead McAreavey (in CAH)

Medical Education
Kelly Jones

- Lenore Peile
- Eoin Daly (in CAH)
- Sonia Ferris
- Siofra McSherry (in DHH)

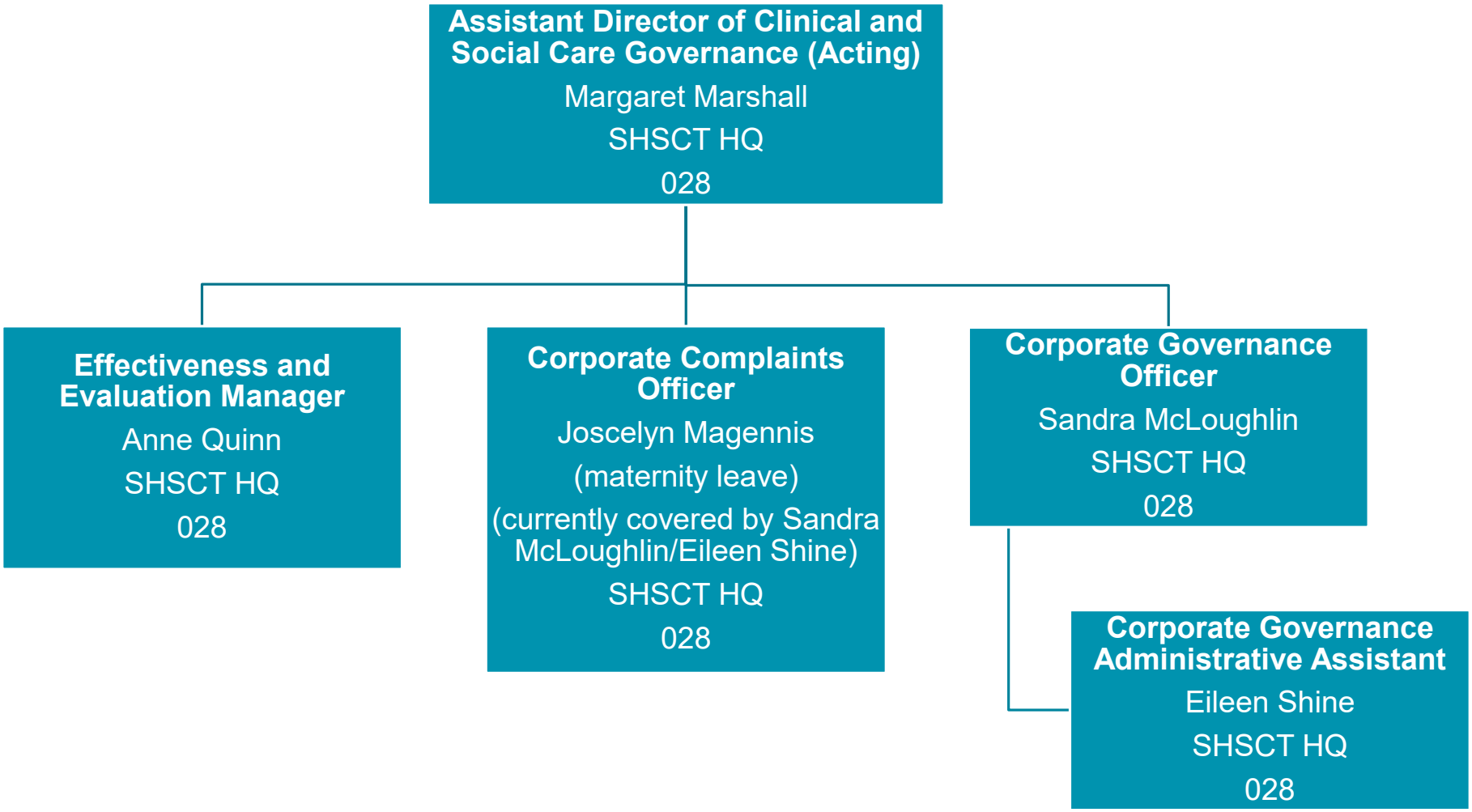
Revalidation Manager
Norma Thompson

- Katie Shields
- Patrick Morrison (in DHH)
- Diane Davidson
- Elizabeth McCreary (in CAH)

Emergency Planning
Teresa Cunningham

- Ann Corvan (in DHH)

Medical Directorate



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Southern Health and Social Care Trust
Quality Care - for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board Meeting 30th August 2018
Title:	Annual Report 2017-2018 Medical Appraisal and Revalidation
Lead Director:	Dr Ahmed Khan, Interim Medical Director
Corporate Objective:	Safe, high quality care Valuing our staff
Purpose:	For Approval

Summary of Key Issues for Trust Board

High Level Context:

This Annual Report summarises the work undertaken by the Revalidation Team to ensure Consultants, SAS Doctors and Long Term Locums continue to meet the requirements of Medical Appraisal and Revalidation as per General Medical Council (GMC) requirements. The first five year cycle of revalidation has ended and the second cycle is currently underway. This report also highlights the wide number of initiatives put in place to support the medical workforce.

Key Issues:

- First 5 year Medical Revalidation Cycle completed successfully
- Second cycle of Medical Revalidation commenced
- 2016 Appraisal Round achieved 100% completion
- 2017 Appraisal Round currently in progress – 63% complete which is higher

Summary of SMT challenge/discussion:

- It was identified that the planned move to the proposed Regional Electronic Medical Appraisal System (currently being developed) may have impact on completion levels during implementation
- It was noted that there were benefits in linking appraisal objectives into the job planning processes which needed to be maximised

Internal/External engagement:

Engage with Medical Appraisers twice per year (Appraisal and Revalidation Strategic Group) to ensure they are fully aware of Medical Appraisal and Revalidation requirements. Appraisal training has also taken place with the medical workforce and Medical Appraisers.

Also engaged with medical staff in relation to subject areas for medical leadership and development days and ELD / HSC Leadership colleagues in relation to the AMD/CD Development Programme which has now been rolled out to Consultant and SAS Doctors.

Contents

1. Medical Appraisal and Revalidation

1.1 Introduction

All medical members of staff are required to undertake an annual medical appraisal which covers their whole practice. The Trust currently employs 228 Consultants and 117 SAS Grades and also has approximately 22 long term agency locums for whom it currently undertakes appraisal.

The Trust achieved 100% completion rates for the 2016 medical appraisal round (January to December 2016) and the January to December 2017 medical appraisal round commenced in April 2018 as all of the supporting information for appraisal became available to the Revalidation Team to issue to individual doctors.

1.2 Current Appraisal Status

As of 16th August 2018, the status for the January to December 2017 medical appraisal round is as follows with monthly reminders being issued to individual doctors:

Directorate / Division	No. of Eligible(1) Doctors	2017 Appraisals Completed / In Progress(2)
Children & Young People's Services	51	73%
Mental Health & Learning Disability	26	62%
Anaesthetics, Theatre & ICU	42	67%
Surgery & Elective Care	62	34%
Cancer & Clinical Services	38	66%
Medicine & Unscheduled Care	91	70%
Integrated Maternity & Women's Health	29	72%
Emergency Medicine	28	58%
TOTAL	**367**	**63%**

Table 1: 2017 Medical Appraisal Status as at 16th August 2018

(1) Eligible means those that are with the Trust six months or more during the appraisal year and who qualify to undertake a full appraisal otherwise an Appraisal Induction is completed (see para 1.3).

(2) Complete / In progress means the appraisal is either fully completed and signed off, or is underway and is awaiting final sign-off.

1.3 Appraisal Induction

As part of an induction process, all new medical employees to the Trust on either permanent or temporary contracts and who are expected to have six months or more service, are required to complete an appraisal induction three / four months after commencing employment. The appraisal induction includes a review of previous NHS appraisals (if available); the development of a Personal Development Plan; an assessment of any complaints or incidents for the period the staff member has been working for the Trust; and completion of Health, Probity and Insurance declarations. As a

further part of this induction process, a short meeting is arranged for all new permanent medical staff with the Medical Director or Corporate Lead for Appraisal Revalidation during which various support initiatives are outlined to them i.e. the role of the Revalidation Team, the Trust's Medical Mentoring Scheme, the availability of the opportunity to job-shadow a non-clinical manager for a half day and the various Medical Leadership and Development events that they can avail of.

1.4 Appraisers

Currently, the Trust has 72 trained Medical Appraisers across all specialities within the Trust which also includes 16 SAS Appraisers who undertake appraisals of both SAS and Consultant colleagues. Each appraiser is expected to undertake 5 appraisals each per calendar year and protected time is allowed for them to undertake this role. Appraisees are also encouraged to seek an appraiser from outside their specialty.

1.5 Quality Assurance of Medical Appraisal

The Trust's Revalidation Team continue to oversee the quality of the medical appraisal process and review all appraisal documentation received into the Medical Director's Office to ensure there is sufficient evidence of appropriate supporting information, discussions and actions agreed. Where gaps are identified, the appraisal documentation is returned to both the appraiser and appraisee asking them to address the specified areas and resubmit the documentation for final approval. To date, the standard of medical appraisal within the Trust is extremely high and very few (less than 2%) of appraisal forms have been returned for resubmission.

1.6 Medical Appraisal and Revalidation Training

The total number of medical staff trained in the Trust's medical appraisal processes and the General Medical Council's (GMC) revalidation requirements is now 373 as at the end of 2017-2018. It is planned to hold one 'mop-up' session each year in recognition that almost all doctors should now be familiar with the requirements for both medical appraisal and revalidation. One further training session for new Medical Appraisers was held in April 2018 in recognition that some appraisers had left the Trust or relinquished the role and a further one will be held early 2019.

1.7 Medical Revalidation

To date (16th August 2018) all 322 doctors that have a GMC connection with the Trust have successfully revalidated during the first five year cycle which ended in March 2018. The second five year cycle is well under-way and there are approximately 65 doctors revalidating between 1 April 2018 to 31 March 2019, each of whom have been issued with all of their supporting information for revalidation and have been, or are in the process of being, registered for Patient and Colleague Feedback.

All doctors receive one to one support and advice during their revalidation process. This includes the provision of checklists and supporting documents required for revalidation, two face-to-face meetings, i.e. initial revalidation meeting and sign-off revalidation meeting to ensure the doctors meet both Trust and GMC standards for revalidation before a recommendation can be made by Medical Director to the GMC.

1.8 Appraisal and Revalidation Leads

After the retirement of Dr Joan McGuinness in June 2018, Dr Damian Scullion, Consultant Anaesthetist assumed the Corporate Appraisal and Revalidation Lead role. He was previously the Consultant Appraisal and Revalidation lead. Through an appointment process, Mr Robin Brown, Consultant Surgeon was appointed to the vacant role of Consultant Appraisal and Revalidation Lead.

1.9 Development of Regional Electronic Medical Appraisal System

The Head of Revalidation participates on a Regional Group tasked with developing a Regional Electronic Medical Appraisal System to be used by all five Trusts. The system is currently undergoing rigorous testing by Regional Group members with a view to it being rolled out to Trusts from October 2018 and implemented within the Southern H&SC Trust by January 2019. This will be resource intensive for the Revalidation Team in terms of developing an e-learning module, delivering practical 'hands-on' training and general support to the Trust's medical workforce who have been advised that the introduction of a fully electronic appraisal system is imminent.

2. Medical Leadership and Development Training

2.1 General Training

As per previous years, during 2017-2018 a number of Medical Leadership and Development Events were held for Consultants and SAS Doctors with input to these from the GMC, Medical Defence Union (MDU) and Trust staff. Feedback from the events has been extremely positive and it is planned to hold further events during 2018-2019.

2.2 Roll Out of Medical Leadership and Management Development Programme to Consultants and SAS Doctors in 2018

Early 2017 saw the launch of the newly established Development Programme for Associate Medical Directors and Clinical Directors. As a result of the positive feedback and in order to facilitate succession planning for medical staff within the Trust, this programme was rolled out to Consultants and SAS Doctors early 2018 – click here for the brochure and detail of each module. A second cohort has been planned for October to December 2018 and twice each year thereafter.

2.3 Fourth Regional SAS Conference

In recognition of the huge success of the first three regional SAS Conferences, a fourth event entitled "SAS Doctors – Leading the Way: Your Career, Your Choices" was held on 26th April 2018 in the Seagoe Hotel, Portadown. Speakers included Mr Charlie Massey, Chief Executive and Registrar of the GMC, along with staff from the Southern Trust and other Trusts across the region. Over 140 SAS Doctors attended the conference which, once again, received very positive feedback (click here for this year's and the previous three year's Conference Evaluation Reports – password 2012 if asked).

2.4 Medical Mentoring Scheme

A Medical Mentoring Scheme was launched in December 2015 and the Trust now has 13 trained Mentors. To date, the uptake of a Mentor by the existing workforce has been low. However, all new permanent medical staff are expected to avail of a Mentor during their first six months employment with the Trust and this is actively encouraged by the Revalidation Team. Feedback from Mentees has been extremely positive with all of them reporting that they felt they had benefitted significantly from having a Mentor. The Revalidation Team will continue to promote the Trust's Medical Mentoring scheme for existing and new medical staff.

3. Professional Governance Issues

The Medical Director's Office continues to respond to all professional governance issues for medical staff and there are quarterly Employer Liaison meetings with the GMC Northern Ireland office.

ONE DIRECTION – Ten Steps to Success

Meaningful Job Planning for Consultants and SAS doctors working with the Southern Health and Social Care Trust

July 2018

R E R Wright

Version 3

18th July 2018

ONE DIRECTION -10 steps forward

Meaningful Job planning for Consultant and SAS doctors working with the Southern Health and Social Care Trust

Context

Since the introduction of the 2003 Consultant Contract a regular annual job plan review has been recommended to maximise opportunities for the Trust and the doctor to work together to provide effective patient care. Participation in the process is both a professional and contractual obligation. Job planning in NI has traditionally been based upon a number of key documents such as the *Step by Step guide for Consultants in Northern Ireland*- BMA(Last updated June 2016) , BMA *Job planning for Staff and Associate Specialist and Specialty doctors: Introduction* (Last updated February 2017). In addition The Southern HSC Trust recently commissioned an internal Audit of the Job Planning process, *SHSCT-Management of Consultant Medical Staff 2017/18* (April 2018) which has highlighted a number of areas for improvement. Within the UK NHS Improvement has produced a highly relevant paper entitled *Consultant Job planning: a best practice guide* (July 2017).

In addition, the SHSCT is keen to improve the delivery of the job planning process and the effectiveness relevance of job planning for both the doctor and the Trust. This paper incorporates the best practice described in these papers, outlining specifically how the Trust will address the job planning challenges over the next few years keeping the delivery of care to our patients and clients as its main focus. It will also address the specific terms of reference set out below as outlined by the Chief Executive.

Terms of Reference

1. Improved Engagement with Doctors resulting in a high percentage of contemporaneously agreed meaningful job plans that address the Trust , the Doctor's and most importantly the patients' needs
2. Improved compliance with internal Audit job planning recommendations
3. Improving attractiveness of SHSCT as an employer of medical staff thus improving recruitment and retention
4. Sustainability of process

Methodology

A review of the current relevant published documents as outlined above was undertaken. Note was taken of views expressed at the job planning review group together with individual discussions with a range of AMDs CDs Ads Directors and Medical HR staff.

Principles underpinning the job planning process

- The job plan should be developed in a spirit of partnership
- It should be a prospective agreement setting out duties, responsibilities and objectives
- It should cover all aspects of professional practice
- It may be modelled wholly or partly on the previous year's plan
- The plan may be wholly or partly be team based
- It should include local, regional or national objectives
- It should include personal objectives
- Resources and support required are agreed and stated
- The process is separate from, but linked to appraisal

Current Trust Position

The job planning process and guidance will ideally be approved in conjunction with the BMA Local negotiating Committee (LNC) in the spirit of collaboration and mutual respect. It is important to create the right climate by adopting a non-threatening partnership approach rather than a coercive one. Trust job planning guidance should be applied fairly and consistently. The current updated guidance is with LNC for consideration at present. This process may take several months, however this should not hold up further improvements to the job planning process as outlined below.

An active process of engagement with AMDs , CDs ,Ads and medical staffing is ongoing in a bid to drive the current years job planning process as far as is possible within the current system and good progress is being made with a high level of engagement.

Job Planning and Appraisal

Although job planning and medical appraisal inform each other, they should be separate processes. Doctors have told me that they currently feel a disconnect between the two processes. The previous doctors' appraisal should be made available to the Clinical Director(CD) or other job planner who should be aware of the contents and in particular the Personal Development plan (PDP) prior to the JP meeting. This will require cooperation between the appraisal team and the medical workforce job planning team, however, the introduction of the new on line doctor appraisal system in 2018 should make this technically much easier with only minimal additional administration time. It is a shared responsibility of the job planner and the individual doctor to bring relevant appraisal issues to the job planning discussion

- **Recommendation 1 The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal , taking note of and where practical facilitating the agreed personal development plan (PDP) as part of the prospective job plan**

Making Technology Work

- In order to minimise the administrative burden, effective use of electronic and digital systems should be available in line with best practice. This Trust already utilises the *'Allocate'* (formerly *Zircadian*) system. This is the most common system used for this purpose in the UK. A number of suggestions for further improvement have come from the Associate Medical Directors (AMD) Job Plan review group which have been partly implemented. This programme of improvement should continue. Already this year significant training opportunities have been provided from the supplier and the in house medical management scheme.
- Discussion with AMDs, ADs (Associate Directors) and CDs (Clinical Directors) has suggested that there is limited added value in having a third 'sign off' often at Director Level. The current three stage system presents the opportunity for unnecessary delays in the sign off process. There is acknowledgement that service directors need an assurance about the process, but the consensus was that this could be better facilitated in the form of directorate reports that could be provided by the medical staffing /*Allocate* team on a regular perhaps twice yearly basis.
- There was consensus that it would be useful for the *Allocate* system be set up to send systematic email prompts to both the doctor and the CD in advance of their sign off date and when a JP is overdue.

Recommendation 2. ***The Trust should continue to offer further training opportunities for staff regarding the use of 'Allocate' in a systematic and planned way together with ad hoc training opportunities.***

Recommendation 3. ***Further simplification of the sign off and notification process should be implemented as agreed with the AMD group with a reduction from 3 to 2 signatories.*** **'Allocate' should be asked to send timely alerts to job-planners and doctors to remind them of renewal dates**

Making Job Planning a prospective annual process

- The recent internal Audit clearly demonstrates that currently a significant percentage of doctors do not have an annual job plan review and that it is often retrospective rather than prospective rendering the process less meaningful. Acknowledgement needs to be given to increasingly complex patterns of working such as the 'consultant of the week' model.

- Linking the job planning cycle to the Trust's business planning cycle would be helpful in aligning organisational objectives and would make it easier to predict when job planning should occur. Flexibility will need to be given to job planners (CDs and AMDs) within their own job plan to allow intense periods of job planning activity at certain times of the year.

Whilst work continues currently to deliver the 2018 JPs, to ensure Job plans are in place PROSPECTIVELY for April 1st 2019 the following cycle should be implemented. This is based upon the *NHS Improvement* paper entitled 'Consultant Job planning: a best practice guide (July 2017).'

Quarter 2- July – September
Clinical director sends out preparation for and invitation for job plan review, giving 6 weeks notice. Appraisal documentation shared with CD.

Quarter 3 October to December
Team Job planning meeting to discuss and agree objectives, SPAs and any required rota changes. CD, Associate Directors, Service Managers Consultants and SAS doctors present.
JPs entered on Allocate by 31st December allowing 3 months for mediation/appeal if required.
JP consistency team (See later) check a proportion of JPs for consistency and fairness

Quarter 4 January to March
Mediation and/or appeals

Quarter1 April to June
Job plan effective 1 April

Recommendation 4 The directorates should implement a systematic, timely prospective process similar to that outlined including team meetings with doctors CDs Ads and Service managers within quarter 2

When a job plan is not agreed

Consultants are expected to engage in the annual job planning process; failure to do so could constitute one of the grounds for deferring pay progression for the year in question. Doctors however should NOT be penalised for failing to meet objectives for reasons beyond their control. Both employers and consultants have a responsibility to identify potential problems with achieving objectives as they emerge rather than waiting for an annual job plan review meeting.
Where a job plan is not agreed because it is in dispute, the doctor should not suffer any detriment whilst a potential mediation or appeals process is progressed. The informal process of facilitation with a third party as outlined in the terms and conditions of the consultant contract. Experience in this cycle has shown that this is can be an effective means of achieving resolution of difficult issues.
Formal appeal may considered by either party if facilitation is unsuccessful.

Medical Job Plan Consistency Committee

A proportion of job plans (as high a percentage as practical) should be reviewed by a committee to ensure Trust job planning guidance is being followed with a consistent and fair approach.

Membership

The committee should consist of a Medical Director representative, Associate Medical directors, human resource medical staffing representative, and relevant CDs as required .

Purpose

To ensure consistency and an even handed approach across the Trust. It is NOT a mediation or appeal forum.

Recommendation 5 A Medical Job Plan Consistency Committee should be established reporting to the job planning lead (see later)

Making Job plans Competitive and Attractive

- Doctors should understand what is expected of them by the Trust and know they are being treated fairly with other team members.

- Job plans should contain an agreed baseline of commitments detailing attendance and activity expectations for the year ahead. These should be transparently reviewed and agreed, and be clearly documented for future reference. Activity expectations should be based on a minimum of 42weeks in the working year. A job plan covers the whole of the week, including – where relevant – weekends and nights (to ensure consistent delivery of high quality patient care).

- Supporting professional activities (SPAs) underpin direct clinical care and should be linked to clear objectives. The Academy of Medical Royal Colleges estimates that 1 to 1.5 SPAs per week are the minimum for a consultant's continuing professional development (CPD) for revalidation purposes. The Trust supports this view. Additional SPAs may be awarded for specific responsibilities or duties by agreement . There is a view held by many Trust doctors that currently the SHSCT average SPA allocation is lower than other comparable Trusts within Northern Ireland. Our current average SPA allocation is currently 1.68 PA for full time consultants only. The range is from 0.375 PA to 2.75 PA …… and our current non DCC PA (Including SPA, APA and other external duties) allocation average is 2.52 PAs

  It is my view that given the current recruitment and retention difficulties it would be worth guaranteeing each new consultant a minimum of 2.5 SPAs at the time of appointment and 1.5 SPAs for SAS doctors at the time of appointment, both for a period of 3 months initially during which time there would be a job plan review. This would facilitate induction for new staff and would be an attractive package for recruitment and would solve the increasing difficulties we are having in getting new job plans approved by the Royal Colleges because of

the SPA issue. After 3 months the SPA allocation could be reduced to 1.5 and 1 SPAs for Consultants and SAS doctors respectively with additional non clinical Pas (SPA/APA) agreed locally for specific roles. Such measures would be likely to have an immediate impact on recruitment if jobs were explicitly advertised with this on offer. We already offer an average of 2.52 non clinical Pas to all other consultants. Ideally We should work towards reducing the range so that most consultants can expect 2.5 non clinical SPAs made up of SPA and APA

Currently full time SAS doctors receive an average SPA allocation of is 1.55 PA across the Trust with a range is from 0.75 PA to 2.00 PA
In line with our ambition of developing SAS doctors we should consider working towards an allocation of 1.5 SPA

This would help to imbed the Consultant and SAS group as valued staff members, would be transparently fair and would allow the CD share much of the current administrative burden around the team. It would be consistent with the principles of the *HSC leadership strategy 2018* by encouraging leadership roles at the coal face and could be used creatively to move forward major pieces of project work as required by the Trust. In my view such a move would send a powerful message to potential job applicants that this organisation is a good place to work for doctors.

Recommendation 6 Move to a position where each new consultant receives a minimum of 2.5 at initial appointment and 1.5 for SAS Doctors.

- *Flexibility of SPAs in relation to off site working*

There is a growing awareness that within NI some Trusts offer some flexibility about a proportion of their SPAs being worked off site. Within our own Trust this already offered in some departments. The AMD job plan JP review task force have reviewed this issue and have accepted this has some value when appropriately managed. This as yet is not widely implemented.
It is my view that all doctors should be offered the opportunity of working up to 1 SPA off site as long as they can evidence the work they have done through the appraisal process. A number of parameters would need to be understood by all. For instance, the doctor would need to remain available to be called on site should an emergency arise and that their annual appraisal needs to show that their CPD requirements are being met. These parameters have been clearly outlined within the Draft Trust Job Planning guidance document.

Recommendation 7 The Trust should offer the opportunity to every doctor to work 1 Core SPA off site.

- *Emergency on call for senior doctors*

There is a growing body of evidence to show that emergency on call work becomes more problematic for a doctor as they grow older associated with increasing stress. There is also a

body of evidence that shows an increase in the number of adverse incidents related to out of hours working as doctors grow older. This is increasingly stated as a factor contributing to early retirement for doctors. In my view each team should consider the minimum number of doctors required to provide a sustainable out of hours on call service with a clear indication that older doctors have a reasonable expectation of coming of the on call rota prior to the normal retirement age. Teams would then be able to forward plan for service provision on this basis. It is my belief this would help retention of staff in the long term.

Recommendation 8. The Trust should facilitate senior doctors to come off the on call rota if requested. Local teams should agree criteria and timescale

- **Sustainability**

A job planning lead should be appointed for the Trust with clinical credibility. This could be similar to the current appraisal lead as a stand alone post or possibly as one of the roles of a deputy medical director with 1 PA time allowance to oversee and coordinate the job plan process. Their roles and responsibilities would include potential challenge to AMDs over process and would and include a reporting remit to SMT and Trust board. In order to support this role and facilitate the job planning administration team within medical HR it is likely that some additional administration support will be required for this team. The medical HR team believe a full time band 4 post would be appropriate to cover the workload and proactively manage the system

Recommendation 9

A clinical job planning lead should be appointed who reports job planning status and issues to SMT on a quarterly basis. This should be supported with appropriate administrative resource within medical HR staffing

- **Ongoing Oversight**

A Senior Job Planning Oversight Committee (JPOC) should be established perhaps meeting quarterly to oversee progress and strategic direction. It would receive reports from the Job Planning lead and consider suggested changes to the job planning guidance. It would consider implications of any potential changes to the consultant contract and take note of new best practice guidance from relevant national or regional bodies.
It would be chaired by the Medical Director and include the Director of HR, Finance Director and Operational Directors. It could be supported by an AD from the Medical Director's office

Recommendation 10

A Job planning strategic oversight committee should be established set strategic direction, review progress receiving reports from the job planning lead and reporting to SMT

Conclusion

The above report has considered current best practice recommendations and the issues raised within our recent internal audit report related to Trust Job Planning. It has considered

the Terms of Reference outlined by the Chief Executive and made 10 major recommendations to address the issues raised.

TOR 1

Improved Engagement with Doctors resulting in a high percentage of contemporaneously agreed meaningful job plans that address the Trust, the Doctor's and most importantly the patients' needs.

The new easy to understand job planning timetable aided by a simplified allocate prompt and sign off system will allow JPs to be agreed prospectively rather than retrospectively. The Job Planning lead will drive the process forward with fairness ensured by the consistency committee resulting in an open and transparent process. The formal link to appraisal and agreed objectives will enhance both the JP and appraisal systems

TOR 2

Improved compliance with internal Audit job planning recommendations

As above. The JP lead will report regularly to SMT and through them to Trust Board on behalf of the Medical Director resulting in direct accountability for the process. The simplified process will ensure timelier processing of JPs. The Consistency committee will ensure that JP principles are adhered to.

TOR 3

Improving attractiveness of SHSCT as an employer of medical staff thus improving recruitment and retention

The enhanced commitment to Non DCC time is likely to have a positive effect on recruitment and retention whilst ensuring that important roles required by the Trust are fulfilled.
Offering 2.5 SPAs to all new start consultants would be a powerful recruitment tool.
A more flexible approach to limited off site SPA time is potentially a decisive factor in doctors making a choice between prospective employers.
The commitment to link appraisal agreed objectives to the JP process will further demonstrate how the Trust values its staff.
The reasonable expectations for older consultants to withdraw from the on call rota in a planned and coordinated manner is likely to assist with retention as this has been raised as an issue by leaving doctors at their exit interviews

TOR

Sustainability of process

The appointment of a clinical lead to drive the process and the establishment of the Job planning oversight committee together with the changes to the cycle and sign off process should ensure sustainability and deliverability over the next few years.

Summary of Recommendations (10 Steps to success)

Recommendation 1 The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal , taking note of and where practical facilitating the agreed personal development plan (PDP) as part of the prospective job plan.

Recommendation 2 The Trust should continue to offer further training opportunities for staff regarding the use of 'Allocate' in a systematic and planned way together with ad hoc training opportunities.

Recommendation 3 Further simplification of the sign off and notification process should be implemented as agreed with the AMD group with a reduction from 3 to 2 signatories. 'Allocate' should be asked to send timely alerts to job-planners and doctors to remind them of renewal dates.

Recommendation 4 The directorates should implement a systematic, timely prospective process as outlined including team meetings with doctors ,CDs Ads and Service managers within quarter 2

Recommendation 5 A Medical Job Plan Consistency Committee should be established reporting to the job planning lead

Recommendation 6

Move to a position where each new consultant receives 2.5 SPA and 1.5 Spa for SAS doctors at the time of appointment. An early job plan review should then determine the need for any non clinical Pas above 1.5 and 1 respectively

Recommendation 7 The Trust should offer the opportunity to every doctor to work 1 flexible SPA off site.

Recommendation 8

The Trust should facilitate senior doctors to come off the on call rota if requested. Local teams should agree criteria and timescale

Recommendation 9

A clinical job planning lead should be appointed who reports job planning status and issues to SMT on a quarterly basis

Recommendation 10

A Job planning strategic oversight committee should be established set strategic direction, review progress receiving reports from the job planning lead and reporting to SMT

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee on 6.9.2018

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood **Scoring Descriptors**	**Score**	**Frequency** **(How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

OVERVIEW OF CORPORATE RISK REVIEW AS AT AUGUST 2018

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	3	7	0	10

Following the Trust Board Workshop on 26th April 2018, when a deep dive into 2 risks was undertaken, the Chief Executive, along with the Senior Management Team, undertook a substantive review of the Corporate Risk Register during July and August 2018. This work has been completed and resulted in the following key changes:-

Number of new risks identified by SMT for escalation to Corporate Risk Register	**2** Risk 7 - Deterioration of exposed concrete on building exterior, Daisy Hill Hospital. Risk 8 – Loss of electrical power to main hospital block, Craigavon Area Hospital
Risks removed from the Register	**5** • GP Out of Hours • Safeguarding of residents from risk of potential financial abuse • Shortage of ED Consultants, Daisy Hill Hospital • Telecommunications infrastructure These risks will be managed at Directorate Risk Register level

	• Registered Nursing and social care staff shortages in mental health and disability services. The Nursing element of this risk has been merged with the nursing workforce risk. Potential risk area of social work and social care staff shortages Trust wide to be further explored.
Merged risks	**1** Lack of Data Processing Contract with BSO merged with Shared Services risk
Number of risks where overall rating has been reduced	**0**
Number of risks where overall rating has been increased	**1** Risk 3 – Medical Workforce shortages and vacancies from medium to high risk

SUMMARY OF CORPORATE RISKS AS AT AUGUST 2018

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page	Movement from last review
1	**BSO Shared Services** • Payroll/Travel • Recruitment • Lack of Data Processing Contract	1&4	**MEDIUM**	**7**	Unchanged
2	**Cyber Security**	1	**HIGH**	**13**	Unchanged
3	**Medical Workforce shortages and vacancies**	1	**HIGH**	**19**	Increased
4	**Registered Nursing Workforce Shortages**	1	**HIGH**	**21**	Unchanged
5	**HCAI**	1	**HIGH**	**24**	Unchanged
6	**Deterioration of exposed concrete on building exterior, Daisy Hill Hospital**	1	**HIGH**	**26**	New risk
7	**Loss of electrical power to main hospital block, Craigavon Area Hospital**	1	**HIGH**	**27**	New risk
8	**Compliance with procurement and contract management guidance**	1&4	**MEDIUM**	**29**	Unchanged
9	**Breach of statutory duty of break-even in-year** **Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support.**	4	**MEDIUM**	**33**	Unchanged
10	**Clinical risk associated with inability to manage patient care within clinically indicated timescales**	1	**HIGH**	**35**	Unchanged

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Possible (3) **Impact: Moderate (3)** **Total Score: 9** **Risk Rating: MEDIUM** **Previous Score: 9**		**RISK OWNER: Director of Finance & Procurement** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre:-** **Payroll & Travel** The risk that staff pay and travel reimbursements are inaccurate due to the control environment of the Business Services Organisation (BSO). This has the potential for financial hardship for staff, negative media attention and reputational damage for the Trust.	1. A range of KPIs have been agreed with BSO for each Trust which identifies where there has been improvement or deterioration and triggers appropriate action 2. The Trust has a process of reimbursing staff as quickly as possible once an underpayment is identified as quickly as is feasible 3. Once an overpayment has been identified, BSO enact the overpayments policy 4. Annual Internal Audits	Assistant Director of Finance Assistant Director of Finance Assistant Director of Finance Assistant Director of Finance	1. Monthly KPIs 2. Payroll data 3. Schedule of Overpayments and Recovery Plan 4. Internal Audit reports and action plans

		5. Regional audit of BSO Payroll Shared Services, currently twice a year	Assistant Director of Finance and Internal Audit	5. Audit reports and action plans
		6. Trust wide communication to all managers to remind all in respect of timely completion of paperwork	Assistant Director of Finance	6. Global communications
		7. Trust active participation in a number of regional groups to provide guidance, assistance and challenge to achieve necessary improvements	Finance Directorate	7. Minutes of meetings

Additional actions and timescales

1. Progress updates provided to Audit Committee and from October 2018 onwards, BSO have been asked to provide a written report in advance of each Audit Committee.
2. Ongoing review of Internal Audit recommendations. For those that are the responsibility of the Trust, they will be picked up and reported on at the IA Forum initially before going to Audit Committee.
3. Ongoing attendance at Customer Forums and Business as Usual meetings.
4. Ongoing attendance of Director of Finance at Customer Assurance Board which has been established to oversee 3 new payroll workstreams in an attempt to address the issues.

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: MEDIUM** **Previous Score:12**		**RISK OWNER: Director of Human Resources and Organisational Development** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre -** • **Recruitment and Selection** The delays in recruitment and selection pose a risk to service continuity for front line services	1. Implementation of an action plan to address a range of local resourcing issues over the next 12 months. 2. Use of Bank and Agency for short/medium term interim cover, where possible and subject to appropriate approvals. 3. Internal Audit reviews of RSSC and Trust Recruitment & Selection. 4. Trust participation at Head of Service / Assistant Director level in regional Strategic Resourcing Innovation Forum (SRIF), with 4 workstreams (Attraction and Retention; Performance Improvement; Selection; and	Acting Head of Resourcing	1. Resourcing Operational Plan 2. Monthly Bank Block Booking and Agency reports 3. Internal Audit assurance reports 4. SRIF annual work plans and dashboard

		Systems) each with a 12-month workplan to deliver and report to HR Directors. 5. Bi-monthly customer forum and monthly operational review meetings with RSSC to escalate issues requiring to be addressed. 6. Establishment of an Operational Group within SRIF to meet monthly and develop/implement key service improvements. 7. Monthly KPI data shared with the Trust which identifies where there has been improvement or deterioration and triggers appropriate action. Trust management information reports issued to Directorates in relation to vacant posts. 8. Trust wide communications in relation to managers' roles and responsibilities for recruitment and selection, as well as associated Key Performance Indicators. 9. Alignment of Resourcing Team Leaders to support Directorates taking action to minimise any delays in the recruitment process in conjunction with RSSC		5. Minutes of Customer Forum 6. Minutes of Operational SRIF Group 7. Monthly RSSC Performance Reports and Directorate vacancy reports 8. Global communications to Trust managers, process documents and user guides

		10. Development and introduction of new approach to reduce pre-employment checks for internal (Trust) appointments from October 2017 now implemented across the HSC from March 2018.		

Additional actions and timescales

1. Proposals developed by Strategic Resourcing Innovation Forum (SRIF) Operational Group for how pre-employment checks can be streamlined for appointees moving within the HSC. Comments to be submitted by 31.7.2018.

2. Review and implementation of all outstanding elements of Internal Audit recommendations by 31st August 2018.

3. Significant piece of work to be undertaken in conjunction with service directorates to further streamline corporate waiting lists and Trust approach to maintaining these – to be commenced by 31st August 2018

4. Further improvements to the depth and quality of management information produced from the E-Recruitment system – timescale dependent on progression of a 'Change Request' by the BSO Business Services Team, but likely to be by 30th September 2018.

5. Collation of regular feedback from key stakeholders via bespoke software, throughout 2018/19, to ensure their continued engagement and involvement in the process of design and implementation of solutions.

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: MEDIUM** **Previous Score:12**	**RISK OWNER: Director of Performance and Reform** **DATE RISK ADDED: August 2016** **Reworded: August 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre -** Absence of a MoU or Agreement between the Trust (as the data controller) and the BSO (as the data processor) in relation to the processing of personal data of staff, patients and clients. This would have an impact if there were a data breach or dispute as there are no clear roles and responsibilities outlined by the Trust and BSO. The new DPA 2018 and Article 28 of GDPR places a clear responsibility on the Data Processor and this needs to be clearly documented and agreed by all parties. ICO guidance clearly states that there should be a contract in place between the Data Controller and Data Processor	1. Both organisations adhere to the Data Protection Act 2018 and the ICT security framework. 2. This issue is on the e-health agenda for awareness and also on the SIRO regional meeting agenda. 3. BSO has provided a letter of assurance outlining the controls they have in place, but no signed agreement between the two organisations which needs to be progressed by the task and finish group.	Regional IGAG group chaired by the Department of Health SIRO regional forum and E-Health Programme Board	1. Data Controller/Data Processor Task and Finish Group chaired by the Director of Human Resources in the BSO with Trust representatives
Additional actions and timescales				
1. Agenda item for the Strategic Information Group which will include Information Governance issues. Trust is represented on this group. To be in place by January 2019.				

Likelihood: Likely (4) **Impact: Major (4)** **Risk Rating: HIGH**		**RISK OWNER: Performance and Reform Directorate (Cybersecurity Lead)** While this risk will be led by P&R from a cybersecurity assurance perspective, this risk is a corporate risk requiring ownership by Directorates as follows: • **Performance & Reform Directorate** (in relation to assurance of 'technical' ICT **DEFEND & RECOVER** / back up processes) • **Medical Directorate** (in relation to lead role in assuring effective Emergency Planning) • **Operational Directorates** (in relation to assurance of effective Business Continuity Plans to **RESPOND** to potential incidents)		
		DATE RISK ADDED: July 2017 **Reworded: June 2018**		
		TIMESCALE FOR REVIEW OF CONTROLS: Monthly		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
2	The key risk emanating from a cyberattack is potential for **significant business disruption.** Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, HSC information, systems and infrastructure may become unreliable, not accessible (temporarily or permanently), or compromised by unauthorised 3rd parties, including criminals.	**1.<u>REGIONAL</u>**: In the context of Northern Ireland, with a single Health and Social Care structure, and also a single HSCNI network, with Regional diagnostic services and NIECR, the impact in Northern Ireland of a cyber attack affecting the Network or Regional Data Centres has been assessed as potentially a National Civil Contingency (NCSC). Therefore, critical to managing risk at local level is the work progressed at regional level to mitigate risk through the <u>Cybersecurity Programme Board</u> and the extant policy and processes for <u>Regional Emergency Planning</u> led by the Chief Medical Officer.	1. Regional Cyber Security Programme Board (Trust Rep: Director P&R) established 2nd May 2018. 2. Regional Cyber Security Officers Forum established in June 2018	Minutes of meetings Minutes of meetings

	This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendances or diagnostic services such as Labs or NIPACs) or data contained within. This could lead to a range of impacts or core service areas for example: • Service disruption impacting on operational service delivery including waiting times, delayed urgent clinical interventions, suboptimal clinical outcomes etc. • Risks in the ability to deliver safe care in the community, for example, accessing electronic records for the c. 5,000 clients in receipt of domiciliary care. • Potential for unauthorised access to Trust systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations. • This could potentially bring liabilities for the Trust including potential fines and reputational damage.	**2.<u>LOCAL - TRUST LEVEL CONTROLS:</u>** If information systems are not available, the Trust needs to consider contingencies to accessing information on patients, clients, care packages in the community etc Current controls to DEFEND, RESPOND and RECOVER are as outlined below.	Cyber Security Task and Finish Group (I) (To be established)	
Additional actions and timescales				
Plan Regional “faux” cyber security exercises to test user behaviours, service continuity / disaster recovery plans **September 2018.**				

There are three aspects to the management of this risk within the Trust, as outlined below.				
		Key Current Controls	**Who monitors the control?**	**How is it evidenced?**
	1. DEFEND: To maximise the Trust's technical defences to minimise the risk of a cyber attack;	**1. <u>Technical Infrastructure</u>** • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client 'Patching' regime • 3rd party Secure Remote Access • Data & System Backups **2. <u>Policy, Process</u>** • Regional and Local ICT/Information Security and Incident Management Reporting Policies and Procedures • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Awareness raising • Resources – 2017/18 -SMT agreed financial resources to support additional capacity into ICT defence including: 2 wte Band 6 and 1 wte Band 7 to support progress of Priority 1 actions from IA and Foursys report.	Head of IT Quarterly Reporting to Governance Committee	IT Self-Assessment against NCSC10 Steps (I) IT Audit (I) Technical Risk Assessments, or Penetration Tests (E) FourSys (Network Security Expert) Report May 2017 (E) Awareness sessions held in August and September 2017, as well as a cyber assimilated event in January 2018. Action plan to be followed up by Cyber Task and Finish Group. Phishing Exercise undertaken and findings reported to SMT Global emails, 'SIRO says' campaign highlighted in desktop messages and Southern-I to raise awareness

Additional actions planned and timescale
The following recommendations have not yet been addressed to maximise technical defences: **Priority 2:** Patch Management Vulnerability Scanning Managing User Privileges Incident Management Monitoring **Priority 3:** Secure Messaging Education and Awareness CRL required in 2018/19 to address Priority 2 weaknesses **by 31st March 2019** Interviews for 3 additional staff for patching and monitoring of software logs scheduled **for July 2018** SMT to consider proposal to make cyber training mandatory for all staff **August 2018**

		Key Current Controls	Who monitors the control?	How is it evidenced?
	2.RESPOND: Services to consider how they would deliver safe and effective care in the event of diagnostics, appointment and client information being unavailable and plan for this;	**1. Policy, Process – Operational Services** • Emergency Planning & Service/Business Continuity Plans • Corporate Risk Management Framework, Processes & Monitoring • Regional & Local Incident Management & Reporting Policies & Procedures **2, <u>User Behaviours - influenced through:</u>** • Induction Policy • Mandatory Training Policies, particularly Information Governance • HR Disciplinary Policy • Professionals Academic training includes DPA • Contract of Employment • 3rd party Contracts / Data Access Agreements • Communication and Awareness	Cyber Security Task and Finish Group (I) (To be established) Human Resources and Organisational Development, Education, Learning and Development/Line Managers Assistant Director Informatics	

Additional Actions planned and timescale
Business Continuity Plans need to be updated by all services to plan for a cyber attack. A Cyber Task and Finish Group will be established, led jointly by the SIRO and Medical Director to ensure that this is progressed. This will also help raise awareness. TOR to be approved for Cyber Task and Finish Group – **June 2018**

		Key Current Controls	Who monitors the control?	How is it evidenced?
	3. RECOVER: To test and improve 'Back up and Recovery' of critical information systems in the Trust and BSO to be assured that in the event of a cyber attack, data can be recovered by IT as quickly as possible to minimise impact on services.	There are 3 levels of restore available PC Level; Application and Server. PC restore is fully tested; Application level and Server restore require agreement to bring down specific systems which has not yet been performed in the Trust. However there have been system upgrades and outages that have required the IT team to restore. Therefore there is some level of intelligence for a range of applications and servers.	IT Controls Assurance Board (CAB) meets weekly	Minutes and full audit trail from LanDesk.

Additional Actions Planned and Timescale
Some Applications and Servers require Full Restore Testing. Task & Finish Group to agree applications to be tested and a schedule of downtime - **October 2018.**

CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Almost Certain (5) **Impact: Moderate (3)** **Total Score:15** **Risk Rating: HIGH** **Previous score: 9**		**RISK OWNER: Director of HROD and Medical Director** **DATE RISK ADDED: July 2015** **Reworded: August 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Four weekly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
3	Risk to Patient safety due to medical workforce shortages and vacancies within some specialties including: • Emergency Medicine • Radiology • General Medicine • Acute Medicine • Paediatrics • Intensivists • Trainee doctors	1. Monitoring of vacancy position through Medical Staffing and Directorates 2. Analysis and improvement of recruitment and advertising strategies 3. Locum agencies to fill gaps 4. Collaborative working with other Trusts, when required 5. Independent Sector 6. Greater use of alternative roles through advanced practitioners – nursing and AHPs 7. International recruitment 8. Escalation of pressures to HSCB and DOH 9. Adverts now include a sentence asking for expression of interest from doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept.	Director of HROD Medical Director	1,2,3,7 Papers to SMT

		10. Trust is currently involved in training of Physician Associate Students, and have appointed first qualified PA 11. Regional support from existing ED Consultants to fill gaps on rota. Escalation arrangement at Chief Executive level where necessary		

Additional Actions Planned and Timescale

1. NIMDTA Trainee allocation gaps paper presented to SMT on 15th August 2018 by Head of Medical Staffing with action plan agreed.

2. Ongoing efforts to increase capacity of internal banks/ locums to reduce reliance on expensive agency locums. Update on ED Clinical Fellows presented to SMT on 15th August 2018.

3. Summary of medical recruitment at consultant and SAS doctor level over last 12 months, and current vacancies and long term locum usage to be presented to SMT on 5th September 2018.

4. HRDs and Medical Directors met on 10th August to discuss medical workforce issues relating to payment rates, and standardising across HSC. Awaiting Departmental guidance on formality of this approach.

5. Transformation Implementation Group (TIG) process for medical recruitment in place to seek to avoid further destabilisation of Trust services through greater collaboration – this was discussed at recent HRD & Medical director's forum. Awaiting Departmental guidance on formality of this approach.

6. A draft Job planning review paper with recommendations has been presented to SMT by Medical Director. Final paper to be presented at SMT by end of August 2018. This would have the potential to make the Southern Trust more attractive for recruitment & retention of medical staff.

7. A meeting is being sought with NIMDTA by Medical Director Office to identify solutions to the critical shortfall in Junior Trainee Doctors since 1st August 2018.

8. Expansion of Clinical Co-ordinators in the out-of-hours period to improve the trainee experience of FY1s

CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Almost Certain (5) **Impact: Moderate (3)** **Total Score: 15** **Risk Rating: HIGH** **Previous Score:15**		**RISK OWNER: Interim Director of Nursing , Midwifery and AHP's** **DATE RISK ADDED: April 2015** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
4	**There is a risk to the consistent provision of high quality nursing care due to a shortage of Registered Nurses and Midwives across all Directorates within the Trust.**	1. Escalation processes are in place within each Directorate to respond operationally to immediate Registered Nurse shortages.	Operational Assistant Directors	1. Twice daily review at Operational patient safety meetings.
		2. Use of bank and agency to support required staffing levels.	Operational Assistant Directors and Head of Resourcing	2. Information on shift fill rates.
		3. Open registration to Nurse Bank	Nurse Bank Manager	3. HR information
		4. International recruitment campaigns with international recruits commencing employment within the Trust.	Assistant Director Nursing Workforce , Development and Training	4. HR recruitment information
		5. Open advertisement for Band 5 Registered Nurses with interviews taking place on a 2-3 weekly basis	Head of Resourcing	5. HR Information

		6. Recruitment activities, such as jobs fairs, local and across the UK, are now attended by the 5 H&SC Trusts as a collaborative. 7. SHSCT staff also continue to engage with students, both within universities and whilst on placement, to encourage consideration of SHSCT as an employer. 8. Excellent preceptorship and induction programmes in place for new employees with optional rotation scheme for newly qualified staff 9. SHSCT continues to work with Department of Health to influence an increase to the supply of Registered Nurses 10. Increased the numbers allocated to Open University training scheme for mental health and adult nursing inclusive of the overall increase in training places.	Assistant Director of Nursing Workforce Development & Training Assistant Director of Nursing Workforce Development & Training “	6. Executive Director of Nursing Directorate records Increase of 200 places across nursing and midwifery since 2016 Training / HR information

Additional Actions Planned and Timescale
1. Planning to evidence daily staffing levels through the use of Allocate rostering software where implemented.. March 2019 2. Planning to review the optimisation of bank availability. March 2019 3. Regional target is to recruit 622 nurses by March 2020. The project is on target to deliver. . 4. SHSCT will review capacity to support the additional students in line with the increase in pre-registration nursing places by DoH. **5.** SHSCT has received additional funding from DoH to increase the number of staff accessing the Open University (OU) Pre-Registration Nursing Programme (Adult and Mental Health) 6. Review of learning from Project Retain which took place in 2 Trust wards in 17/18. 7. Trust work streams commenced to optimise recruitment and retention in nursing and midwifery March 2019

CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Possible (3) **Impact: Major (4)** **Total Score: 12** **Risk Rating: HIGH** **Previous score: 12**		**RISK OWNER: Medical Director** **DATE RISK ADDED: June 2011** **Reworded: August 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
5.	**Risk to patient safety due to the potential to develop a healthcare acquired infection**	1. Strong leadership through the existing governance framework of the Strategic and Clinical Forum meetings	Medical Director	1. Provision of monthly assurance to Trust Board
		2. Isolation of patients with transmittable infections and those who are immunocompromised	Relevant Operational Director	2. Use of IPC checklist within ED. Policy on isolation of patients
		3. Robust handwashing processes	Lead Nurse, IPC	3. Monthly presentation of audit data
		4. Comprehensive cleaning policies and procedures	Assistant Director – Functional Support Services	4. Regular environmental cleanliness audits
		5. Awareness of appropriate antibiotic prescribing	Consultant Microbiologist	5. Presentation of data on antibiotic usage

	Increasing emerging infections (CPE/VHF)	1. Ongoing ward rounds relating to antibiotic stewardship 2. Isolation and active screening of patients transferring from other hospitals, or history of admission within the last 12 months	Consultant Microbiologist Relevant Operational Director	1.Use of IPC checklist within ED. 2.Policy on isolation of patients
Additional actions planned and timescale				
Trust agreement of 3 year IPC Strategy detailing the 10 elements of delivering safe care, to be presented to Trust Board by October 2018 Development of VHF Management Plan				

CORPORATE OBJECTIVE: 1 – PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: HIGH** **Previous score: N/A**		**RISK OWNER: Director of HROD/Estates** **DATE RISK ADDED: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
6.	Deterioration of exposed concrete on Daisy Hill Hospital building exterior, leading to detachment of concrete debris with a risk of loss of life / injury to service users, public and staff	1. Hammer tests carried out in October 2017 and March 2018 in order to remove loose debris. To be carried out on a minimum 6 monthly basis. 2. Temporary 'heras' fencing erected in order to create a barrier between the building and main pedestrian areas 3. Erection of scaffold (with brick catcher) and netting to underside of first floor level of phase one building in an attempt to help mitigate the risks caused by spalling concrete.	Assistant Director of Estates	1. Records available in Estates 2. Visible on site 3. Visible on site

Additional Actions Planned and Timescale

1. Regular inspections of the structure in the short term, removal of loose concrete and suitable concrete repairs as per Taylor & Boyd LLP Report (2018). It is noted that this will not mitigate the o/a risk and deterioration will still occur.
2. 6 monthly hammer tests being carried out to remove any loose areas of concrete – next due September 2018
3. On 11.07.2018, SMT approved revenue funding of £400k to carry out interim structural repairs to the concrete heads and lintels as recommended by the Structural engineer. Estates Capital Works are now taking these works forward and plan to have completed by 31.03.2019. (This should provide the Trust 7-10 years to implement a long term solution involves over cladding and window replacement, to a value of circa £2,000,000)

CORPORATE OBJECTIVE 1 – PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: HIGH** **Previous score: N/A**		**RISK OWNER: Director of HROD / Estates** **DATE RISK ADDED: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
7.	Loss of electrical power (LV) to main CAH hospital block leading to a significant interruption to services with a risk of loss of life and/or serious harm to patient(s).	1. Competency of estates staff in carrying out emergency electrical switching and regular dummy runs do deal with various scenarios 2. Estates Operations have a formal CAH fixed breaker emergency plan in place and electrical staff have been trained in how to deal with various scenarios. Copies of the document have been placed in the main switchrooms 3. Presently, estates have an identical fixed breaker on site which can be fitted if there is a failure. This eliminates the 6 week delivery delay experienced in 2017. This breaker will still take at least 8 hours to fit once the switchboard was isolated.	Assistant Director of Estates	1. Experience and training of Estates colleagues 2. Printed document in Estates office and electrical switchrooms 3. Spare circuit breaker on-site in Stores electrical switchroom.

		4. Use of mobile phones if VOIP telephony system is lost		4. Business continuity arrangements

Additional actions planned and timescale

Phase 1a
New dual 2.0MVA transformers in Energy Centre (for future CT scanner).

If one of the fixed breaker in the Stores switchboard fails these transformers will provide a mains supply to Maternity & Ward-N. However, if there is another fault or general mains failure there will not be a standby generator to provide power.

To mitigate this risk, in the event of a fixed breaker failure and this transformer was called on, a mobile generator could be hired within a few days to provide extra resilience.
Approximate cost: £700k + 15% fees = £805k

Funding to be sourced from DOH in year 2018/19.

Phase 1b
New 2.0MVA generator in Energy Centre and internal fuel tanks.

This will provide standby generator power for the new transformers in the Energy Centre and give it the resilience necessary to be a clinically-rated supply.

Approximate cost: £800k + 15% fees = £920k

Funding to be sourced from DOH in year 2019/20.

Phase 1c
Replace Stores switchboard containing 4no. fixed breakers with a new board containing withdrawable breakers. This will require the switchboard to be isolated for one month and should only be done once the 2.0MVA transformers are installed in the Energy Centre and have standby generator backup.

Approximate cost: £115k + 15% fees = £132k

Funding to be sourced from DOH in year 2019/20.

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Possible (3) **Impact: Moderate (3)** **Total Score: 9** **Risk rating: MEDIUM** **Previous score: 9**	**RISK OWNERS: All Directors** **DATE RISK ADDED: July 2011** **Reworded: August 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
8.	**i) Failure to comply with general procurement and contract management Department of Health guidance resulting in lack of assurance regarding VFM / risk of legal challenge**	**1.** Oversight by Trust Procurement Board, now reporting to Trust Board sub-committee from 2018/19 onwards	Director of Finance	1. Meets at least three times per year and provides Annual report to Trust Board Annual monitoring of Direct Award Contracts by Audit Committee
		2. Use of COPEs by Trust – PALS and CPD - HP	Director of Finance	2. PALS and CPD – HP both attend Trust Procurement Board
		3. PALS KPIs reported quarterly to the Trust	Director of Finance	3. Minutes of meetings of Trust Procurement Board
		4. Internal audit assignments consider procurement and contract management arrangements in annual audit programme	Director of Finance	4. IA reports, minutes of Audit Committee meetings

		5. PALS liaison post in place, procurement advice and guidance available on sharepoint, training provided	Director of Finance	5. CAG training – April 2018 Contract management training – Feb/March 2018 EProcurement training quarterly
	ii) Failure to comply with social care procurement guidelines 2018/19 resulting in lack of assurance regarding VFM/ risk of legal challenge / sector instability	1. Oversight by Trust Procurement Board, now reporting to Trust Board sub-committee from 2018/19 onwards	Director of Finance	1. Social care procurement standing agenda item on Trust Procurement Board
		2. Assistant Director of Performance & Improvement member of regional social care procurement Implementation Board, reporting to Regional Procurement Board	Director of Performance & Reform/Director of Finance	2. Social care papers shared with Trust Procurement Board as appropriate
		3. Use of COPE by Trust – PALS - SCPU for <u>above</u> threshold procurement; in line with regionally agreed procurement plan.	"	3. PALS Head of SCPU attends Trust Procurement Board
		4. Trust has dedicated procurement officer who works under 'Influence' of SCPU for any agreed deviations from plan to meet local need		4. Internal procurement work plan in place

		5. Trust has Contract Initiation Documentation process in place to regulate award of contracts under threshold.	All Operational Directors	5. Protocol in Place
		6. New under threshold service contracts are being procured by Trust staff under influence of SCPU.	Director of Performance & Reform/ Operational Directors	6.Internal procurement work plan in place.
	iii) Failure to manage social care /domiciliary care/voluntary sector contracts to ensure safe and effective care delivery to clients and VFM	1. Domiciliary Care Oversight Group in place to provide focus to domiciliary care specific contract management.	Director of Older People and Primary Care/ Director of Finance	1. Terms of Reference in place and Minutes of Meeting
		2. Professional Head of IS contracts for Domiciliary Care in Place to provide oversight on quality arrangements.	Director of Older People and Primary Care	2. Internal review/validation of payments in the domiciliary care sector conducted in 2017/18 for 6 largest providers
		3. Independent Sector Governance group in place, cross programme and profession (finance, contracts, safeguarding, governance and operational) to review contract management issues in the regulated sector		3. Terms of Reference in place and Minutes of Meeting Internal Audit review of contract management in 2018/19
		4. Approach to guide consistent approach to performance management of contracts in place		4. Standard Operating Procedures

		5. Director of Older Peoples Services member of regional Review Group and SHSCT local Review Group in Place to review learning from CoPNI report (Dunmurry Manor) 6. Action plan in place to consider learning from Console Review for voluntary sector	Director of Older People and Primary Care Director of Finance / Older People and Primary Care	5. Terms of Reference in place 6. Action Plan in Place

Additional actions planned and timescale

i) General

- Director of Finance will bring revised Procurement Strategy to Trust Board Autumn 2018.
- Amended TOR of Trust Procurement Board to be considered at September TPB.
- Revision of controls assessment process for non pay commissioning in 2018/19 in line with DOH circular – March 2019
- Development of composite KPIs for procurement, including Pharmacy, Estates and Social care – 2018/19 workplan
- A paper will be brought to SMT September 2018 for consideration of investing in additional resource to provide contract management training to Trust staff.

ii) Social Care

- Trust to further develop approach to below threshold procurement, working with other HSC organisations during 2018/19.

iii) **Social care /domiciliary care/voluntary sector**

- Proposal for additional monitoring arrangements to be developed in 2018/19. Trust action plan in place arising from CFS review and validation exercise.
- Action plans in place for 6 providers to be worked through in 2018/19.
- Review of Terms of Reference for IS Governance Group
- Recommendations from workstreams to be brought forward in 2018/19
- Additional work to examine potential use of benchmarking to establish VFM in social care contracts to be undertaken in 2018/19.
- Roll out of regionally agreed assurance framework for voluntary sector providers to be considered in 2018/19
- Review of structures for contract management to be undertaken

CORPORATE OBJECTIVE: Making Best Use of Resources				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: Medium** **Previous Score: 12**	**RISK OWNERS: Operational Directors** **DATE RISK ADDED:** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
9	**i) Breach of statutory duty of break-even in-year**	1. Draft Financial Strategy has been developed and agreed with Directors	Director of Finance	1. Monthly financial performance detail reports to all budgetholders Monthly reporting to SMT, Trust Board, HSCB and Department of Health
		3. Formal financial monitoring system in place including forecasting year-end outturn	Director of Finance	2. Monthly monitoring returns prepared for issue to DoH and HSCB
		4. Chief Executive accountability meetings with Directors at least 3 times annually	Chief Executive	3. Minutes of meetings and agreed action plans
		5. Monthly financial accountability meetings between budget-holders and finance	All Directors	4. Minutes of meetings and agreed action plans

	ii) Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support.	1. The continual update of the Trust's recurrent deficit and reporting of same to HSCB/ Department of Health 2. Work has commenced on planning for 2019/20	Director of Finance Director of Finance/ Department of Health/HSCB	Trust Delivery Plan, Monthly monitoring returns, Board Papers Minutes of SFF and DoF

Additional actions planned and timescale

i) Breach of statutory duty of break-even in-year

- The Director of Finance is working with the HSCB and DoH in order to secure clarity on the possibility of additional funding support to ameliorate emerging pressures. Due to complete in advance of final TDP submission end of August 2018.
- Director of Finance reviewing the robustness of the emerging pressures and to the extent that they might crystallise in year. Due to be completed in advance of final TDP submission end of August 2018.
- Final Financial Strategy to be presented at August 2018 Trust Board for approval.
- Finance will carry out a mid-year hard close – October/November 2018

ii) Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support

- Director of Finance is continuing to work with HSCB and Department of Health in relation to the capitation inequity gap. Work during 2017/18 financial year secured a nil general savings target for the Trust going into 2018/19. All Directors continue to raise this with professional leads at HSCB/PHA and Department of Health – Ongoing.

CORPORATE OBJECTIVE: 1 – PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: HIGH** **Previous score: 16**		**RISK OWNER: Relevant Operational Directors** **DATE RISK ADDED: November 2010** **Reworded: August 2017** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
10	**Clinical risk associated with** **i) inability to diagnose/assess treat urgent/red flag patients within clinically indicated timescales** **ii) Review or planned assessment/treatment waiting beyond the clinically indicated timescales** **iii) Reporting of diagnostic testing beyond the clinically indicated timescales**	1. Prioritisation of capacity to accommodate red flag and urgent demand 2. There is a mechanism in place for triage and identification of red flag and urgent new patients 3. There are established processes in place for booking of patients within the clinically indicated timescales and escalation where capacity is not available 4. There are mechanisms to monitor at patient tracking level, red flag referrals and agreed process for escalation	Assistant Directors Assistant Directors Operational Service Leads/ Assistant Directors	Reports, minutes and actions from performance meetings Cancer tracking team escalate via email to Operational Service Leads/Heads of Service at each stage of the 62day cancer pathway for those patients who are not progressing and may breach. Each breach is discussed at the monthly cancer performance meeting This risk is on the performance Risk Register. Divisions have submitted non recurrent bids to address these backlogs. It is discussed on a monthly basis with the each division & the performance team.

		5. There are mechanisms to monitor the waiting times for urgent patients, review patients and planned patients waiting longer than their clinically indicated timescales at specialty and Consultant level 6. There is weekly and monthly monitoring information in place to assist with oversight and identify and escalate those requiring prioritization 7. Monthly Head of Service Specialty meetings to review/escalate situations where risk presents in managing patients within their clinically indicated timescales 8. Monthly Assistant Director Cancer and Divisional Performance meetings to review/escalate situations where risk presents in managing patients within their clinically indicated timescales. Risk assessments completed as appropriate and options developed for management of same 9. Monthly Directorate Performance and Governance meetings for escalation and review of risk management		

		10. Monthly External Performance meetings with Health and Social Care Board to account for performance and highlight risks in relation to patient safety and long waits		

Additional Actions Planned and Timescale

Non-recurrent funding as available will be allocated to provide additional activity to areas to address the risk associated with inability to manage patient care within clinically indicated timescales

The Trust will continue to re-direct any available internal resources to areas of greatest risk

Ongoing engagement with clinicians in respect to what is a clinically acceptable wait

Review of performance management arrangements

Hynds, Siobhan

From: Wallace, Stephen [redacted]
Sent: 01 August 2020 09:13
To: Donnelly, Mary; McCullagh, Rose
Cc: McClements, Melanie; OKane, Maria; Hynds, Siobhan; Toal, Vivienne; Haynes, Mark; Corrigan, Martina; Carroll, Ronan
Subject: Administration Review Terms of Reference

Follow Up Flag: Follow up
Flag Status: Flagged

Rose / Mary, please see terms of reference for the administration review below

Give me a call if you have any questions

Thanks
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

- The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources
- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes
- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

Timing

The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

Governance and Methodology

The Reviewer will be accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

16 September 2010

1.0 Introduction

1.1 **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem.

1.5 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.6 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.7 This guidance should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.

2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
An informal process. This can lead to resolution or move to:

Appendix 2
A formal process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.

3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Exclusion / Restriction

** If co ndertaken by the appropriate Associate Medical Director (AMD). If concern arises l Director

Appendix 1

Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

The Clinical Manager should seek advice from NCAS. This may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding compliance.

Appendix 2

Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

↓

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

↓

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

↓

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 3a

Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

During the hearing:

- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:

- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:

- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:

1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

If the decision is to exclude the Practitioner:

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II point 28 for review process.

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Medical Directors Office 2018/19

Accountability Scorecard

Signed off- 28/06/18

Medical Directors Office
2018/19
Final

Department	Ref	Indicator	Measurement		
			Baseline	**Target**	**Progress as at Xx/yy**
1. Infection Prevention & Control (Shared responsibilities between operational Directors & Medical director)	1.1	HCAI 3 years Strategy development	No Baseline	August 2018	
	1.2	Priority for Action Target: Clostridium difficile incidence in 2018/19	46 in 2017/18	Target is set by PHA, usually go for 5% less than last year's target; 17-18 target was 31 ? 29 – 31	
	1.3	PHA Target: Percentage of positive Gram Negative bacteraemia.	365	30% reduction from baseline Therefore target of 256	
	1.4	Percentage of staff who have completed their 2 yearly IPC Mandatory Training.	68%	85% by March 2019	
2. Research & Development	2.1	Number of days for approval of Studies and Clinical Trials compared to other Trusts in NI	90%	95% within 30 days by October 2018	
3. Medical education	3.1	Deanery assessments of provision of specialty teaching:		Improvement in Deanery assessment by one grade from last visit to the next visit	

Specialty	**Date**	**Baseline**
Psychiatry	2017	**A2:** Good
Paediatrics (CAH)	2017	**C**: Borderline
Paediatrics (DHH)	2017	**C:** Borderline
General Medicine (CAH)	2018	Visit in May
General Medicine (DHH)	2018	Visit in April
General Surgery (CAH)	2018	Visit later in 2018
General Surgery (DHH)	2018	Visit later in 2018
Obstetrics & Gynaecology (both sites)	2016	Being obtained
ED (both sites)	2016	Being obtained
Pathology and Radiology Services	2017	Being obtained

Department	Ref	Indicator	Measurement

			Baseline	Target	Progress as at xx/xx
3. Medical education	3.2	Percentage of Consultants with trainees who have successfully completed all 4 elements of training to become a "Recognised trainer"	94%	95%	
3. Medical education	3.3	The percentage of students in the QUB student survey who respond that the quality of undergraduate teaching is either "good or very good"	85%	90%	
4. Medical Revalidation and appraisal (Shared responsibilities between operational Directors & Medical director)	4.1	Percentage of doctors to revalidate successfully	45% by Quarter two 65% by Quarter three 100% by Quarter four	60% by end Quarter two 80% by end Quarter three 100% by end Quarter four	
	4.2	Percentage of annual medical appraisals completed	35% by Quarter one 60% by Quarter two 85% by Quarter three	40% by end Quarter one 70% by end Quarter two 95% by end Quarter three	
		Job Planning-	Current Baseline	70%	
	4.3	Design, pilot and rollout of regional online medical appraisal system	Key milestones to be confirmed		
5. Clinical audit and clinical guidelines	5.1	Develop Audit Strategy for 2018/19	No Baseline	August 2018	
	5.2	Percentage participation in eligible national audits, as defined by the Healthcare Quality Improvement Partnership programme	20 out of 36 in 2017/18 = 55%	2018/19 programme not finalised. ?75% target	
	5.3	Percentage of national audit outcomes and improvement plans included in the 6 monthly Audit Assurance Reports	65%	80% by November 2018	
	5.4	Percentage of 19/20 Directorate Annual Clinical Audit Work plans approved.	No baseline – work just commencing	90% by 31 March 2019	
	5.5	Percentage of clinical guidelines which are beyond their review date,	42% are out of date (206 out of 490)	25% by December 2018	
Department	**Ref**	**Indicator**	**Measurement**		

			Baseline	Target	Progress as at xx/xx
6. Mortality & Morbidity	6.1	Establish M&M chairs forum		July 2018	
	6.2	Establish M&M outcome review group for assurance		August 2018	
	6.3	"Backlog" of deaths IMMIX/NOTE system (n=131): Percentage of mortality reviews completed	 66%	80% by June 2018 95% by September 2018	
	6.4	Regional Morbidity & Mortality System: Percentage of mortality reviews completed within 8 weeks of death	78%	85% by August 2018	
	6.5	Establishment of the independent audit of a sample of deaths through the Outcome Review Group	Zero	10 deaths independently reviewed per quarter	
7. Emergency Planning and Business Continuity	7.1	Number of Major Incident training sessions facilitated at corporate level within 2018/19	Zero	1 session	
	7.2	Number of Major Incident or Business Continuity training sessions facilitated with wards/departments during 2018/19	Acute 0 OPPC 1 CYP 0 MHLD 0	Acute 4 OPPC 2 CYP 2 MHLD 2	
	7.3	Completion of top 4 corporate plans: • Acute Services Major Incident Plan • Corporate Major Incident Plan • CBRN Major Incident Plan • Lockdown Plan	None signed off by SMT as at 1st April 2018	All to be completed and corporately approved by August 2018	

Clinical and Social Care Governance – Accountability Score Card 2018

Set out below are proposed Clinical and Social Care Governance Objectives for 2018. In identifying objectives below consideration has been given to the following:

- Patient Client Experience Work Streams
- SHSCT quality Improvement Strategy
- Internal Audit Recommendations
- The Recommendations of the Public Inquiry into Hyponatraemia related Deaths
- Findings of the Trust Safety Climate Survey 2016
- Regional CSCG Work Streams

Immediate Objectives (3-9 months) Patient Safety, Patient Experience, Quality Improvement, Clinical Engagement, Learning and Development)

Objective	Measure	Baseline	Target	Updates
The Development of Lessons Learned Framework	Terms of reference agreed	NA	August 2018	
	Membership agreed	NA	August 2018	
	Programme of meeting dates agreed	NA	June 2018	
	Draft Framework proposal to SMT	NA	September 2018	
	To identify the number lessons considered through the lessons learned forum which results in a change in practice or quality improvement initiative	Baseline Zero	1 Quality Improvement initiative established in year 1 as a result of lessons learned	A Lessons Learned forum has been recently established (January 2018) Safety Climate survey completed 2016

Objective	Measure	Baseline	Target	Updates
	Engage all Trust staff in the lessons process though proactive communication	Baseline Zero	Quarterly communication targeting all staff of key cross directorate / Trust wide lessons to help improvement patient and staff safety July 2018	Links to regional Quality 2020 work plan – SHSCT leading on project Strengthening Our Responses to Adverse incidents
Complaints	Number of complaint acknowledgements issued within two days of complaint receipt	96% Quarter 4 2018	100% Quarter 4 2019	
	Number of complaint responses issued within 20 days	58% Quarter 4 2018	75% Quarter 4 2019	
	Number of complaint responses issued within 30 days	83% Quarter 4 2018	95% Quarter 4 2019	
	Perform a regular review of complaints using the HCAT tool across all directorates for benchmarking 1. Use the Tool to produce Complaints data for SMT and quality improvement steering group 2. Trial the use of HCAT with patient stories (10,000 voices) received	Zero	Each quarter code 50 randomly selected complaints using the HCAT tool 1. Each quarter produce a rolling report analysing trends in complaints and identifying areas for quality improvement 2. Use HCAT code and analyse 250 patient stories 3.	DoH has adapted the SHSCT and London School of Economics work to code complaints regionally. Continue to work with the LSE on the trail of the patient Experience information tool
Standards and Guidelines	All S&G received to be logged corporately within 5 working days of receipt	No Baseline	100% Quarter 4 2019	

Objective	Measure	Baseline	Target	Updates
	A Change Lead has been identified within 12 weeks (per DoH requirement).	Baseline 100%	100% Quarter 4 2019	Standards and Guideline – snap shot audit April 2018 baseline figures provided
	Assurances forwarded to external agencies within timescales requested	Baseline 100%	100% Quarter 4 2019	
Serious Adverse Incidents	Percentage of SAI's processed within Regional Timescales	Number of SAIs outstanding (Qtr. 1 2018) – 32 Of the 32 84% outside of regional timescales	To ensure 100% of level 2 and 3 SAIS are completed within regional timescales	SAIs are monitored on a rolling basis and reported figures will be based on current snapshot of SAIs outstanding
	Implement a programme of training for clinicians involved in incident investigation and review which focuses on: 1. Human factors 2. Systems Analysis methodology Patient Service User Involvement	Percentage of staff trained (currently no standardised baseline measurement)	50% of all SAI chairs will have received formal best practice training by 2019	Programme agreed for testing by SAI chairs – September / October 2018. Content aligned to best practice internally and Hyponatraemia Inquiry recommendations
Development and Implementation of a Senior Safety Walk Programme	1. Develop a Trustwide safety walk framework based on best evidence based practice to include a reporting framework at team, directorate and SMT level 2. Develop an information resource for staff on models of senior safety walks based on best practice	1. TBC	1. Developed by Quarter 1 2019 2. SMT proposal paper by November 2019	SAFE ward initiative commenced in Paediatrics Nursing safety walk programme in progress OPPC directorate

Acting Medical Director's Walkaround M&Ms, 16 April 2018 :

- Reflection and review within M&M is central to patient safety and ongoing quality improvement
- Delighted to see 15 robust M&M structures across the Trust.
- Regional Workshops M&M and child deaths : March 2018
    - CMO: "culture has changed positively".
    - Challenges at regional level:
        - How do we know the learning from M&M is shared and embedded?
        - Where not already established, recommend move to MDT approach
- Regional M&M System - just over 1 year old.
- Work in progress regionally: All Trusts are seeking H&CNo to be added to email alert to Consultant.
- Acknowledge your progress in reviewing deaths using this system – monthly paper to AMD Forum since Nov 2017.
- Continuing support from M&M Facilitators to "mop up" older cases. Aim for July 2018.
- DHSSPS : Training on Phase 2 changes to Regional M&M System : 17/31 May.
- Develop a rolling programme of training on Regional M&M within Trust.
- Re-establishing M&M Chairs Forum : 17/31 May
- Establishing of M&M Outcome Review Group , June 2018
- Importance of your clinical leadership and voice to inform how we can do things better, or easier
- Role of M&M Chair is very significant

Specifics for individual M&M:

Surgical subspecialty meetings: Anaesthetics , ICU, ENT, T&O, Urology (Months 1 & 2)	• Benefit of subspecialty M&M meeting: allows more detailed review of cases within your specialty • Enables identification of cases for further review and shared learning at the quarterly combined surgical/anaesthetic meeting - below. • Meetings can include also audit, complaints, learning from SAIs, Incidents
Combined surgical, anaesthetics (Quarterly meeting)	• Opportunity to share learning from cases discussed at specialty meetings • Forum for further peer review challenge • Inputs from pharmacy, infection control, resuscitation officers, SAIs • Recent focus on Trauma
IMWH	**MRRRACE: Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (excellent summary of progress against actions in Audit Assurance Report, Nov 2017)** ➢ Primarily audit meeting, followed by perinatal M&M ➢ Move to cross site **obstetric** audit/perinatal meeting (timescale) ➢ Current challenge duplicated discussion on child deaths …. ➢ So plan to streamline by ➢ Combined **IMWH / CYP** cross site meeting for perinatal / child deaths ➢ Additional internal and external reflection through Annual Perinatal Meeting ➢ Dr Henderson reps IMWH on Regional Child Death Review Group. ➢ Case studies at Child death Learning Event 12/3/2018 – share at M&M Chairs Forum ➢ PHA totally dependent on content of information on child death notification form to identify patterns, learning etc.
General Medical CAH, Lurgan & South Tyrone Incorporates deaths, Acute Care at Home	➢ Highest number of deaths monthly ➢ Acknowledge huge progress in completing M&M reviews. ➢ Well structured agenda, covering SAIs, IRI, PMs, established trigger list (deaths before post take wardround), medication incidents, infection control, etc ➢ Challenges around ownership of ICU deaths: work in progress ➢ Dr McNeilly's last M&M. Acknowledge clinical leadership and enthusiasm…..

Southern Health and Social Care Trust

Clinical Directors meeting

Friday 24th August 2018 – 2pm

ACTION NOTES

Present

Dr Ahmed Khan	Dr Jo Minay
Dr Pat McCaffery	Mr Geoff McCracken
Simon Gibson	Dr James Hughes
Dr Chris Clarke	Dr Arun Subramarian

1. Items for discussion

Job planning

Dr Khan briefed the meeting on progress being made to improve the job planning process. It was agreed during discussions that team job plans would be ideal, to ensure consistency between colleagues and sites. It was also noted that there was a need to obtain prospective cover within job plans (particularly in light of workforce difficulties).

It was noted that Internal Audit were scheduled to visit the Southern Trust in the late autumn, and there was an expectation that the current level of completed job plans (39% completed with a further 9% at 2nd/3rd sign off).

Dr Khan summarized some of the proposals in the new Job Planning paper which were directed to try and attract recruits to the Southern Trust, including:

- 1.5 Core SPA's and upto 1.0 additional SPA (for additional Non clinical duties) to be agreed with the Trust
- Up to 1.0 SPA can be undertaken flexibly (such as at home)- to be agreed at JP meeting by AMD/CD
- A date at which senior clinicians may come off the on-call rota but take on different roles, to encourage retention of senior clinicians rather than retirement

Dr Khan also summarized the work being undertaken at SMT and regional level to help with medical recruitment

IPC 3 Year Strategy

Dr Khan summarized the progress being made in supporting the IPC and Microbiology team, and creating a 3 year strategy looking at a range of issues

It was commented that there may be benefit in applying some operational common sense to the IPC audits, for example in relation to the EAW. It was also discussed that there were benefits in ensuring antibiotic ward rounds were undertaken in combination with the managing clinicians

It was agreed to circulate the current draft strategy to CDs for comments

Action: Simon Gibson

Medical Leadership review

Dr Khan summarized the current draft paper. It was noted that an appropriate allocation for Clinical Directors was being proposed (1.5PA's), alongside admin support for the Clinical Directors.

It was identified and recognized that undertaking appraisal was not formally part of the role of Clinical Director

Medical workforce issues

Anaesthetics – Issues in both Interventionists and General Anaesthetists

O&G – Gaps are more at training grades and trust grades

Psychiatry – gaps in Old Age Psychiatry, plus impact of consequence of MHO status. Need to get NIMDTA to review their workforce projections and training places)

Geriatric Medicine – Vacancies in DHH Geriatrics could impact upon Pathfinder Project

Community Paediatrics – It was noted that there were severe shortages in this area

Learning Disability – It was noted that there were gaps in this area, in comparison to the Royal College guidelines

2. Agenda items for information

Hyponatremia update

Dr Khan provided a brief on the regional progress relating to the implementation of the O'Hara recommendations. It was agreed to circulate the latest update with the action notes.

Action: Simon Gibson

Health & Wellbeing

It was noted that there was a requirement for each Clinical Directors to consider what they could do to improve the health and well-being – physical and mental – of themselves

Action: All to note

It was noted that Dr Khan was hoping to improve the facilities for on-call Junior onsite doctors as part of improving the health & wellbeing

Action: Dr Khan

3. **Any other business**

4. **Date of next CD meeting for your diary:**

Friday 30th November 2018 at 2.00pm – 3.30pm in Meeting Room, Trust HQ, CAH with v/l to Committee Room 2, DHH.

Date	Time	Venue
Friday 19th January 2018	2.00pm – 4.00pm	Boardroom, Trust HQ, CAH
Thursday 15th February 2018	2.00pm – 4.00pm	Boardroom, Main Hospital, CAH
Friday 16th March 2018	2.00pm – 4.00pm (CANCELLED)	MEDICAL FORUM Meeting Room, Brackens CAH with V/L to Committee Room 2, DHH
Tuesday 10th April 2018	2.00pm – 5.00pm	Meeting Room, THQ, CAH
Thursday 10th May 2018	2.00pm – 5.00pm	Boardroom, DHH
Friday 15th June 2018	2.00pm – 5.00pm	Boardroom THQ, CAH
FRIDAY 27th July 2018	2.00pm – 5.00pm	Meeting Room, THQ, CAH
Thursday **23rd** August 2018	2.00pm – 5.00pm	Meeting Room, THQ, CAH
Friday 14th September 2018	2.00pm – 5.00pm	Meeting Room THQ, CAH
Tuesday 9th October 2018	2.00pm – 5.00pm	Clanrye House Meeting Room, DHH
Thursday 8th November 2018	2.00pm – 5.00pm	Seminar Room 1, MEC, CAH
Friday 14th December 2018	2.00pm – 5.00pm	Meeting Room THQ, CAH

Southern Health and Social Care Trust

Minutes of Associate Medical Directors Meeting
Tuesday 10th April 2018 - 2pm
Meeting Room, Ground Floor, Trust HQ

Present:

Dr Ahmed Khan (Chair), Mr Simon Gibson, Dr Damian Scullion, Dr Philip Murphy, Dr Mark Haynes, Dr Shahid Tariq, Dr Martina Hogan, Dr Peter Sharpe, Dr McMahon, Mr Colin Weir, Mrs Anne Quinn, Mr Shane Devlin, Mrs Laura White (minute taker).

Item:

1.0 Apologies and Welcome

Apologies noted from Dr David Rodgers.

Dr Khan welcomed everyone to the meeting and an extended welcome to Dr Pat McMahon our new AMD for Mental Health.

2.0 Minutes of last meeting

The minutes of the last meeting 15th February 2018 were agreed.

3.0 AMD Forum – reflection and review

Following discussion the following was agreed:

- Team to meet monthly even if MD not available, to keep continuity. MD would nominate deputy to chair this meeting in his absence
- Agenda and minutes to be issued 7-10 days in advance of the meetings
- It's highly recommended for AMDs to attend this forum meeting.
- AMD to arrange for CD to cover when not available to attend the meetings
- If AMD not attending a short written report should be provided (via e-mail) to the MD.
- Operational Directors to be invited (scheduled in advance) to come for half an hour at the beginning of the meeting
- AMD forum meeting will be held on CAH & DHH sites on 70:30 distribution
- Medical Forum (CX to Chair) on a quarterly basis which may be a separate forum from AMDs forum meeting
- Dr Damian Scullion to meet with Simon Gibson and Dr Khan before next AMD meeting to take forward
- New appointments to be available for the next meeting (**Laura to request from HR**)
- It would benefit that new consultants/trainees/Adept Fellows to attend AMD meeting as observers (**Laura to invite to next meeting**)

4.0 Agenda items requiring decision

- **Mortality and Morbidity – Assurance structures**

Anne Quinn discussed the above information with the team. It has now been six months into monitoring the M&Ms; good progress has been made in completing mortality reviews. Further training on ECR system changes will be provided by Department of Health representatives.

A number of actions by the Clinical Audit / M&M team were agreed as outlined in the M&M Dashboard Report which Anne will provide.

Action: Anne Quinn to contact Dr McMahon for a separate meeting.

Simon discussed power point presentation which summarised the recent Regional meeting considering M&M structures.

Action: Simon Gibson and Anne Quinn to draft TOR and draft membership and e-mail in advance of next AMD meeting.

5.0 Agenda items for discussion

- **Medical Leadership structures**

Dr Khan discussed the paper with the team. Other Trust to share with us their structures, job plans etc., before next AMD meeting we will have something to share.

Action: Dr Khan and Simon Gibson to work on initial draft

- **Hyponatremia – Southern Trust Action Plan**

Simon Gibson gave an update to the meeting. Of the 76 applicable recommendations, evidence of what is required to make us fully compliant is required in 8 weeks' time. These meetings need to be organised 6 weeks in advance due to clinical commitments. The next one is to take place on Tuesday 29th May at 2pm.

Action: Laura to send out next date to staff.

- **Management of Job Plans – Internal Audit report**

Simon Gibson discussed with the team. Revised Job Plan guidance from Zoe Parks and Malcolm Clegg had been issued – comments are being sought.
Some element of flexibility is required as and when roles change (6 months maximum).

Action: Simon Gibson to feed back to Malcolm Clegg and Zoe Parks to action. Issues re - signing off to be discussed with Malcolm and Zoe. There are still 3 sign offs required the CD, AMD and Medical Director.

Simon Gibson to send to AMDs for comment and bring back to next AMD meeting.

Action: There is a paper in place – Simon to discuss with Zoe Parks. Internal Locum Consultant rates are different and creating a big issue. Simon to look into this
Vivienne Toal looking at the Regional consistency – we need to progress with a 'Trust' rate.

- **Divisional Update**

IMWH – Dr Hogan mentioned that 2 SAIs are high level – maternity and baby group A Strep.

S&EC - Dr Haynes mentioned that Urology mid-grade not fully staffed. Simon Gibson confirmed that there is no formal process in place at the moment but he will discuss with Zoe Parks.

Action:
Simon Gibson to check with Zoe Parks. Vivienne Toal looking into Regional consistency.

C&YPS - It was noted that there are challenges in Peads and T&O for under 14 year olds for non-fracture. Replacement temp; AMD post going out tomorrow working to increasing age limit – discussion phase – paper to be shared with Dr M and Dr S.

ATICS - The delivery of elective services are critical, therefore we are only delivering Red Flag cases. Ongoing risks – urgent waiting times in Urology.
There are 4 year / 6 weeks waiting times for Men and Women (Gynae/Breast) in different specialties, we have to bring waiting times down.

ICU – down to 4 staff members, with no locum cover. "Winter still here" - CAH and DHH not much better.

USC/Med - CAH running on locums – 50% DHH locums. Unscheduled care being looked after by locums.

C&CS - There is no oncologist in the cancer services.

R&D – Dr Sharpe mentioned that the Laboratory department have a long standing problem as not enough micro-biologist staff.
Radiology department are relying on locums, rates are low and not taken up by in-hose staff.
The outcome is that locums are being paid nearly double the rate.
Recruitment: a couple of months ago – looking after patients as locum to start with the Trust.
Re-advertising for Registrars

MH&D – Dr McMahon mentioned that they are 2 people down with a locum covering in psychiatry for old age. Trainees interested in posts but long-term.
Looking at winter pressures / efficiency. Junior coming on board

Action:
Dr Khan to talk to Esther before taking to SMT.

Mr Devlin introduced himself, he recognised the importance of clinical leadership within the organisation and the need to support with strong clinical management. He mentioned that he will be meeting all the AMDs on a 1-1 basis in the near future.

Date of next meetings:
AMD meeting : Thursday 10th May at 2pm in Boardroom DHH
Medical Forum : Friday 15th June at 2pm in Boardroom, THQ with v/l to Committee Rm 2, DHH.

Southern Health and Social Care Trust

Quality Care - for you, with you

Southern Health and Social Care Trust

Incident Management Procedure

October 2014

Procedure Checklist

Name of Procedure:	Incident Management Procedure
Purpose of Procedure:	To describe the Trusts systems and processes in relation to Incident Management
Directorate responsible for Procedure:	Corporate Governance, Office of the Chief Executive
Name & Title of Author:	Mrs Margaret Marshall, Interim Asst Director CSCG
Does this meet criteria of a Procedure?	Yes
Trade Union consultation?	No
Equality Screened by:	
Date Procedure submitted to Policy Scrutiny Committee:	
Members of Policy Scrutiny Committee in Attendance:	
Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible:	Chief Executive
SMT Approved/Rejected/ Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet:	
Date for further review	

Contents

1.0 Introduction:

The consistent identification, monitoring and review of incidents is central to the Trust"s strategic and operational processes to ensure it can achieve its vision for safe and effective care. As recommended in the document „Safety First: a Framework for Sustainable Improvement in the HPSS" (HPSS 2006) the Trust recognises that incident reporting is a fundamental element of its Risk Management Strategy.

1.1 Purpose:

The purpose of this procedure is to guide all employees of the Trust in the following:

- Identification, reporting, review, monitoring and learning from all incidents which have resulted in or had the potential to result in injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure.
- Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimise exposure to associated risks.
- Enable staff to participate in, and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice.
- Notification and recording of incidents from third party organisations from which the Trust commissions services.
- Notification of incidents where appropriate to other relevant agencies, for example the Regional Health and Social Services Board (RHSCB), Regulation Quality and Improvement Authority (RQIA), Department of Health, Social Services and Public Safety (DHSSPS) via appropriate Early Alerts, HM Coroner, Northern Ireland Adverse Incident Centre (NIAIC), Health & Safety Executive Northern Ireland (NIHSE), Police Service of Northern Ireland (PSNI), etc. Please see **Appendix 2.**

1.2 Scope of the Procedure:

The following procedure applies to all employees of the SHSCT. Some aspects, including reporting a serious adverse incident, also applies to independent providers / contractors commissioned or engaged by the Trust. It addresses the Trust's governance responsibilities in relation to incidents and is one element of the Trust's Risk Management Strategy.

2.0 The Roles and Responsibilities:

2.1 Chief Executive:

The Chief Executive is the responsible Officer for the Trust"s statutory duty of quality and is required to drive the delivery of the Trust"s corporate priorities, particularly the priority to provide safe, high quality care. Through the overview of this Trust Policy and Procedure, the Chief Executive will seek to embed the Trust"s corporate values throughout the organisation, to promote the Trust"s values of all staff being open and honest and acting with integrity, to listen and learn and to embrace change for the better.

The Assistant Director for Clinical and Social Care Governance (AD CSCG) reports directly to the Chief Executive and will provide the Chief Executive, Trust Board, Senior Management Team (SMT) and Governance Committee with an on-going overview of this Policy and Procedure through the continuous corporate review and monitoring of Incidents and Serious Adverse Incidents (SAIs).

2.2 Assistant Director of Clinical and Social Care Governance (AD CSCG):

The AD CSCG will provide leadership to ensure a systematic and organisation-wide approach to the reporting of clinical and social care incidents and near misses and will work with SMT to embed a culture of appropriate and timely reporting, analysis and learning across the organisation.

The Assistant Director will participate in monthly meetings with the Clinical and Social Care Governance Coordinators in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

It is the responsibility of the AD CSCG to present a trend analysis report quarterly of all incidents reported in the Trust to:

- Senior Management Team (SMT)
- the Governance Committee
- CSCG Working Body

This report will be used by the SMT to inform organisational risk management and governance priorities and will escalate concerns in relation to trends and /or learning.

On behalf of the Chief Executive and SMT, the AD CSCG will provide assurance reports to Governance Committee in relation to the adoption and implementation of procedures relating to incident reporting, monitoring and learning. This includes evidence of cross organisational learning through appropriate forums including the Trust Governance Working Body.

The AD CSCG will act as a conjugate between the Directorates and the Chief Executive, appraising the latter of all major and catastrophic incidents, internal reviews and Serious Adverse Incidents. They will also liaise on behalf of the Trust with the Department, the Public Health Agency (PHA) and the HSCB to ensure the Trust contributes to and is involved in any Regional opportunities for learning.

2.3 Directors:

- Directors are responsible for leading a culture of openness, transparency and learning within their area of responsibility and for ensuring that the actions from any learning are appropriate and the most effective way to minimise risk and provide good care services
- Directors shall ensure that processes are in place to effectively identify, report, review, monitor and learn from all incidents within their Directorate and that the processes are as laid out within this procedure
- They shall ensure that the reviewing, learning from and monitoring of incidents is included on the agenda of all directorate, divisional and team governance meetings
- They shall ensure that action plans and learning to be implemented from incidents are an effective response with an appropriate timescale, prioritised and are reviewed on an on-going basis at directorate governance meetings
- Directors shall consider learning from moderate, major and catastrophic incidents and any trends identified from insignificant / minor incidents to inform directorate governance priorities, education, training and directorate and organisational learning. The latter should be identified through the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- They shall ensure that all current risks recognised from this governance of incidents are considered for the Directorate / Corporate Risk Register
- Training – liaise with the appropriate Executive Directors with responsibility for professional and organisational training

2.4 Assistant Directors & Associate Medical Directors (AMD's for clinical incidents):

All incidents recorded on Datix Web must be reviewed by an ***Incident Review Team*** on a ***weekly*** basis***.*** It is the responsibility of all Assistant Directors / Associate Medical Directors (AMDs) to put in place ***Incident Review Teams*** within their divisions/teams. The membership of an Incident Review Team should include a Head of Service / Senior Manager and an identified Clinician where ***clinical incidents*** are under review.

The Assistant Director / AMDs must also:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services

- Include the management, review, monitoring and learning from incidents on the agenda of divisional, service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at divisional meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying directorate and divisional governance priorities, education, training and organisational learning in a timely way
- Organisational learning should be identified through to the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- Identify training needs to the appropriate Heads within the Trust
- Ensure through their Heads of Service that any barriers to implementing the learning from moderate, major or catastrophic incidents is risk assessed using the SHSCT risk assessment matrix, highlighted at Directorate Governance Fora and placed on the appropriate risk register if not immediately actioned

2.5 Head of Service/ Team Manager:

It is the Head of Service/Team Manager"s responsibility to:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services
- Include the management, review, monitoring and learning from incidents on the agenda of service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at team meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying service and team governance priorities, education, training and organisational learning in a timely way
- Escalate any barriers to implementation of action plans relating to incidents to the appropriate Assistant Director and consider if they need to be placed on the appropriate Risk Register
- Ensure through the function of the ***Incident Review Team*** that feedback is provided to the incident reporter on the outcome of incident investigations for all moderate, major and catastrophic incidents

2.6 Incident Review Team:

- The purpose of the ***Incident Review Team*** is to review all incidents, determine any learning from them, make recommendations as to what would constitute an effective response which will minimise risk and communicate this within their teams (and to Heads of Service / Team Manager if they are not part of the Incident Review Team). Learning / effective response to any risks highlighted should then be communicated to the appropriate Head of Service / Team Manager for action within the operational teams. Any barriers to implementation of action plans relating to incidents should be escalated by the appropriate Head of Service to the Assistant Director.

The Review Teams should also consider and review the following:

- The information submitted by the reporter including the incident grade
- Consider the need for additional internal and/or external reporting e.g. Health and Safety, RIDDOR, NIAIC, HSCB, RQIA, Adult Safeguarding (PVA). See **Appendix 2**
- Develop time bound and prioritised action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require an action plan which **must** include relevant learning points
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of incident
- Close all incidents following completion of the review process

All Incident Review Teams should adhere to the Datix Web User Guide for Managers/Reviewers which can be accessed from the Trust intranet site. See Hyperlink:

[redacted] f

2.7 The Directorate CSCG Coordinator:

The CSCG Coordinator will ensure that processes are in place for the recording, reviewing, monitoring and learning from incidents and will provide timely and appropriate information on incidents to the Directorate. Reports will be tailored for Directors, Assistant Directors, Heads of Service and Team Managers.

The CSCG Coordinator will also be responsible for interpreting and analysing incident information to identify risks and/or trends. They will feedback this information to the Directorate through the Directorate Governance structures.

The CSCG Coordinator will provide regular and timely information to the Directorate on the action plans and learning arising from incidents and SAI"s and the progression of these action plans.

On behalf of the Director, the CSCG Coordinator is responsible for monitoring that within each service team, incident information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety and facilitate teams to make any links required from issues identified in incident management to appropriate Risk Registers. They will also ensure that a process is in place to escalate any concerns relating to incidents to the appropriate Director, and that there are appropriate processes in place to identify SAIs in line with the Health & Social Care Board (HSCB) process.

The CSCG Coordinator will participate in monthly meetings with the Assistant Director of Clinical and Social Care Governance in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

2.8 All SHSCT Staff:

All SHSCT staff are required to provide safe, high quality care and this includes the reporting of incidents for organisational learning and good risk management as defined below and further in **Appendix 1**, in accordance with this procedure and participate in any subsequent review if required.

3.0 Procedure for the Identifying and Reporting of Incidents – ALL STAFF

3.1 Incident Identification:

A useful definition of an incident is:

"Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."

The incident may arise during the course of the business of the Trust or any of its commissioned / contracted services.

However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.

3.1.1 Other Systems for Reporting:

An incident can sometimes also be reported through other systems such as Adult Safeguarding, Case Management Review, Mortality and Morbidity meetings, etc.

The Trust mechanism for recording all incidents is **Datix Web** and the electronic incident form (IR1) should be completed as soon as possible after the incident occurs or is discovered to have occurred. Staff should then think through what other reporting systems, such as notifying their Line Manager, may need to be considered.

3.1.2 Incidents Occurring Within Services Contracted or Commissioned by the Trust:

Incidents occurring in contracted / commissioned services which are not observed / witnessed by Trust staff and / or not reported to Trust staff are dealt with under the regional contractual arrangement with independent providers. This states that all incidents occurring within the regulated sector which are notifiable to RQIA will also be notified to the appropriate Trust via a central email. From here they will be distributed to the appropriate Directorate for review as per section 4 of this procedure.

If a member of Trust staff observes or witnesses an incident occurring within a service contracted or commissioned by the Trust or has an incident reported to them by a Trust client and / or their family / carers which relates to care provided by a contracted or commissioned service i.e. domiciliary care services, private nursing home, etc. then the member of staff has a duty to report the incident using the Trust Datix web system. The staff member will also instruct the contracted service to report the incident via their reporting mechanisms (which include notifying RQIA and Trust of significant incidents) and this instruction should be documented by Trust staff. If reported to the Trust by the contracted service the Datix incident reports should be merged by the appropriate governance team. **The original incident should be reviewed as per section 4 of this procedure.**

3.1.3 Immediate Action Checklist Following Identification of an Incident:

When an incident is identified and before it is reported please complete the following **immediate action checklist:**

- The extent of injuries/damages to person(s) or property should be ascertained and a determination made regarding the need for emergency or urgent treatment / action. For patient / client care related incidents, contact the relevant medical team to assess where required. The situation must be made safe
- Appropriate obvious treatment / actions should be taken to minimise the likelihood of the incident recurring
- Any equipment involved in the incident should be removed from use and clearly labeled, “Do not use”, until appropriate checks can be carried out. Do not dispose of equipment involved in an incident
- **The patient/client and/or their relatives / carers** should be informed, as soon as possible of the incident and of any treatment that may be necessary taking into consideration any consent issues and referring to the Trust‟s “Being Open” guidance in **Appendix 4**

- Any incident involving a patient or client, and the action taken, should be recorded in their healthcare record
- If the incident is major or catastrophic and requires an immediate action plan to prevent further harm the line manager (if out of hours, the Senior Out of Hours Manager) should be informed
- For incidents requiring further in-depth investigation e.g. SAIs/Internal Root Cause Analysis (RCA"s) / Reviews, patient/client records should be returned as soon as is practical to the Directorate Governance Coordinator to ensure all recorded information is available for review. Retrospective notes are permitted as long as these are clearly marked as being made in retrospect
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation.
- Security staff and/or the PSNI should be informed where appropriate
- Consideration should also be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures)

3.2 Reporting an Incident:

Where: All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on „Datix Web")**

By Whom: This form must be completed by either the member of staff involved in or who has witnessed the incident, or by the person the incident has been reported to.

When: All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred **or** its occurrence became known.

How: Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:*

http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf

Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager, relevant Assistant Director and the Assistant Director of Governance in an email via Datix Web.

In circumstances where the incident is considered as a potential **Serious Adverse Incident (SAI),** *(see **Appendix 1** for the definition of an SAI)* immediate telephone contact should be

made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Associate Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. This group must complete a major/catastrophic incident checklist for all incidents screened as possible SAIs. This checklist, regardless of the outcome of the screening process, will be held by the Directorate CSCG Coordinator and copied to the Assistant Director of Governance via the Corporate Governance Office**. (**See **Appendix 6)** In the event of the incident meeting the Serious Adverse Incident criteria; **section 5.0** of this procedure should be followed and where appropriate, the Director should brief the Chief Executive on SAIs as soon as possible.

4.0 Procedure for Reviewing, Monitoring and Learning from Incidents:

All incidents are to be reviewed on a weekly basis by the service area‟s Incident Review Team. As indicated earlier the purpose of the Incident Review Team is to undertake a local assessment / review of the incident in a timely manner. This review should include:

- Quality assure the information submitted via the Datix system and the initial severity rating given to the incident. Where the review team believes the severity rating should be changed – the incident reporter should be contacted and this should be discussed and agreed
- Calculate the actual and potential risk rating for the incident using the Risk Grading Matrix and impact Table – this is explained on the Datix screen and also in **Appendix 3**
- Consider the need for additional internal and /or external reporting e.g. RIDDOR, NIAIC, HSCB, RQIA, Vulnerable Adults (PVA), Fire **(See Appendix 2 for guidance on advisory contacts re: these additional reporting routes)**
- If the incident is also an adult safeguarding review (this will be recorded on Datix) then the Incident Review team should link with the adult safeguarding Designated Officer (DO) for that incident. If the incident is proceeding to a safeguarding investigation the Incident Review Team should participate in that or at a minimum, review the learning from that investigation and implement as appropriate
- Develop and agree learning and action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require a time bound action plan which **must** include relevant learning points. This learning should be communicated and actioned within teams
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform the Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of the incident
- Any barriers to implementation of action plans relating to incidents should be escalated to the appropriate Head of Service and the Assistant Director

- Close all incidents following completion of the review process

4.1 Incident Review:

The following risk assessment process should be applied to all incidents at the time of occurrence in order to decide what level of investigation is required and at what level within the Trust the investigation should be conducted.

***Step One** – What was the impact of the incident at the time of the incident? (Actual Harm)*

4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident"s severity in the range Insignificant to Catastrophic.

4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis.

4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required.

***Step Two** – What might the impact be if the incident happens again? (Potential harm)*

4.1.4 Where the potential harm of the incident is being considered, staff must ask the following in the context of "if no further action was taken".

- Was the harm caused by a chance happening?
- Could the actual harm caused realistically have been a lot worse?
- How many people might be hurt if it happened again?
- How seriously might someone be hurt if it happened again?
- What are the control measures already in place, today?

4.1.5 It is important that grading on actual harm and potential harm are completed as separate exercises. This will ensure that the most severe incidents where the level of actual harm is higher are dealt with as a priority. All incidents with a lower level of actual harm but with a potential for a higher level of harm must be managed appropriately.

Step one	Deciding what was the impact / harm of the incident today **(actual)**
Step two	Where there is insignificant to moderate actual impact/harm, deciding what might the realistic impact/harm be if the incident were to happen again under similar circumstances. **(potential impact)**
Step three	Decide what are the chances of the incident happening again under similar circumstances. At this stage consideration should also be given

	to reviewing similar incidents that have happened in the past. **(Likelihood)**
Step four	Decide what the overall risk grading for the event is by plotting: **Impact** multiplied by **likelihood = risk grading**

The level of review applied to an incident is determined by the actual severity (impact) of the incident and/or the potential impact and is as follows:

INSIGNIFICANT AND MINOR – These incidents will usually not require detailed review, however the following questions should be asked to establish any learning:

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

However, these incidents could be subject to detailed review if similar incidents are found to occur frequently i.e. where there is a trend. It is the review team"s responsibility to identify such trends and advise the appropriate Head of Service/Team Manager or Assistant Director regarding improvements or action plans required if a trend is identified. Heads of Service and Assistant Directors should also be identifying and analysing trends through their Team / Service / Divisional Governance meetings. Action plans and lessons learnt from this trend analysis should be discussed and actions recorded in the notes of team, service and divisional governance meetings.

MODERATE – These incidents **must** be reviewed as part of the incident review process on a weekly basis. The review team must ensure that an investigation is completed within four weeks and that there is a documented action plan and learning points recorded on Datix Web. These actions and the learning should then be reviewed by the team, division and directorate with respect to progress of implementation.

In undertaking a Moderate Incident review the following questions should be answered **as a minimum:**

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

Further guidance on incident review is available in **Appendix 7.**

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation. Action plans and implementation of learning should also be reviewed at the Directorate Governance forum by the Director.

MAJOR AND CATASTROPHIC - This level of incident will, as previously described, have been automatically notified by the Datix system to the Head of Service, relevant Assistant Director and the Assistant Director of Governance at the time of reporting. It is the responsibility of the relevant Assistant Director to inform the Director and Associate Medical Director (AMD) (in the case of clinical incidents) and the appropriate CSCG Coordinator for that area of the incident.

The incident must be considered against the HSCB (October 2013) criteria for a Serious Adverse Incident (SAI) by the relevant Director, Assistant Director, AMD and CSCG Coordinator. This review of the incident should be documented by the CSCG Coordinator on the major / catastrophic incident checklist which must be completed by the group. Regardless of the outcome of the screening, the completed checklist should be shared with the Assistant Director of Governance via the Corporate Governance Office. In the event of the incident meeting the SAI criteria, **section 5.0** of this procedure should be followed.

If the incident does not meet the SAI criteria the relevant Director may either appoint an independent internal team to review the incident using a Root Cause Analysis methodology (the method used to review an SAI -see section 5) or the incident may be reviewed by the service Incident Review Team. **(**See **Appendix 7)**

Whatever the method of reviewing the incident – either as an SAI, an internal review by an independent team within the Trust or by the clinical review team within the division itself, the service team involved in the incident **must** be informed of the decision regarding how the incident is to be reviewed at the earliest opportunity, by the Assistant Director / Associate Medical Director, and **before** the review commences.

Where an incident is to be reviewed internally by an independent team or if it is the subject of an SAI, the patient /client and/or family/carer must be informed of this review at the earliest opportunity (as per the HSCB SAI guidance April 2014) as should the coroner where the case has previously been referred to them. This action forms part of the major / catastrophic incident checklist and should be documented. In exceptional cases where it is not appropriate to share this decision with the patient /client and/or family/carer, the reasons for this decision **must** be documented on the checklist and on the SAI notification form.

The findings and recommendations of the review - irrespective of how it is carried out, will be discussed and documented at relevant team, service, division, Morbidity and Mortality meetings and directorate governance meetings.

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation.

Action plans and implementation of learning will also be reviewed at the Directorate Governance forum by the Director.

Cross Directorate learning points should be escalated to the Assistant Director of Governance by the CSCG Coordinators when they meet monthly.

The findings and recommendations of an internal review of an incident or an SAI should be shared with the patient / client and/or family / carer, RQIA and the coroner (if previously referred) at the earliest opportunity.

5.0 Procedure for Reporting and Completing a Review of a Serious Adverse Incident (SAI):

Following the review meeting of the relevant Director, Assistant Director, AMD and CSCG Coordinator where it is agreed to report an incident as a SAI, the SAI notification should be electronically reported to the HSCB, via the Corporate Governance Office, as per the HSCB Procedure for the Reporting of SAIs (HSCB October 2013)

See Hyperlink:
http://www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

The Directorate CSCG Coordinator will populate the HSCB SAI notification form on behalf of the appropriate Director and forward to the Corporate Governance Office for the attention of the Assistant Director of Governance. All SAI notification forms **must** be fully completed and accurate with an appropriate Datix ID number when submitted to the Corporate Governance Office and should be done so **within 72 hours** of the incident occurring. The Director / their designate should also report the SAI to the Chief Executive.

If the SAI concerns the death of a patient and the death has been reported to the Coroner by the appropriate medical professional this will have been recorded on the major/catastrophic review checklist and the SAI Notification. In this case the Corporate Governance Office will automatically inform Litigation (litigation generic email account) of the SAI review and this will on completion be submitted to the Coroner.

Where the SAI notification form indicates that the RQIA should be informed the Corporate Governance Office will automatically share the notification and report (when finalised) with the RQIA.

If the SAI requires an Adult Safeguarding Investigation, the Adult Safeguarding Investigation will inform the SAI process. The PVA Designated Officer will liaise with the appropriate Governance Coordinator, relevant HoS, and a representative from the Adult Safeguarding Team to compose the Adult Safeguarding Investigation review team membership. That review team must be approved by the Director, Assistant Director, and where appropriate AMD. The PVA Investigation Officer will produce an Adult Safeguarding Investigation report which will be submitted to HSCB/RQIA and to the Coroner if appropriate etc as the SAI report.

5.1 Procedure for Conducting a SAI Review (This procedure should also be applied when conducting an Independent Internal Review):

Timescale	Action	Lead
0 -72hrs	Discuss with Director, Assistant Director, AMD and CSCG Coordinator. Consider the incident against HSCB (Oct 2013) definition of a SAI and using the Major/Catastrophic incident checklist.	Director / CSCG Coordinator
0-72hrs	If above group decides the incident is an SAI they will inform the service team involved in the incident of their decision and the patient/client and/or their relatives. This group should identify nominations for the SAI review team including a Chair. (Advice for Chairpersons - see Appendix 8) Those nominated should have had no involvement in the incident for review, should be from another site / team and should be available to participate during the subsequent 12 weeks. There is the option to nominate external independent persons from other organisations onto the review team – this is done via the Director and Chief executive. This option may be useful when there is a need to engage the appropriate expertise, the incident is particularly distressing for staff involved or is particularly sensitive, where carers and relatives have expressed significant dissatisfaction with a service team or the organisation at an early stage, where a service team is small and based on one site only, where the case may be subject to external or legal scrutiny at a later stage or at any other time where it may be deemed to offer a benefit.	Director / AD/AMD/CSCG Coordinator
0-72hrs	Following confirmation of their involvement all review group nominees will receive an email with the following information: • Notification of their nomination and who nominated them. • Membership and Chair of the group • A brief description of the incident • Timescale for completion of the report • Guide to RCA methodology. The relevant A/D will check and ensure the case note /records have been forwarded to the CSCG Coordinator.	CSCG Coordinator
Week 1	CSCG Coordinator and Chair of review group will agree draft terms of reference for the review. Draft terms of reference and a copy of the case note / records will be circulated with potential dates for meeting 1 of the review. All relevant information will be distributed to the group for consideration prior to meeting 1 of the group.	Chair/CSCG Coordinator
Week 2-3	Meeting 1 will take place. This meeting will normally agree a terms of reference – including the scope of the review. The timeline of events will be discussed - and all relevant points for further analysis identified together with any points needing further clarity from the professional team involved in the incident. It is often useful and appropriate to meet with some / all of the staff involved in the incident so they can give their account to the review team in person, indicate their thought processes at the time and clarify any	Review Team

	outstanding issues. The appropriate members of the review can meet those of similar profession from the team involved in the incident.	
Week 3-6	**Actions from meeting 1 will be completed, including follow up meetings with staff involved in the incident and all information can be forwarded to CSCG Coordinator.**	**Review team**
Week 6	**Meeting 2 can take place. It may be appropriate in less complex cases to have Draft 1 of the report tabled at this meeting for further discussion. However this meeting is more likely to pull together all information received and to analyse the incident and make conclusions, recommendations and propose an action plan.**	**Review team / CSCG Coordinator**
Week 7-9	**A complete draft of the report will be prepared by members of the review team and circulated to all for comment.**	**Review team /CSCG Coordinator**
Week 9-10	**Comments from the review team will be reviewed by the Chair and CSCG Coordinator / review facilitator and a final draft agreed and then circulated to the review team.**	**Chair/ CSCG Coordinator**
Week 10-12	**The final draft will be circulated / shared with all members of the service team involved in the incident for factual accuracy checking and information. The Final Draft will then be forwarded to the appropriate Director, Associate Medical Director and Assistant Director for quality assurance prior to presentation at Directorate governance meetings.**	**Chair/CSCG Coordinator**
Week 12	**Following approval by AD CSCG the report will be submitted to HSCB/ RQIA via the Corporate Governance Office. The report may also be submitted to SMT for information sharing / discussion and if a case involves a death being reviewed by the Coroner it will be shared with their office also.**	**CSCG Coordinator / Corporate Governance**

5.2 Points of Best Practice When Undertaking a SAI Review (Applicable when undertaking an Internal Review of an Incident also):

- The service team involved in the incident are provided with support and assistance following the incident and during and after the review. See **Appendix 5**
- The patient / client and/ or relatives are informed of the review taking place, **BEFORE** it commences, to provide assurance to them that any learning related to the incident is identified and acted upon. See **Appendix 4**
- The service team involved in the incident are informed as soon as possible and **BEFORE** it commences how the incident will be reviewed. They are kept informed with respect to review progress and they can interface with the review team to provide additional information and or clarity when required. The draft review report should be shared with the service team involved in the incident for factual accuracy and information
- The review must be chaired by someone with relevant professional experience and expertise from another geographical area of the Trust who has had no involvement in the case or direct line management responsibility for any of the team involved in the incident

- The review team should be multidisciplinary and have the appropriate expertise to review the incident appropriately. They must be independent from being involved in the care and treatment provided to the patient / client
- There is the option of seeking external independent review team members and this should be considered at the outset by the Director, Assistant Director, and Associate Medical Director and CSCG Coordinator. This option can be used at any time throughout the review
- The facts, findings and recommendations from the review will be shared with the patient /client and /or family / carers. See **Appendix 4**
- Where the case has previously been referred to the Coroner, their office will receive a copy of the review report
- Learning and action plans from SAI"s will be managed in the same way as that from other incidents – **see section 4**

(subject to service users consent)

APPENDIX 1:

KEY DEFINTIONS

Definitions: The following terms describe events, which are defined as incidents and will be recorded and reported within the scope of this procedure and through Datix Web.

Terminology	Definitions
Incident/ Near Miss	Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of an HSC organisation / Special Agency or commissioned service (including a breach of security or confidentiality). However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.
Near Miss	**Incidents** that do not lead to harm but could have, are referred to as near misses.
Serious Adverse Incident (SAI)	The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident (SAI) **Serious Adverse Incident Criteria:-** serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self-harm*) of : a service user a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years) a staff member in the course of their work a member of the public whilst visiting an HSC facility. unexpected serious risk to a service user and/or staff member and/or member of the public unexpected or significant threat to provide service and/or maintain business continuity serious assault (*including homicide and sexual assaults*) by a service − on other service users, − on staff or − on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years). - serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.
Harm	Injury (physical or physiological), disease, suffering, disability or death. In most instance harm can be considered to be unexpected if it is not related to the natural cause of the service user's illness or underlying harm („Doing Less Harm, National Patient Safety Agency)
Concern	A worry or "gut feeling" about something that could lead to an incident. To highlight a situation which could lead to a full blown incident or suboptimal standards of equipment, practice or performance.

APPENDIX 2:

When and How an Incident Should Also Be Reported To Other Sources

All adverse incidents should initially be reported using the Datix Web incident management system. However some incidents should also be reported to other sources either internally within the Trust and / or externally to other agencies. The following table provides a list of types of incident and where they should be reported to following being recorded as an incident. There is also a list of useful contacts and Web links for additional advice and help.

TYPE OF INCIDENT	WHERE ELSE IT SHOULD BE REPORTED TO	USEFUL CONTACTS AND LINKS ON HOW TO REPORT IT
Potential Adult Safeguarding Incident	Definition available on the link opposite	Info available from Trust Intranet: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SAFEGUARDINGVULNERABLEADULTSPROCEDUREGUIDANCEVERSION4.pdf Report form available on: http://vsrintranet/SHSCT/HTML/PandP/documents/PVA1BLANK.pdf
Health and Safety Incident	Via the Datix Web form Incidents should be automatically reviewed by Health and Safety	Contact: (Internal) Health & Safety Dept Number: Personal Information redacted by USI Email: http://vsrintranet.southerntrust.local/SHSCT/HTML/HR/documents/ReportableDiseases.pdf
MHRA	Should be notified (although voluntary) when an Adverse Drug Reaction occurs (ADR)	A paper form can be found in the back of every BNF or alternatively can be completed online at www.mhra.gov.uk/yellowcard
RIDDOR	An Incident is RIDDOR reportable if: **1)**The injury sustained is major, **2)** If a member of the public on Trust premises is killed or taken to hospital **3)** If the injury is sustained is an „Over 3 day injury" **4)** If there has been a Dangerous occurrence	Appropriate information should be completed on the Datix Web IR1 form which alerts the Trust"s Internal Health and Safety Dept. The above department is also contactable on Personal Information redacted by USI Personal Information redacted by USI or

	5) If a notification of a reportable work-related disease has been received Further guidance available on Trust Intranet	
SABRE **SHOT**	For adverse blood reactions and events the MHRA (above) has a web based system for reporting known as ***SABRE*** - ****Serious Adverse Blood Reactions and Events**** The hospital blood bank should be informed who will inform a member of the Trust Transfusion Team and the Haemovigilance practitioner will complete online reporting to SABRE. There is an option in the SABRE reporting system also to report to the ***Serious Hazards of Transfusions (SHOT)*** enquiry. All SABRE incidents are discussed at the Hospital Transfusion Committee meetings.	For further information on both SABRE and SHOT please visit www.mhra.gov.uk
CMR	Case Management Review	*New processes have been put in place under Safeguarding Board NI.*
Fire	Relates to all fire Incidents:	An FPN 11 Form should be completed within 24 hours of the Fire Incident. FPN 11 form is available on the Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html and should be sent to: Fire Safety Department, Meadowview, Daisy Hill Hospital, when completed.
RQIA	***RQIA are notified about Incidents such as*** -serious injury to, or the unexpected/unexplained death -unexpected serious risk to service user and / or staff member and / or member of the public -unexpected or significant threat to provide service and / or maintain business continuity.	Corporate Governance Office to notify RQIA on receipt of appropriate SAI Notification form.

	-serious assault (*including homicide and sexual assaults*) by a service user -serious incidents of public interest or concern involving theft, fraud, information breaches and data losses	
HM Coroner	There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.	Guidance on reporting a death to the coroner available at: http://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland%20(PDF).pdf and on the Trust Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/clinical_guidelines.html Corporate Governance Office to also notify Coroner on receipt of SAI Notification form
NIAIC	An incident is NIAIC reportable if it relates to a Medical Device	Contact: Specialist Estates Services Dept (internal) Medical Devices Liaison Officer Email: [redacted]
DHSSPS Early Alert	Guidance available on Early Alerts at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html	Notification sent by Corporate Governance Office
HSCB Early Alert	As above -	Notification sent by Corporate Governance Office

Appendix 3

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
	• Minimal disruption to routine activities of staff and organisation.	and organisation, rapidly absorbed.	delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	and organisation - absorbed with some formal intervention with other organisations.	delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 4:

Guidelines on being open with patients, service users, families and carers when things go wrong or outcomes are unexpected and /or unexplained

- Any incident involving a service user should be discussed with this individual as soon as is appropriate by a senior member of the service team and preferably the lead professional. If the service user is a child or is unable to give consent due to their physical condition or mental capacity the incident should be discussed with their named next of kin contact. If the service user is able to provide consent and wishes the incident to be discussed with another carer or relative, the service team should facilitate this request.

- Specifically those incidents graded moderate, major and catastrophic should be discussed immediately with the service user and/or their relatives / carers, with consent. Those incidents of an insignificant and minor nature which occur out of hours can be discussed with those required at the most appropriate time within the next 24 hours.

- When discussing an incident with a service user and / or designated relatives / carers, the lead professional should outline the facts of the incident as known, the actual and potential consequences for the service user and how the team will review the incident for future learning. If the service user and/or designated carers / relatives wish to have the outcome of the incident review fed back to them the service team should consider this as good practice and should be conducted with consent of the service user if applicable. These interactions should be documented and attached to the incident report on Datix.

- If an incident meets the criteria for notification as an SAI or internal RCA, (**refer to Section 5**) the service user and / or designated relatives / carers must be informed of this decision before the SAI / RCA review begins. Where possible this should be undertaken by the Lead professional involved in the service user"s care. Where this is not possible to due relations being strained or it is judged to be inappropriate the Chair of the SAI /RCA review group supported by the Directorate CSCG Coordinator will undertake this role. This

individual will continue as the point of contact for the service user and / or designated relatives / carers throughout the period of the review and until the findings have been fed back.

- When an SAI / RCA review is completed and has been approved by the Directorate the point of contact for the service user and / or designated relatives / carers should offer to feed back the factual findings and recommendations of the review. This can include a meeting between parties and / or giving the review document to the service user and / or designated relatives / carers. How this process of review feedback is managed should be guided as far as possible by the wishes of the service user and / or designated relatives / carers.

APPENDIX 5:

Guidance on Support for Staff following an Incident

The Trust promotes an open, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed to enable lessons to be identified, active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to support staff when an adverse incident occurs and during its review.

Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.
- Contacting the relevant staff member(s) as soon as possible following the incident to discuss.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it. It is usually best to do this in a team setting with all those involved in the incident present.
- Informing staff of the Directorate"s processes in relation to incident review; keeping staff informed of likely next steps in that process and informing staff of who they can contact for advice including the Directorate Governance Office who coordinate all serious adverse incident reviews.
- At any time staff can seek advice from outside their team, for example from Directorate and Corporate Governance Offices, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Line managers should be visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an review and provides an accessible resource for clarification of any issues staff may have.
- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.

APPENDIX 6:

Major / Catastrophic Incident Checklist

Directorate:	
Reporting Division:	
Date of Incident:	
Incident (IR1) ID:	
Grade of Incident:	
If Incident involved the death of a service user, was the coroner informed:	
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	
Brief Summary of Incident:	
Summary of discussions re SAI / RCA/ Major / Catastrophic incident review:	
Decision on Level Review Type AND rationale for this:	
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	

Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☐ YES ☐ NO
Contact for service user and / or designated relatives / carers:*(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	
(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

This form once completed, regardless of Outcome, should be shared with the AD of Governance via Corporate Governance Office

APPENDIX 7:

Incident Review Guidance

A key principle of the CSC governance framework is that incidents are reviewed and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident review is that when an incident occurs the important issue is not „who is to blame for the incident?" but „how and why did it occur?

Although there will be some incidents which require review using methodologies as contained within e.g. individual agency reviews, adult safeguarding reviews, health and safety reviews, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) Root Cause Analysis Tools. Nonetheless all incident reviews will ask the core questions of:

- What actually happened? *(The facts)*
- How did what happened vary from what should have or was expected to happen?
- Why did it happen in that way? *(The causes)*
- Is there any learning to share with the team or wider Trust services to minimise the likelihood of recurrence?

The above can be expanded to include where appropriate:

- Was there anything about the task/procedure involved?
- Was there anything about the way that the team works together or perceives each other's roles?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training and education of the staff in relation to their competence to:-

  (a) provide the care/service required, and

(b) manage the incident when it occurred?

- Was there anything relating to communication systems between individual members of the team, departments, or electronic communications, for example, test results via computer?
- Was there anything about the availability, or quality of any guidance notes, polices or procedures?
- Was there anything about the Trust"s strategy, its strategic objectives and priorities?

Further detailed advice in relation to incident review techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Coordinators or visiting the NPSA RCA toolkit resource here.

APPENDIX 8

Brief Guidance on the Role and Responsibilities of an SAI Review Chairperson

The Chairperson leads an SAI Review Team. The Chairperson's main aim is to ensure that the SAI Review Team explores in an open, fair and critical manner the circumstances surrounding the incident, and establishes what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise the likelihood of reoccurrence of the incident. The review should identify not only areas for improvement but also areas of good practice. The Chairperson will be assisted by the relevant Governance Coordinator or their nominated review facilitator.

The main responsibilities of the review Chairperson are:

1.0 Prior to the Review

1.1 Reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident to enable them to lead the initial meeting of the Review Team.

1.2 In conjunction with the Governance Coordinator, prepare a draft Terms of Reference for consideration by the Review Team at the initial meeting.

2.0 During the Review

2.1 Ensuring that all attendees at the review are introduced to each other and are aware of their role.

2.2 Facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.

2.3 Ensuring that the review is open, fair and participative. That if required appropriate members of the Review Team are delegated to meet members of the service team involved in the incident to obtain clarity on events.

2.4 Chairing the Review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed.

2.5 Ensuring that Review Team members, service teams and patients / clients and /or relatives and carers are kept informed with respect to the review and its progress as required. See **Appendix 4** and **section 5.**

3.0 Following the Review

3.1 Liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that the service team involved in the incident are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to it being sent to the AMD /Assistant Director / Director.

3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their review of the draft report, the Chair should consider these and reconvene the Review Team if necessary to address same.

3.3 Report practices, systems or other issues which the Review Team feel require immediate attention to the relevant Assistant Director, Head of Service and AMD, where appropriate.

3.4 If the Chairperson is the nominated contact with the patient/client and or family/ carers, they will be responsible for sharing the facts/ recommendations and action plan with them as outlined in **Appendix 4.**

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

CONTENTS

SECTION TWO - APPENDICES

SECTION THREE - ADDENDUM

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

SECTION ONE - PROCEDURE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a ‘statutory duty of quality’ on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any

case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2012 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide'. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  It is acknowledged these incidents should already have been reported to RQIA as a ***'notifiable event'*** *by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be

undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for

consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  '.hscni.net',
  'n-i.nhs.uk'
  'ni.gov.uk' or
  '.ni.gov.net'

  No sensitive or patient/service user data must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  Note: Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  Step 1 Contact the recipient and ask for their email address.
  Step 2 Send a test email to the address provided to ensure that you have inserted the correct email address.
  Step 3 Ask the recipient on receiving the test email to reply confirming receipt.
  Step 4 Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on:
Tel [redacted] [irrelevant redacted by the USI]

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level

- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents@hscni.net

HSC Trusts to copy RQIA at seriousincidents@rqia.org.uk in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated

correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents@hscni.net.

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising

of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

12.6 Review/Learning Summary Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

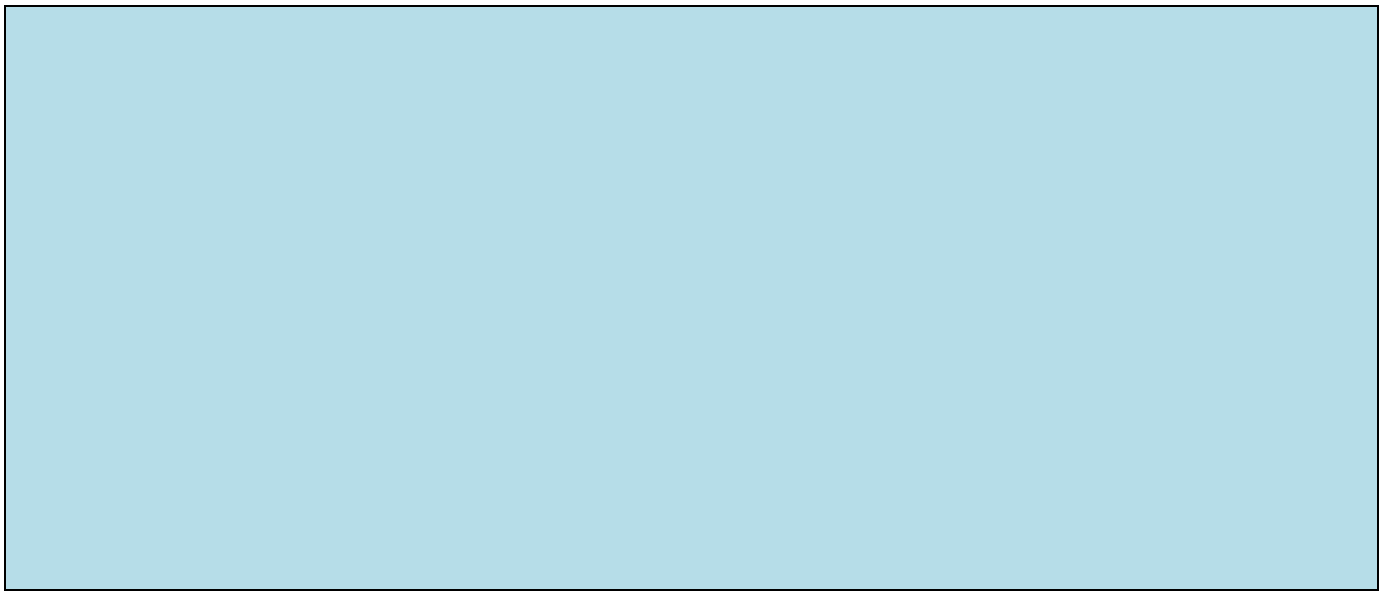
13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION TWO APPENDICES



APPENDIX 1

Revised November 2016 (Version 1.1)

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes
SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT? Yes/No *(please select)*	If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
Where relevant *please provide details on the current condition of the service user the incident relates to.*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)*	YES	NO	N/A

14. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.

The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 3
Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ DESIGNATION: _____

Email: **Telephone:** **Date: DD / MM / YYYY**

Completed proforma should be sent to: seriousincidents@hscni.net

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1	
1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY
14. WHAT HAS BEEN LEARNED:
15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?
16. RECOMMENDATIONS (please state by whom and timescale)
17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:
18. FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	24. DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report				
	b) Plan to share final review report at a later date and further engagement planned				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory*	
8. SUMMARY OF EVENT: ***As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)***	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER: *Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10*	10. TEAM MEMBERS PRESENT: *NAMES AND DESIGNATIONS*
11. SERVICE USER DETAILS: ***Complete where applicable*** *DOB / GENDER / AGE*	
12. WHAT HAPPENED? *(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).*	
13. WHY DID IT HAPPEN? *(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)*	

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

20. PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*

24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)***							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
			NO	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 7
Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

The following is a sample list of statements of purpose that may be included in the terms of reference:

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] *http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787*

[5] *http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355*

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report				
	b) Plan to share final review report at a later date and further engagement planned				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***		
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate** (✓)				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)***							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate** (✓)	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate** (✓)	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate** (✓)	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the review
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

• Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

• Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

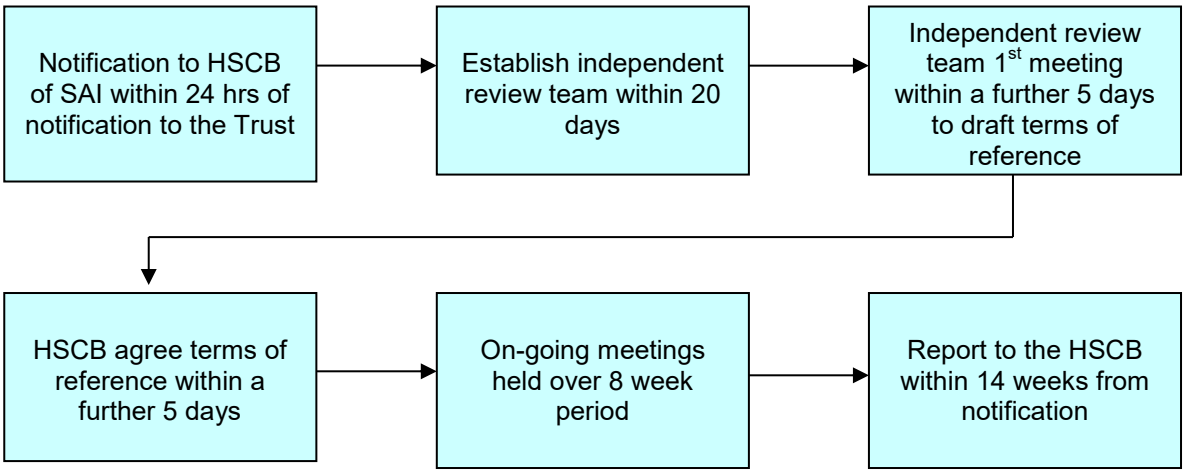
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 15

ADMINISTRATIVE PROTOCOL

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: ***seriousincidents@hscni.net***
and RQIA: **seriousincidents@rqia.org.uk**

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

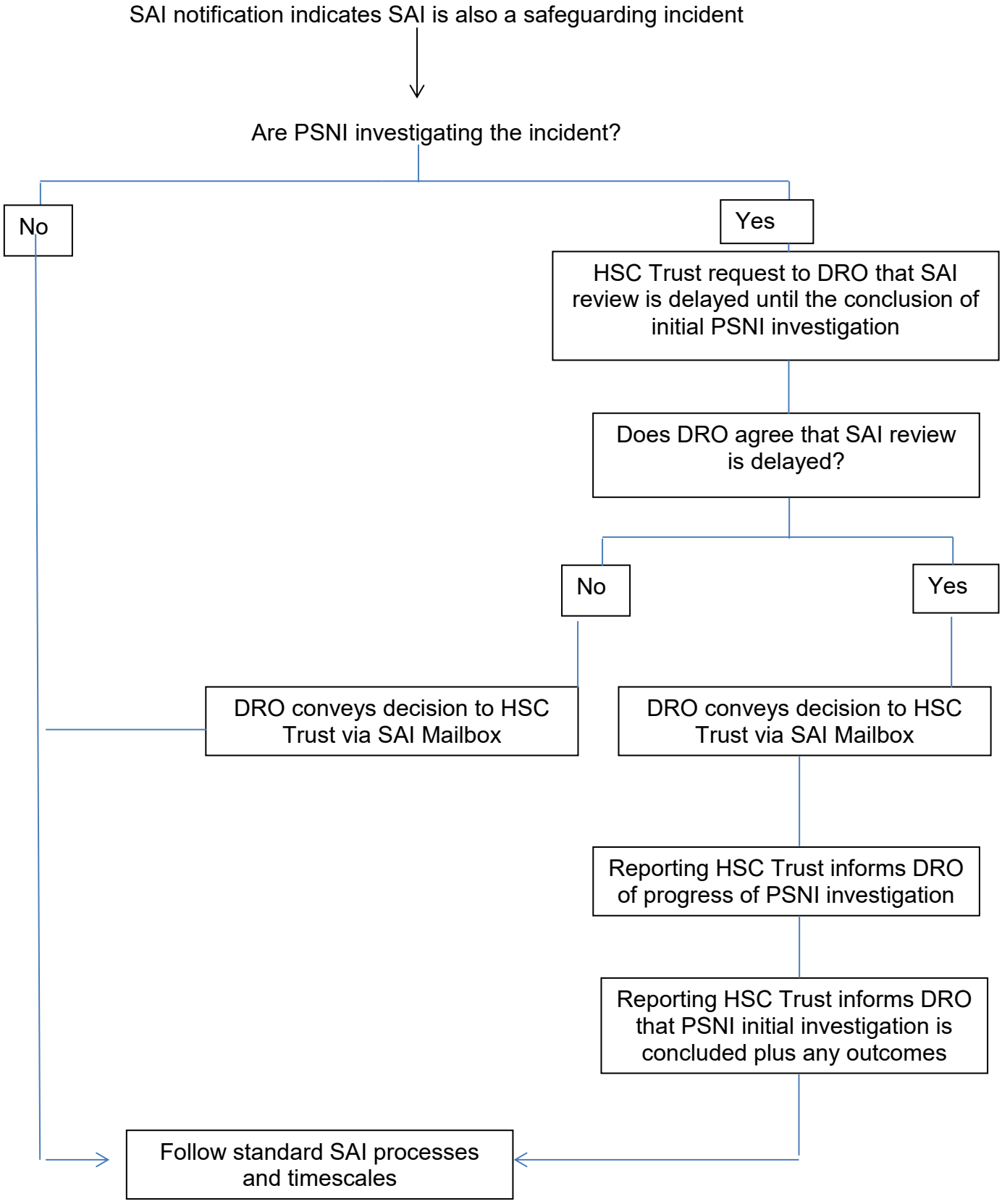
In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

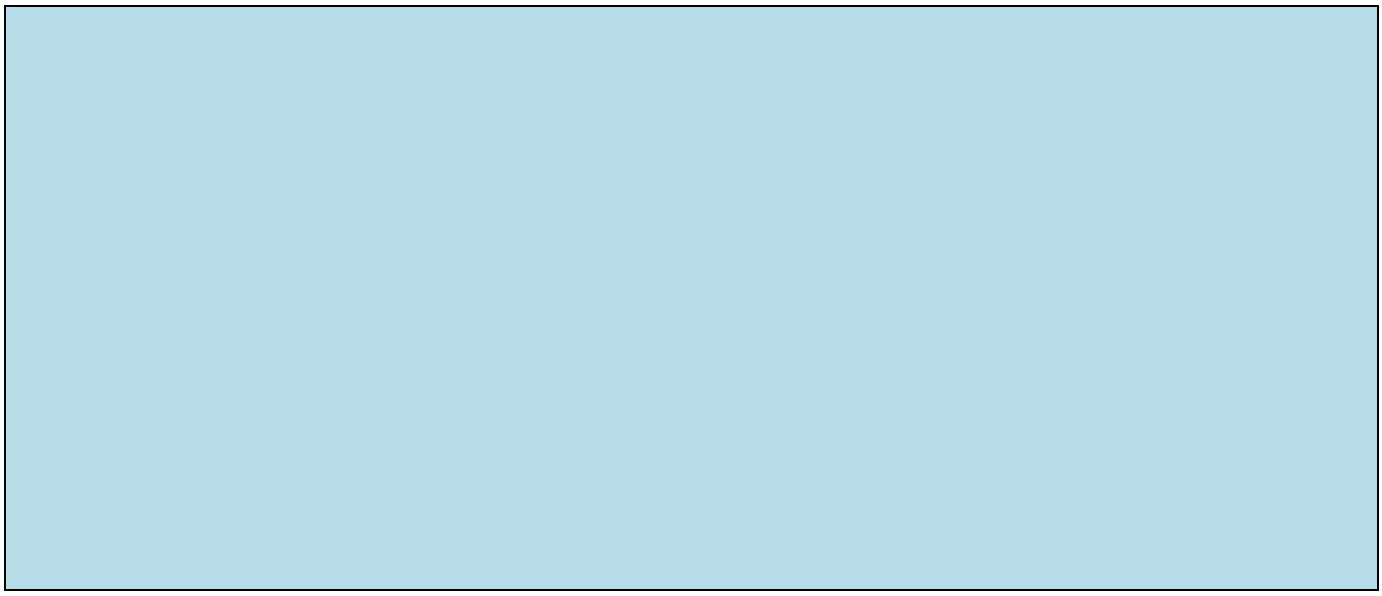
In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM



ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff

should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social

care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with

the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you" **Your understanding of their Story: (Summarising)** "I understand from what you said that" xxx "and you are very upset and angry about this"

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) "Am I right in saying that you……..." **Your Story** "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? "Do you mind if I tell you what we have been able to establish at this stage?" "We have been able/unable to determine at this stage that……." "We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds" "You may at a later stage experience xx if this happens you should ……."
Inquire	"Do you have any questions about what we just discussed?" "How do you feel about this?" "Is there anything we talked about that is not clear to you?"
Solutions	"What do you think should happen now?" "Do you mind if I tell you what I think we should do?" "I have reviewed your case and this is what I think we need to do next" "What do you think about that?" "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?" "I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?"
Progress	"Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen" "We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future” “I will be with you every step of the way as we get through this and this is what I think we need to do now” “We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team” “Would you like us to contact you to set up another meeting to discuss our progress with the review?” “I will be seeing you regularly and will see you next in….days/weeks. “You will see me at each appointment” “Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……” “If you think of any questions write them down and bring them with you to your next appointment.” “Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”

Appendix 4

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING	***Note taking***
There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____

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REPORT SUMMARY SHEET

Meeting	Governance Committee December 2018
Title:	Lessons Learned Forum Update
Lead Director:	Dr Ahmed Khan Interim Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	The Purpose of this report is to provide Governance Committee with an update on: • Elements of work progressed by the lessons forum • An overview of Lessons Identified and Recommendations made on Serious Adverse Incidents that have been closed by the Health and Social Care Board (Qtrs 2 and 3 2018)
Summary of Key Issues for Governance Committee	
High level context: The paper proposes a phased approach in the development of a lessons learned framework which should focus initially on learning from SAI's and Morbidity and Mortality structures. The paper also provides inform on the progress of this forum since April 2018.	
Key issues/risks for discussion: • Forum Recommendations	
Internal/External Engagement: • Forum Members (inc governance coordinators and M&M chairs) • SMT • ADEPT Fellow	

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Lessons Learnt Forum Update December 2018

Contents

Introduction

Purpose of Report

The Purpose of this report is to provide Governance Committee with an update on:

- Elements of work progressed by the lessons forum
- An overview of Lessons Identified and Recommendations made on Serious Adverse Incidents that have been closed by the Health and Social Care Board (Qtrs 2 and 3 2018)

Background

1. The Lessons Learned forum is a formal corporate cross directorate interface for the identification and sharing lessons learned initially from adverse incidents and progressing to include learning from complaints and litigation cases, both internal to the Trust, regional and national.

2. The Trust is committed to quality improvement and will continue its strong focus on delivering high quality, safe and effective services. The Trust Lessons Learned forum will assist in the identification, sharing and appropriate risk mitigation of areas of concern.

3. The forum recommend that in the first instance the role of the Lessons Learned forum will be in the first instance identify areas for improvement taken from the lessons learned extracted from the Trust serious adverse incident and morbidity and mortality processes and if appropriate, propose system changes and to provide challenge and scrutiny to Trust adverse incident processes and focus clinical audit and quality improvement activities.

4. The terms of reference of the forum have been agree as follows
    - Forum members will be responsible for presenting potential sharing lessons learned from their service areas
    - Forum members will assist in sharing information on Lessons Learned from the Forum with their respective service areas

- Forum members will participate in assurance processes in respect to the implementation of lessons learned

Lessons Learned Forum Update

The Forum has been active since April 2018 and has had 3 meetings to date. The template below sets out progress to date in line with the Forums roles and responsibilities.

Forum Responsibility	Work Progressed to Date	Recommendations
The role of the Lessons Learned forum will be in the first instance identify areas for improvement regarding Trust adverse incident and morbidity and mortality if appropriate as part of a phased approach to further roll out to other potential sources of learning.	Standardised template for lessons learned developed for SMT approval. Communication with staff groups to inform templates.	Operational Directorate teams to consider how information is quality assured for content and accuracy.
Forum members will be responsible for presenting potential sharing lessons learned from their service areas	A template for staff to use to identify areas of learning and a process for central coordination of information has been designed by Dr Kathleen Hadden ADEPT Fellow and was presented at the recent Lessons Learned Forum meeting (Presentation attached). Views on this model were taken from a number of staff groups	ADEPT Fellow to progress development of supporting information and communication strategy for staff and prepare a paper for SMT (December 2018)

	including M&M chairs. The forum agreed the template and the next stage is to seek agreement from Trust SMT.	
Forum members will participate in assurance processes in respect to the implementation of lessons learned Forum members will be responsible for presenting potential sharing lessons learned from their service areas	The Forum members have reviewed the quality and wording of lessons learned within SAI reports finalised in quarter 3 2018. The purpose of this exercise was to inform the development of a Lessons Learned template that can be used for team, directorate and Trustwide learning.	A focus training of SAI chairs and team members in order that the quality of lessons learned are articulated clearly within SAI reviews and aligned to SAI review recommendations.
Reporting and Monitoring of Lessons Learned Forum The forum will provide 6 monthly update reports to Trust Governance Committee featuring details including: • Number of Lessons Learned Identified • Trust responses to Lessons Learned such as Quality Improvement Initiatives • Details of any evaluation work conducted to assess embedding of Lessons Learned	A SWOT analysis was carried out by those present at the meeting to inform SMT and Governance Committee on their views in respect to future reporting to SMT and Governance Committee. The SWOT analysis indicated that challenges exist towards reporting lessons learned outcomes	A phased approach to reporting is required, therefore the first report will provide an overview of SAIs that have been closed by the HSCB within the last two quarters with lessons learned and recommendations identified via SAI teams and status of progress on implementation within the directorates set out in Appendix 2.

Appendix 1 - SWOT Analysis /Challenges

Strengths	Weaknesses
• Regional Expectation • Process available in Trust • Some guidance available • Open to team • Accept that we need to consider lessons learned culture • Structures in place at directorate level to support the process • SAI awareness of types of incident with information about the incident to be able to carry out level of thematic review • Potential to find system failures and solutions • Feedback from and to IHRD work-stream • Potential to present to governance committee and SMT • Systems are in place to capture information • Trust is keen to implement learning, I feel there is a real enthusiasm with the forum to drive forward change	• Quality of SAI reports weak • Recommendation and lessons learned not clear • Challenge function • Roles and responsibilities of clinical staff • Quality of current report, recommendations data • Categorisation of what a lesson learned, what needs to be shared how do they fit the recommendations • Are SAI recommendations properly embedded • Challenge function required • Links between lessons learned and recommendations • Lack of a template to record SAI that can be validated • Quality of investigations • Confusion between lessons learned vs recommendations • Quality of SAI varies depending in area / Directorate lead • Lessons learned are not lessons learned in some cases
Opportunities	**Threats**
• Review of SAI process • Lessons learned for whole organisations • Assurance process improvement • Link to QI • System rather than individuals • Human factors • Review of process / challenge within directorate input to the lessons learned group • To be able to identify areas / themes • System focus, regionally • Focus lessons learned forum on classification and analysis of SAI's over the last 2 years • Shape audit programme based upon outcomes • Could provide training and guidance to all SAI leads • Link QI to provide framework for implementing change • Try to standard of SAI reports and the quality of lessons learned	• Patient safety • Trusts reputation • Quality of Care • Resource constraints, Cost and Time • Fear of litigation, personal accountability for individual staff how do we change this? • This forum might be seen as the 'final decision making' rather than a forum to collate learning and ensure that appropriate actions are in place to improve safety • Regional changes may be required • Litigation threat • Inconsistency between Trust interpretation and other orgnisations (eg PSNI) • Need to focus on SAIs / MM forums complaints later • Resources Time training robust process • Regulatory bodies • Insurance • Lack of consistency of SAI leads • Operational pressures take priority

Appendix 2 – Lessons Learned from SAIs (Qtrs 2 and 3 2018)

Appendix 3 – Lessons Learned Forum Membership

As agreed on 2nd November 2018

- Medical Director (Chair)
- Trust Non-Executive Director
- Assistant Director Clinical and Social Care Governance
- Assistant Director of Quality Improvement
- Communications Team
- Associate Medical Directors
- Directorate Governance Coordinators
- Assistant Director Professional Lead Social Work and Care
- Assistant Director Professional Lead Nursing Governance
- Operational Assistant Directors as nominated by Directors
- Project Manager Clinical and Social Care Governance
- Governance Officer, Clinical and Social Care Governance
- Litigation Manager

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Minutes of a meeting of the Confidential Governance Committee held on Thursday, 6th December 2018 at 9.15 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Ms E Mullan, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs E Gishkori, Director of Acute Services
Mrs C Harney, Interim Director of Mental Health and Disability Services
Dr A Khan, Interim Medical Director
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Interim Director of Older People and Primary Care
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Interim Executive Director of Nursing and Allied Health Professions
Mrs S Judt, Board Assurance Manager (Minutes)

1. WELCOME AND APOLOGIES

Ms Mullan welcomed those present. Apologies were recorded from Dr M O'Kane.

2. DECLARATION OF INTERESTS

Ms Mullan asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CONFIDENTIAL MINUTES OF MEETING HELD ON 6th SEPTEMBER 2018

The Minutes of the meeting held on 6th September 2018 were agreed as an accurate record.

4. UPDATE ON INVESTIGATION INTO DR DUFFIN'S CONCERNS

Mr Devlin referred members to the update in their papers on the work of the adverse incident review group tasked with reviewing Dr Duffin's concerns in respect to adverse incident reviews. Members were advised that the second meeting of the group took place on 26th October 2018 when the Terms of Reference of the adverse incident audit were agreed. Mrs H Trouton, is a member of the group, and she reported that the audit process has started and it is hoped to complete this by end January 2019.

The Chair asked if Dr Duffin was content with the progress of the investigation to which she was advised of discussions with Dr Duffin to ensure he was content.

Members asked that a short paper outlining the key themes from the adverse incident audit is brought to the next meeting.

5. NON-EXECUTIVE DIRECTORS' VISITS TO CHILDREN'S HOMES REPORT

Members discussed the report for the period April 2018 – September 2018 and noted that a total of 13 Children's Home visits had been undertaken. Mr Morgan drew members' attention to the key issues which included a range of Estates issues and providing appropriate placements to meet assessed need.
The expectation that Non-Executive Directors would undertake four visits per year was discussed as was the proforma used. Mr Morgan

acknowledged the potential to review the proforma and undertook to raise this at the next regional meeting.

SIGNED: _____ ***DATED:*** _____

Southern Health and Social Care Trust

Policy Checklist

Name of Policy:	Policy for the Management of Complaints
Purpose of Policy:	To ensure that Trust staff are informed and aware off the Trust's complaints handling process and to provide service users, patients and clients with the information they require to make a complaint.
Directorate responsible for Policy	Medical Directorate
Name & Title of Author:	Margaret Marshall, Assistant Director, Clinical and Social Care Governance
Does this meet criteria of a Policy?	Yes/
Trade Union consultation?	Not Applicable
Equality Screened by:	Stephen Wallace
Date Policy submitted to Policy Scrutiny Committee:	9th July 2018
Members of Policy Scrutiny Committee in Attendance: Electronically by Policy Scrutiny Committee 20/07/2018	
Policy Approved/Rejected/ Amended	Approved
Policy Implementation Plan included?	N/A
Any other comments:	Policy Review and Update
Date presented to SMT	N/A
Director Responsible	Dr Ahmed Khan Interim Medical Director
SMT Approved/Rejected/Amended	N/A
SMT Comments	N/A
Date received by Employee Engagement & Relations for database/Intranet/Internet	20/07/2018
Date for further review	2 year default

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Policy for the Management of Complaints Version:2 Reference number/document name:
Supersedes	Supersedes: Policy for the Management of Complaints, June 2013 Description of Amendments(s)/Previous Policy or Version: Reviewed and updated in-line with changes to the Governance structures within the Trust and to ensure continuing compliance with regional complaints procedures.
Originator	Name of Author: Margaret Marshall Title: Assistant Director Clinical and Social Care Governance
Scrutiny Committee & SMT approval	Referred for approval by: Date of Referral:10/07/2018 Scrutiny Policy Committee Approval (Date)19/072018 SMT approval (Date)N/A
Circulation	Issue Date: 20/07/18 Circulated By: Complaints Officer SHSCT Issued To: As per circulation List (details below)
Review	Review Date: July 2020 Responsibility of (Name): Title: Assistant Direct Clinical Social Care Governance

Southern Health and Social Care Trust

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Policy for the Management of Complaints

Authors	***Margaret Marshall, Assistant Director Clinical and Social Care Governance***
Directorate Responsible	***Medical Directorate***
Date of Issue	
Review Date	***July 2020***

CONTENTS

SECTION ONE: INTRODUCTION, PURPOSE AND SCOPE

1.0 *Introduction to Policy*

The Policy for the Management of Complaints has been based on *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*, which was published by the DHSSPSNI on 1st April 2009 (and updated October 2013). The policy also reflects the ongoing regional work with HSC to ensure best practice in the management of complaints.

A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the *Children (NI) Order 1995 Representation and Complaint Procedure*.

1.1 *Policy Statement*

The Southern Health and Social Care Trust (hereafter referred to as the "Trust") believes that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of complaints in improving service provision for patients and the public through listening, learning and improving.

1.2 *Purpose and Aims*

The Trust is committed to developing a culture of responsible openness and constructive criticism, and to encouraging all service users to contribute views on all aspects of the Trust's activities. It has introduced this policy to enable service users to raise any concerns they may have at an early stage and in the right way.

The aim of this policy is to:

- Inform staff of the Trust's processes for complaints handling; and
- Provide service users, patients and clients with the information they require to make a complaint.

1.3 *Scope of Policy*

This Policy is applicable to all services provided by the Trust with the following exception for which alternative procedures are already in place: *Children (NI) Order 1995 Representation and Complaints Procedure*.

1.4 *Legislative Compliance, Relevant Policies, Procedures and Guidance*

The *Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009* requires HSC organisations to make arrangements in accordance with the provisions of the directions for

the handling and consideration of complaints. The *Regional Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning* conform to this legislative framework. Trust staff must also take cognisance of relevant professional standards and guidance to their own profession.

The Regulation and Quality Improvement Authority (RQIA) is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews. RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

1.5 *Equality and Human Rights Consideration*

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the *Northern Ireland Act 1998*. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria; no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the *Human Rights Act 1998*, and deemed to be compatible with the *European Convention Rights* contained in that Act.

This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

1.6 *Alternative Formats*

This document is available on request in alternative formats which include large print, audio disc and in other languages to meet the needs of those who are not fluent in English. These formats can be requested from the Corporate Complaints Officer. P*lease refer to* ***Appendix 3*** *for contact details*.

We Value Your Views leaflets, which provide service users/clients with an overview of the Trust's complaints procedures and contact details, is available from the Trust Intranet in large print and other languages (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html).

SECTION TWO: ROLES AND RESPONSIBILITES

2.0 *Role of the Medical Director*

The Trust Medical Director is responsible for ensuring that our complaints procedure is effective and that our approach ensures that appropriate investigations and actions have been completed before a response sent following the formal investigation of a complaint.

However, the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. The Medical Director must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken in the light of the outcome of any investigation.

2.1 *Role of the Assistant Director of Clinical and Social Care Governance*

It is role of the Assistant Director of Clinical and Social Care Governance (CSCG) to work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action.

The Assistant Director of CSCG also ensures that a 'Lessons Learned' strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads, ensuring systems are in place for effective feedback to staff where issues of concern have been raised and actions identified to address same.

2.2 *Role of Executive Directors*

It is the role of the Executive Directors to refer any professional issues, about which they have concerns to the relevant professional body.

2.3 *Role of Operational Directors, Assistant Directors and Heads of Service*

All Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. This responsibility also includes the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.

All Operational Directors will endeavour to ensure that those tasked with investigating and responding to complaints, implementing and sharing learning and improvement have the necessary resources, the co-operation of all staff and the support of senior management.

It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints.

It is the role of an Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

2.4 ***Role of Line Managers and Front-Line Staff***

Complaints may be made to any member of staff. Staff must be trained and empowered to deal with complaints as they arise. Appropriately trained staff will recognise the value of the complaints process and as a result will welcome complaints as a source of learning. Advice and assistance for staff regarding the handling of complaints is available from the relevant Directorate Governance Team or the Corporate Complaints Officer.

The first responsibility of a staff member who receives a complaint is to ensure that, where applicable, the service user's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be recorded and dealt with rapidly and in an informal, sensitive and confidential manner.

Some complainants may prefer to make their initial complaint to a member of staff who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate member of senior staff (i.e. line manager). The Corporate Complaints Officer and Directorate Governance Team are available to support and advise front-line staff on the handling of complaints.

Where a complainant raises a clinical or professional matter an appropriately qualified person should be asked to review it in light of the investigation and advise on accuracy and details prior to the proposed complaint response being finalised.

All staff are required to promote and maintain service user and staff confidentiality and to comply

with the requirements of legislation, for example the Data Protection Act. The need for sensitivity and confidentiality is paramount.

2.5 *Role of Corporate Complaints Officer*

The Corporate Complaints Officer (CCO) is responsible for providing a first contact for service users, signposting the service users around the organisation, assisting them in problem solving and facilitating them to access and use the Trust's complaints process.

The CCO is also responsible for screening service user contacts and determining if these are enquiries or complaints. The CCO will facilitate either resolution of the enquiry or complaint, or they will help facilitate the complainant in their use of the Trust's formal complaints procedure by directing the complaint to the relevant Directorate Governance Team. The CCO will provide the same support and consideration for those enquiries and complaints from third parties, such as MLAs and the Minister's office. The CCO will alert the Directorate Governance Teams to significant issues at an early stage.

2.6 *Role of Governance Co-ordinators and Governance Officers*

The Governance Co-ordinators will lead their Directorate Governance Team in ensuring that at each level of the Directorate staff have access to timely, high quality and appropriate information in relation to complaints, and that within each service team this information is being acted upon appropriately in order to mitigate risk, improve quality of care and patient/client safety.

The Governance Co-ordinators will co-ordinate via the Directorate Governance Team the timely and appropriate responses to complaints on behalf of the Directorate. The Co-ordinators will ensure that the complaints process is conducted in accordance with Regional and Trust complaints procedures.

The Directorate Governance Team will:

- Manage all complaints received within their respective Directorates;
- Maintain a comprehensive IT system (Datix) of all complaints received;
- Provide support and advice to staff investigating/responding to complaints;
- Take account of any corroborative evidence available relating to the complaint;
- Identify training needs of staff and ensuring that appropriate programme are organised in conjunction with line managers;
- Provide the Directorate and the organisation with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses

to individual complaints;

- Comply with Controls Assurance Standards criteria in respect of complaint management; and
- Be aware of the availability of and advise complainants about:
  the support available from the Patient Client Council;
  the role and availability of conciliation, advocacy, independent experts and lay persons; and
  the Ombudsman/Commissioner for Complaints.

SECTION THREE: MAKING A COMPLAINT

3.0 *What is a complaint?*

The Trust aims to provide the highest possible standard of care and treatment to all service users, at all times, but sometimes things do not always go according to plan. When this happens, it is important for us to put things right quickly.

A complaint is **"an expression of dissatisfaction that requires a response"**.[1] Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments which are really complaints and need to be handled as such.

3.1 *Who can complain?*

Any person can complain about care or treatment, or about issues relating to the provision of health and social care.

This policy may also be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased persons under the Access to Health Records (NI) Order 1993 as an alternative to making an application to the courts.

Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using Trust service and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.

[1] *Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning* (April 2009)

3.2 *Issues this guidance does not cover*

3.2.1 This Policy for the Management of Complaints does not deal with complaints about:

- private care and treatment or services, including private dental care[2] or privately supplied spectacles; or
- services not provided or funded by the Trust, for example, provision of private medical reports.

3.2.2 Complaints may be raised within the Trust which we need to address, but which do not fall within the scope of this policy. While the Policy for the Management of Complaints does not cover the issues listed below the Trust has in place procedures to ensure that such concerns are dealt with. Such issues include:

- staff grievances;
- an investigation under the disciplinary procedure;
- an investigation by one of the professional regulatory bodies;
- services commissioned by the HSC Board;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act2018;
- an independent inquiry;
- a criminal investigation;
- the Children Order Representatives and Complaints Procedure;
- protection of vulnerable adults;
- child protection procedures;
- coroner's cases;
- legal action.

If any complaint received by the Trust indicates a need for referral under any of the issues above in section 3.3.2, they should immediately be passed to the relevant Directorate Governance Team for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under this Complaints Policy. In these circumstances, investigation under this Complaints Policy will only be taken forward if it does not or will not, compromise or prejudice the matter under investigation under any other process. The complainant will be informed of the need for referral.

While the Trust does not investigate complaints made regarding the Northern Ireland Ambulance Service (NIAS), any complaints received by the Trust in relation to the NIAS will be passed onto the NIAS Complaints Officer.

Complaints received by the Trust in relation to GP practices and services will be passed onto the Complaints Manager at the Health and Social Care Board (HSCB).

[2] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints. The Dental Complaints Service can be contacted via the General Dental Council at http://www.gdc-uk.org/

3.3 *Complaints about Regulated Establishments/Agencies and Independent Service Providers*

On occasions the Trust may make use of Regulated Establishments/Agencies and Independent Service Providers (ISP), e.g. residential nursing homes, domiciliary care providers; to provide services for patients/clients. This form of treatment and/or care is subcontracted to the Regulated Establishment/Agency or ISP and funded by the Trust.

Regulated Establishments/Agencies and ISPs are contractually obliged to have in place appropriate governance arrangements for the effective handling of, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints procedures, including the investigation of complaints and the production of literature, which is available and accessible to patients/clients, which outline the establishment's complaints procedure. On commissioning of the services it would be good practice if the commissioner (i.e. Trust staff) informs the patient/client and relatives/carers that the Regulated Establishment/Agency or ISP will have a complaints procedure in place.

If a patient/client or relative/carer has a concern or complaint relating to the contracted services provided by a Regulated Establishments/Agency or ISP they should raise the concern/complaint directly with the provider of care in the first instance. However, where complaints are raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where the complaint raises serious concerns or where the Trust deems it in the public interest to do so.

The Regulated Establishment/Agency or ISP is required to investigate the concern or complaint and provide a written response to the complainant which should be copied to the Trust. If there is a delay in responding to the complainant within the target timescales[3] the complainant will be informed and a revised date for conclusion of the investigation will be provided.

The response letter from the Regulated Establishment/Agency or ISP must advise the complainant that they can progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and who will be responsible for conducting the investigation. The Trust will work closely with the

[3] Under SHSCT complaints procedure a written response should be issued to the complaints within 20 working of the establishment's receipt of the complaint. If the establishment is unable to meet these timescales the complainant should be informed, in writing, as to the reasons why.

Regulated Establishment/Agency or ISP to enable appropriate decisions to be made.

The complainant must also be informed by the Regulated Establishment/Agency or ISP of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the Regulated Establishment/Agency or ISP without Trust participation in local resolution will be referred to the Trust for investigation and action by the Ombudsman.

The Trust has agreed arrangements in place to ensure that Regulated Establishments/Agency or ISPs provide information to annual review meetings relating to all complaints received and responded to directly by them.

It is the role of Trust staff, such as Key Workers, to ensure that patients/clients and relatives/carers are aware of the importance of raising concerns or complaint as close to the source as possible, as this allows for early resolution through discussion and negotiation. The general principle in the first instance therefore would be that the Regulated Establishment/Agency or ISP investigates and responds directly to the complainant.

Should patients/clients or relatives/carers lack confidence in the Regulated Establishments/Agencies or ISPs' complaints handling procedures or are not happy with the response they had received from the provider of care, they can refer their complaint to the Trust's Corporate Complaints Officer so that an investigation can begin. *Contact details for the Trust's Corporate Complaints Officer are listed below.*

Corporate Complaints Officer Southern Health and Social Care Trust, Trust Headquarters,
Craigavon Area Hospital,
Portadown,
BT63 5QQ

Telephone:
Irrelevant redacted by the USI

Email: complaints@southerntrust.hscni.net

The Regulation and Quality Improvement Authority (RQIA) will monitor how complaints are handled and investigated by regulated services and the Trust. *For contact details please refer to **Appendix 3**.*

3.4 ***Complaints about Family Practitioners*** *(family doctors, dentists, pharmacists, opticians)*
All Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure for handling complaints. The practice-based complaints procedure forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaint's Manager if he/she does not feel able to approach immediate staff. The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome if the practice-based complaints procedure.

*Please refer to **Appendix 3** for contact details.*

3.5 ***How can complaints be made?***
Complaints can be made to a member of Trust staff at the point of service delivery
It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation, and by following the guidance in section 4.3 of this Policy.

It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised by service users and are able to distinguish those issues which would be better referred elsewhere. Staff across the Trust can assess the "Policy for the Management of Complaints" and "Complaints in Health and Social Care: A Need to Know Guide for Staff" through the Trust's Intranet.

Where possible complaints should be dealt with immediately and front-line staff should follow the procedures below in their handling of complaints received at point of service delivery:

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should seek advice from the relevant Directorate Governance Team.

3. If a member of staff has resolved a complaint 'at point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form and return to the Corporate Complaints Officer. A *Complaints at Point of Service Delivery* form can be located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

If the person remains dissatisfied, they should be offered a copy of the Trust's 'We Value Your Views' leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

It is important that if you are in this situation, you ask your supervisor or line manager for assistance, if necessary.

3.5.1 ***Formal Letter of Complaint received at Point of Service Delivery***

If a formal letter of complaint is received by staff at a point of service delivery' it should be sent by email the same day to the Trust's Corporate Complaints Officer so that an investigation can begin. *Please refer to* ***Appendix 3*** *for contact details.*

3.5.2 ***Complaints can be made to the Corporate Complaints Officer***

Complaints may be made verbally or in writing and will also be accepted via other methods such as the telephone (including voicemail) or electronically (e.g. e-mail). It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. The Trust is mindful of technological advances and has in place local arrangements which ensure that there is no breach of patient/client confidentiality. Contact details for the Trust's Corporate Complaints Officer are listed below.

3.5.3 ***What information should be included in a complaint?***

A complaint need not be long or detailed, but it should include:	
Relevant Contact Details	✓ Complainants name, address (including postcode) and telephone number ✓ If you are making this comment/complaint on behalf of another person, please provide the following details:

	▪ Their name, their address (including postcode) and their date of birth (if known) ▪ And please indicate your relationship to this person
Who or what is being complained about?	✓ Department/ward/facility where the issues occurred ✓ Hospital site, e.g. Craigavon, Lurgan, Newry, etc. ✓ Include the names of staff, if known
When the events of the complaint happened	✓ Details of the issue(s) relevant to the complaint ✓ Please include dates
Where possible, what remedy is being sought	✓ Such as an apology, an explanation or changes to be made to our services

3.6 *Complaints made by a 3rd Party (including those made by MPs, MLAs and Local Councillors) and Consent*

Confidentiality must be respected at all times and complaints by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complaint the Trust will seek consent from the patient/client concerned or their next of kin where necessary. There will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the subject of the complaint is deceased.

The relevant Governance Team will be able to provide further advice and guidance in relation to this matter. Consent forms can be obtained from the Complaints and User Views section of the Southern Health and Social Trust website.
(www.southerntrust.hscni.net/pdf/Patient_Client_Consent_form_May_2012(2).pdf)
Third party complainants who wish to pursue their own concerns can bring these to the Trust without compromising the identity of the patient/client. The Trust will consider the matter, investigate and address, as fully as possible, any identified concerns. A response will be provided to the third party on any issues which it is possible to address without breaching the patient's/client's confidentiality.

3.7 *Complaints made by staff*

As staff in the Southern Trust, we all have a responsibility to protect our service users, fellow members of staff, the public and the Trust. If you have a concern as a member of staff about any aspect of the quality and safety of our services, another member of staff or about any of the functions of the Trust, those concerns can be raised as per the Trust's *Whistleblowing Policy*. Staff can access the *Whistleblowing Policy* via the Trust's Intranet (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/YOURRIGHTTORAISEAC ONCERNWhistleblowingFramework.pdf)

3.8 *Anonymous Complaints*

If someone approaches the Trust with a complaint we will request their name and contact details. This will enable us to acknowledge their complaint, confirm the issues causing concern and clarify or seek further information and provide information on the outcome of our investigation.

Any request to remain anonymous will be respected as all complaints received by the Trust are treated with equal importance regardless of how they are submitted. However, complaints received with anonymity may mean that a detailed investigation may not always be possible, for example when there is a need to access medical records. Also, a complaint response cannot be issued.

All complaints submitted to the Trust, whether anonymous or not, are viewed as a significant source of learning within the organisation and help us to continue to improve the quality of our services and safeguard high standards of care and treatment. The number of complaints and trends emerging from complaints are continually monitored by each Directorate's Governance meeting and at the Patient/Client Experience Committee meetings.

3.9 *What are the timescales for making a complaint?*

A complaint should be made as soon as possible after the action giving rise to it, normally within **six months** of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is earlier.
In any case where the Trust has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant will be advised of the options available to him/her to pursue this further.

The Trust will consider the content of complaints that fall outside the time limit in order to identify

any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

3.10 *Support for complaints*

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are an important way of enabling people to make informed choices. These services help people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

Inspire Wellbeing NI (Formally ***Northern Ireland Association for Mental Health***) is the largest and longest established independent charity focusing on mental health and wellbeing services in Northern Ireland.. ***Inspire Mental Health*** offers an independent advocacy service which is designed to listen to the compliments, concerns, problems or issues that people may be experiencing whilst using mental health services. An advocate can provide patients/clients with information in relation to the options available to them under four broad areas: clinical, legal, treatment and environment. An advocate will help patients/clients to express any concerns and to pass these on to relevant professionals. Advocates will support the individual to be heard and all discussions will be treated confidentially. *Please see below for contact details.*

Inspire Central
Office Lombard
House
10-20 Lombard Street
Belfast
BT1 1RD
Telephone: (028) 9032 8474
Email: hello@inspirewellbeing.org

In the Southern Health and Social Care Trust, ***Disability Action***'s Centre on Human Rights provides an advocacy service specifically for people with learning disabilities. This service is confidential, provided free of charge and independent. The advocate supports people with learning disabilities to understand their rights and encourages them to speak up if they are unhappy about how they have been treated. The advocate will listen to the person's issue and identify the options available to them and will support the patient/client to take action.

The advocate also provides non-instructured advocacy, when a patient/client cannot give a clear

indication of their views or wishes in a specific situation, e.g. when a person has a profound learning disability. In these cases, the advocate works to uphold the person's rights, ensure fair and equal treatment and access to services and make certain that decisions are taken with due consideration for the patient/client's individual preferences and perspectives. Please see below for contact details.

Human Rights Advocate,
Disability Action's Centre on Human Rights,
Disability Action,
Portside Business Park,
189 Airport Road West,
Belfast,
BT3 9ED

Telephone: (028) 9029 7880
Textphone: (028) 9029 7882
Email: humanrights@disabilityaction.org

VOYPIC (***Voice of Young People in Care***) offers advocacy for children and young people with care experience aged 25 and under. This is a confidential and independent service where children and young people can get advice, information and support outside of Social Services. The service can:

- provide you with information and advice on your rights;
- Go to meetings with a child or young person;
- Help children/young people ask for a service;
- Help children/young people speak out about decisions that affect you; and
- Help children/young people make a complaint.

Please see below for contact details.

Voice of Young People In Care
Flat 12, Mount Zion House
Edward Street
Lurgan
BT66 6DB

Telephone: (028) 3831 3380
Website: www.voypic.org

The **Northern Ireland Commissioner for Children and Young People**'s (**NICCY**) Legal and Investigations team deal with queries and complaints from children, young people, their carers and relevant professionals about the services they receive from public bodies. This team can:

- investigate complaints against public bodies (schools, hospitals, etc) on behalf of children and young people;
- help a child or young person bring their complaint to a public body; and
- help children and young people in legal proceedings against public bodies.

Please see below contact details.

Legal and Investigations Team
Northern Ireland Commissioner for Children and Young People
Equality House
7-9 Shaftesbury Square
Belfast
BT2 7DP

Telephone: (028) 9031 1616
(Monday – Friday: 9:00am to 5:00pm)
Email: listening2u@niccy.org
Website: www.niccy.org

The ***Age NI*** Advice and Advocacy Service offer free, independent and confidential support to older people, their families and carers. The Age NI team provides advocacy support to people experiencing difficulties:

- negotiating the health and social care system
- accessing appropriate levels of community care
- dealing with issues relating to residential and nursing care
- those who have experienced or are at risk of abuse.

Please see below for contact details.

Age NI
3 Lower Crescent
Belfast

BT7 1NR

Telephone: 0808 808 7575
(8:00am to 7:00pm, 7 days a week)
Email: advice@ageni.org
Website: www.ageni.org/advice

The ***Patient Client Council*** (PCC) is an independent non-departmental public body and its functions include:

- representing the interests of the public;
- promoting involvement of the public; and
- providing assistance to individuals making or intending to make a complaint.

If a person feels unable to deal with a complaint alone the staff of the PCC can offer a wide range of assistant and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- helping in accessing medical/social services records.

All advice, information and assistance with complaints is provided free of charge and is confidential. *Please see below for contact details.*

Quaker Buildings,
High Street,
Lurgan,
BT66 8BB

Telephone: 0800 917 0222
Email: info.pcc@hscni.net
Website: www.patientclientcouncil@hscni.net

The Trust's Corporate Complaints Officer and Directorate Governance Teams will also be able to offer advice and support complainants and explain the Trust's complaints procedure, as well as attempt to resolve the complaint. *For contact details of these services please refer to* ***Appendix 3****.*

3.11 *Making a compliment*

The staff who provide services do their best to meet your individual expectations and are often working in difficult circumstances. Therefore we are always keen to know when things have worked out well for our patients/clients and what aspect has made a positive experience for them.

Those patients/clients wishing to make a compliment can do so by completing a *We Value Your Views* leaflet and returned to the Trust's Corporate Complaints Officer. Alternatively, you can contact the Corporate Complaints Officer directly to make your compliment. (*Contact details can be found in* ***Appendix 3***) These compliments, which highlight good practice, will be forwarded to the relevant staff and departments.

SECTION 4: HANDLING COMPLAINTS

4.0 *Accountability*

Accountability for the handling and consideration of complaints rests with the Medical Director. The Assistant Director of Clinical and Social Care Governance is the Trust's designated senior person within the organisation who takes responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. All staff within the Trust are made aware off and must comply with the requirement of this complaints procedure. These arrangements ensure the integration of complaints management into the Trust's governance arrangements.

4.1 *Co-operation*

Arrangements are in place within the Trust to ensure a comprehensive response to the complainant and to that end there is necessary co-operation in the handling of complaints and the consideration of complaints between:

- all HSC organisations;
- Regulatory authorities, e.g. professional bodies, DHSSPS Pharmaceutical Inspectorate;
- NI Commissioner for Complaints (the Ombudsman); and
- the Regulation and Quality Improvement Authority (RQIA).

This duty to co-operate includes answering questions, providing information and attending any meeting requested by those investigating the complaint.

4.2 *Actions on receipt of a complaint*

All complaints received by the Trust are treated with equal importance regardless of how they are submitted. Complainants are encouraged to speak openly and freely about their concerns and are reassured that whatever they have to say will be treated with appropriate confidence and sensitivity. Complainants will be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. On receipt of a complaint the first responsibility of Trust staff is to ensure that the service user's immediate care needs are being met.

The Trust will involve the complainant throughout the consideration of their complaint as this provides for a more flexible approach to the resolution of the complaint. An early provision of information and explanation of what to expect is provided by the Trust to the complainant at the outset to ensure they are informed about the process and of the support that is available.

Each complaint received by the Trust is taken on its own merit and responded to appropriately. It may be appropriate for the entire process of local resolution to be conducted informally. Overall,

arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive manner.

4.2.1 *Informal Complaint*

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation.

Staff across the Trust can access 'Complaints in Health and Social Care: A Need to Know Guide for Staff' via the Trust's Intranet.

Point of Service Delivery

When a complaint is raised at the point of service delivery staff should follow the procedures laid out below.

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

   Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should contact the advocate directly with the patient/client's consent or seek advice from the relevant Directorate Governance Team.
3. If a member of staff has resolved a complaint 'at the point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

   If the person remains dissatisfied, they should be offered a copy of the Trust's **'We Value Your Views'** leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

   It is important that staff in this situation ask their supervisor or line manager for assistance, if necessary.

Complaints made directly to the Trust's Corporate Complaints Officer

The Corporate Complaints Officer will facilitate either resolution of the complaint or they will facilitate the service user in accessing the Trust's formal complaints procedure.

4.2.2 *Formal Complaints*

This is the starting point for anyone is dissatisfied with attempts to resolve their complaint at the point of service delivery or any complainant who expects to receive a written (or alternative format) response from the Trust. The complainant should receive a full response within **20 working days** of the Trust's receipt of the formal complaint.

Acknowledgement

1. The Corporate Complaints Officer is to forward the complaint to the relevant Governance Co-ordinator's office within **1 working day**.

2. The relevant Governance Team should clarify the details of the complaint raised directly with the complainant if required and acknowledge their receipt of the complaint within **2 working days**. This acknowledgement should express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the Trust. A copy of the regional "*What Happens Next?*" leaflet should be included with the acknowledgment letter.

3. If a complaint is made by a third party (including those made by MPs, MLAs and local councillors) and it refers to an individual's care the matter of knowledgeable and informed consent must be considered.

   If consent is required it should be sought from the patient at this point. Investigation of the complaint should be initiated without delay, however a response to specific issues will not be provided unless the consent of the patient is received. (*The 20 working days only starts in these instances on the day in which the consent is received*.)

4. All complaints which occur in the Trust are graded in a standardised manner using the Trust's *Risk Management Strategy*.

5. In the case of complaints which are applicable to more than one directorate, it is best practice for the Governance Team in the directorate where the complaint has first arisen to handle the complaint and seek input from other Directorate Teams where appropriate.

Investigation

1. By **day 2**, Investigating Officer(s) should be given detail of the complaint and advised that they are expected to provide their draft response as well as their action and learning plans, where actions are required following investigation of the complaint, by **day 10**. The names of the staff involved in the complaint, when identified, should be provided to the appropriate Directorate Governance Team.

   A copy of the complaint should be forwarded to the Assistant Director responsible for the service area. Where serious governance issues are identified on receipt of the complaint it must be shared with the relevant Director.

Investigating staff can reference the Trust's 'Investigating Complaints Advice Sheet' for best practice guidance on investigations, which can be accessed via the Trust's Intranet.

Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from the following sources:

- line management support;
- occupational health;
- Care Call; and
- the relevant Governance Team.

2. The draft response to the complainant is to be validated by the Investigating Directorate Governance Team and then forwarded to the appropriate Assistant Director by **day 15** for approval/amendment.

The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong – staff should refer to the *Ombudsman's Guidance on Issuing an Apology* (June 2016) which can be found here:
- https://nipso.org.uk/nipso/publications/services-we-offer/n14c-a4-nipso-guidance-on-issuing-an-apology-june-2016/
- report the action taken or proposals to prevent recurrence, where the need for such actions have been identified following investigation of the complaint;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- advise of their right to make a complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

3. Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. The relevant Assistant Director is required to approve and return to the relevant Governance Co-ordinator by **day 17**. The Assistant Director is to indicate if they are satisfied with the content of any action and learning plans, the details of which will be captured on the Datix system.

Should further work be required on the action and learning plan it is the responsibility of the Assistant Director to initiate this within their division and report back to the relevant

Governance Co-ordinator.

4. All final responses are to be forwarded to the relevant Lead Director for approval by **day 18**.

   The Lead Director's office is required to issue the response to the complainant by **day 20**, sending the Directorate Governance Team copy of the final signed response. The exception to this are those complaint responses being sent to Elected Representations whereby the Chief Executive will, following approval by the Director, sign the final response and send a signed copy to the Lead Director and relevant Governance Team within **10 working days**. **Responses should not be issued to the complainant electronically.**

5. There is some flexibility built into the above internal timescales to allow investigating officers to complete complex complaint issues and to give the Director signing off more than 24 hours to sign if required. Where there are difficulties in gaining a response from the investigating officer the Governance Co-ordinator will escalate any breaches of the timeframes to the appropriate line manager for further action.

4.3 *Acknowledgement of delays*

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the Trust will be unable to meet the 20 working days timescale. The relevant Director should be informed of any delay at this stage also.

4.4 *Further Local Resolution beyond 20 working days*

Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain consideration needs to be given to how the remaining issue(s) can be resolved. All complainants will be advised that if they remain unhappy with the Trust's response they should contact the relevant Governance Team in the first instance to discuss options available or refer their complaint to the Ombudsman. (Please refer to **Appendix 3** for contact details) At this point all complainants should be asked to state clearly which aspect(s) of their complaint remains unresolved. On receipt of this documentation, options may include one or a number of the following:

- Further written response to outstanding issues;
- Meeting with the complainant;
- Local resolution investigation by a second team;
- Conciliation;
- Use of Lay people to assist;
- Use of independent experts.

4.4.1 *Further written response to outstanding issues*

Complainants will be advised in the first response that they should contact the organisation **within 3 months** of the Trust's response if they are dissatisfied with the response or require further clarity. There is discretion for the Governance Co-ordinator to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

The first step of further local resolution should then be that of an offer of a further response to the complainant. This may be in the form of a further written response signed off by the Director(s). This response should be issued **within 20 days** of the complaint being re-opened.

4.4.2 *Meeting with the Complainant*

Offer of facilitation of a meeting with the relevant staff. This will be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting. The notes of the meeting should be agreed upon by all that were present and issued to the complainant. This meeting should take place within **30 days** of a second response being issued.

4.5 *Additional Measures*

In extreme cases where a complainant cannot be satisfied with the response provided along with the facilitation of a meeting and where the Trust has provided further information there are a number of other options available. The decision on which option to be used will be agreed by the lead Director responsible for the management of the complaint and the relevant Governance Co-ordinator, with specific terms of reference and timescales also being agreed. Complainants may wish to include the involvement of the Patient and Client Council in this process and contact details of this service can be found in ***Appendix 3***. Once agreement is reached upon which option is to be used the decision should be acknowledged with the complainant and additional information should be provided on the option to be used. Options include the following:

- Local resolution investigation by a second team
- Conciliation
- Involvement of Lay Persons
- Involvement of Independent Experts
- Review by an Independent Panel

4.5.1 *Local resolution investigation by a second team*

Local resolution investigation by a second team should examine the initial complaint, response to it and all information gathered in formulating that response. The decision to progress to this option will be taken by the relevant Director(s) in conjunction with the relevant Governance Co-ordinator(s). The local resolution team should be chaired and led by a Manager/Clinician from another service area within the Directorate and have a Manager/Clinician from another Directorate as well as the relevant Governance Co-ordinator. This membership will provide a more detailed

response with a measure of independence in responding to the complainant and make best use of Trust resources.

If the complaint progresses to this stage, the following guidelines should be adhered to as best practice.

1. A draft report on findings should be forwarded to the Assistant Director responsible for the service area within **20 days** of the decision to use this option. A copy should be provided to the relevant Governance Co-ordinator.
2. By **day 25** the Assistant Director should have discussed the content of the draft report with the relevant Director and Governance Co-ordinator.
3. A final copy of the findings of the second complaint review team will be sent by the relevant Governance Co-ordinator to the Director for issue to the complainant by **day 30** of the decision to use this option.

4.5.2 *Conciliation*

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to achieve a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but may be helpful in situations where staff feel the relationship with the complainant is difficult and trust has broken down as well as at times where there are ongoing healthcare issues where it is important to maintain relationships or when there are misunderstandings with relatives during the treatment of a patient.

4.5.3 *Involvement of Lay Persons*

Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process. They are not intended to as act as advocates, conciliators or investigators, and neither do they act on behalf of the Trust or the complainant. The Lay Person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements. The relevant Governance Co-ordinator will provide advice regarding the use of Lay Persons should the need arise.

4.5.4 *Involvement of Independent Experts*

The use of an independent expert in the resolution of a complaint may be requested by the complainant at any time; however the Trust reserves the right to accept/decline this request. In

deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution. Input will normally only be required in cases where there are major clinical issues or concerns, but the use of the option may be helpful when it is indicated there may be a risk to patient or public safety or a serious breakdown in relationships which would threaten public confidence in services and damage the Trust's reputation. The relevant Governance Co-ordinator will provide advice regarding the use of Independent Experts should the need arise.

4.5.5 ***Review by Independent Panel***

In a small number of cases where complainant is not satisfied with the Trust's response, the Trust may wish to use an independent panel as a final attempt to resolve the complainant issue. This will only be used in extreme cases. An independent panel should be chaired by an operational Assistant Director with the support of an internal independent person (for example professional governance lead, clinical expert, social care expert, etc.) and an external layperson. The panel would be supported by the relevant Governance Co-ordinator.

The panel would be given clear terms of reference and provided with all the relevant information. They may wish to meet with the complainant or individual members of staff to discuss the complaint in detail and to clarify issues raised.

The panel would provide a draft report and action plan to the relevant Director(s) for discussion and issue to the complainant.

The panel may also wish to comment on other issues as they arise. For example, Trust policies and procedures, team practices, line management arrangements, etc. A separate report should be provided to the Director(s) highlighting areas of concern for further action by the Director(s).

4.5.6 ***Northern Ireland Commissioner for Complaints (Ombudsman)***

Once all options available to the Trust under local resolution have been exhausted and the complainant remains unsatisfied, the complainant should be advised of the role of the Ombudsman and provided with contact details for same. It is for the Ombudsman to determine whether or not a case falls within that Office's jurisdiction. *For contact details please refer to* ***Appendix 3****.*

4.6 ***Joint Complaint Investigations***

Where a complaint relates to the actions of more than one HSC organisation, the *Health and*

Social Care Trusts Interim Memorandum of Understanding Joint Working Processes for Handling Complaints should be referred to. The relevant Governance Co-ordinator will advise on this process.

4.7 *Out of Area Complaints*

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. The Governance Co-ordinator will advise on this process.

HSC contracts include entitlement, by the Trust, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.8 *Confidentiality*

Trust staff are aware of their legal and ethical duty to protect the confidentiality of the patient/client's information. The legal requirements are set out in the *Data Protection Act 1998* and the *Human Rights Act 1998*. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required of their personal information is to be disclosed but more detailed information can be found in the HSC guidance entitled *Code Practice on Protecting the Confidentiality of Service User Information*.

When using a patient's personal information for the purpose if investigating a complaint it is not necessary to obtain the patient's express consent. However, care must be taken throughout the process to ensure that patient confidentiality is maintained (particularly when a complaint is made on behalf of another/when contributing to a response lead by another organisation) and any information disclosed is confined to that which is relevant to the investigation and only disclosed to those who have a demonstrable need to know for the purpose of the investigation. Where a complaint relates to the actions of more than one HSC organisation the complainant's consent must be obtained before sharing the details of the complaint across HSC organisation. Complaint investigations will be conducted with appropriate consideration of the confidentiality due to the staff involved in the complaint.

4.9 *Support and advice for Trust Staff*

Support and advice should be provided to any member of Trust staff involved in either informal or formal complaints by their Supervisor and/or Line Manager at any stage of the process.

Advice and assistance is available to Trust staff at any stage in the complaints process from the

Trust's Directorate Governance Teams. *For contact details please refer to* ***Appendix 3****.*

The Trust has selected Inspire Workplaces as an independent source of support for staff. Inspire Workplaces staff are trained to listen and can offer support, guidance and a fresh outlook on not only issues at work but also personal problems. This service is free to Trust staff and Inspire Workplaces are committed to protecting your confidentiality and anonymity. Carecall is available 24 hours a day, 7 days a week, and 365 days a year, please refer to the contact details below.

Inspire Workplaces
For free, confidential and immediate support call:

Telephone: 0808 800 002

For further information about the service:
Website: https://www.inspirewellbeing.org/our-services/inspire-workplaces

SECTION FIVE: POLICY FOR HANDLING UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

5.0 *Introduction*

People may act out of character in times of trouble distress. There may have been upsetting or distressing circumstances leading up to a complaint. The Trust does not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the Trust or unreasonable behaviour towards Trust staff to be unacceptable. It is these actions that the Trust aims to manage under this policy.

This policy aims:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the Trust, what the Trust can or cannot do in relation to their complaint. The Trust aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered to be unacceptable. All complainants have the right to be heard, understood and respected, as do Southern Trust staff;
- to provide a service that is accessible to all complainants. However, the Trust retains the right, where it considers the actions of a complainant to be unacceptable, to restrict or change access to the service;
- and to ensure that other complainants and Trust staff do not suffer any disadvantage from complainants who are unreasonable, vexatious and/or abusive manner.

5.1 *Unacceptable Actions*

The Trust defines unacceptable action as the following:

5.1.1 *Aggressive or abusive behaviour*

The Trust understands that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards Trust staff, it will be considered unacceptable. **Any violence or abuse towards Trust staff will not be tolerated**.

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of such behaviour include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. The Trust also considers that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

The Trust expects its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a *Zero Tolerance* approach must be adopted. Trust staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards Trust staff.

5.1.2 *Unreasonable demands*

The Trust considers these demands become unacceptable when they start to (or when complying with the demand would) impact substantially upon the work of the organisation. An example of such impact would be that the demand takes up an excessive amount of staff time and in doing so disadvantages other complainants. Examples of unreasonable demands include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; or
- repeatedly changing the substance of a complaint or raising unrelated concerns.

5.1.3 *Unreasonable levels of contact*

Sometimes the volume and duration of contact made to the Trust by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when complainant repeatedly makes long telephone calls to the Trust or inundates the Trust with copies of information that has been sent already or that is irrelevant to the complaint. The Trust considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone or via emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

5.1.4 *Unreasonable persistence*

It is recognised that some complainants will not or cannot accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the Trust persistently about the same issue. Examples of unreasonable persistence include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information. The war in which these complainants approach the Trust may be entirely reasonable, but it is their persistent behaviour in continuing to do that is not. The Trust consider the actions of persistent complainants to be unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

5.1.5 ***Unreasonable use of the complaints process***

Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about the Trust, with which they have a continuing relationship, if subsequent incidents occur. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the Trust from pursuing a legitimate aim or implementing a legitimate decision. The Trust considers access to a complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable – but the Trust reserves the right to do so in those exceptional circumstances.

5.2 ***How the Trust manages aggressive or abusive behaviour***

The threat or us of physical violent, verbal abuse or harassment towards Trust staff is likely to result in a termination of all direct contact with the complainant. Trust staff will directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the Trust are only taken after careful consideration by a more senior member staff. Wherever possible, the Trust will give the complainant the opportunity to change their behaviour or action before a decision is taken.

All incidents of verbal and physical abuse will be reported to the police.

The Trust will not accept any correspondence (letter, fax or e-mail) that is abusive to staff or contains allegations that lack substantive evidence. If such correspondence is received by the Trust, we will inform the complainant that we consider their language to be offensive, unnecessary and unhelpful and will request that they refrain from using such language. The Trust will not respond the correspondence if the action or behaviour continues.

Trust staff will end telephone calls if they consider the caller to be aggressive, abusive or offensive. All staff members taking such calls have the right to make this decision.

In extreme situations, the Trust will inform the complainant in writing that their name is on a “no personal contact” list. This means that the Trust will limit contact with the complainant to either written communication or through a third party.

5.3 ***Managing other unacceptable actions***

The Trust has to take action when unreasonable behaviour impairs the everyday functioning of the Trust. It aims to do this in a way that allows a complainant to progress through its process. It will

try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

Where a complainant repeatedly phones, visits the Trust, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the Trust may decide to:

- limit contact or telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of Trust staff who will deal with the future telephone calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact form the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; or
- take any other action which the Trust considers appropriate.

Where the Trust considers correspondence on a wide range of issues to be excessive, we may inform the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly. In exceptional cases, the Trust will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further. *The Trust will always inform the complainant of what action it is taking and why.*

5.4 *How the Trust lets people know of its decision to restrict contact*

When a Trust member of staff makes an immediate decision in response to unreasonable behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[4] why a decision has been made to restrict future contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

5.5 *Appealing a decision to restrict contact*

The Trust believes that it is important that a decision can be reconsiders and it is on this basis that a complainant can appeal a decision to restrict contact. The Trust will only consider arguments that relate to the restriction and **not** to either the complaint made to the Trust or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable; or that they will adversely impact on the individual because of personal circumstances. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They will advise the complainant in writing[5] that either the restricted contact arrangements will apply or a different

course of action has been agreed.

5.6 *How the Trust records and reviews decisions to restrict contact*

The Trust records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complaints with restricted contact arrangements on a regular basis.

[4] This can be supplemented if written communications are not the most appropriate form for the individual.
[5] This can be supplemented if written communications are not the most appropriate form for the individual.

SECTION 6: LEARNING FROM COMPLAINTS

6.0 *Reporting and Monitoring*

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we, or those providing care on our behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with the Trust's Governance arrangements and continually monitoring the effectiveness of the Trust's complaints procedures. To ensure good practice the Trust:

- regularly reviews its policies and procedures to ensure they are effective;
- monitors the nature and volume of complaints;
- seeks feedback from service users and staff to improve our services and performance; and
- ensuring that lessons are learnt from complaints and using these to improve services and performance.

The volume of complaints received is regularly monitored within the Trust through the following methods:

- Complaints figures are routinely discussed at Directorate Governance meetings/fora, SMT, the Governance Committee and at the Patient and Client Experience Committee meetings.
- Closed complaints figures are regularly sent to the Health and Social Care Board (HSCB) for consideration.
- A Trust complaints report is compiled annually and details how complaints were received and handled, and what lessons were learnt.

6.1 *Learning*

The Trust aims to manage all complaints received effectively and ensures that appropriate action is taken to address the issues highlighted by complaints. We make sure that lessons are learnt from all complaints so as to ensure the same mistakes do not re-occur within the Trust. Learning takes place at different levels within the Trust, with the individual, the team and the organisation as a whole.

Each Directorate within the Trust is provided with analysis and intelligence on the complaints received to ensure that trends are identified and acted upon.

The Trust will use issues raised through the complaints process as an important source of information for safety and quality improvement. This information will inform learning and development and will feed into the Trust's Governance systems as well as being directly fed back to the staff involved.

Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service and Senior Managers to utilise the information and trends from their complaints to ensure learning

and development and to develop and monitor actions and learning plans.

An annual report is presented to Trust Board, which summarises the complaints we have received, how they were handled, the outcomes and lessons learnt. This is published to the public on the Trust website (www.southerntrust.hscni.net).

Learning is a critical part of the Trust Complaints Procedure and the Trust values complaints and comments as an opportunity to improve services for our patients and clients. It is for this reasons that the Trust continually contributes to and learns from regional, national and international quality improvement and patient safety initiatives, and shares intelligence gained through complaints with other HSC organisations in Northern Ireland, the RQIA and the Ombudsman.

SECTION SEVEN: REVIEW AND IMPLEMENTATION

7.0 *Consultation*

During development, this policy was considered in draft form by the Trust's Governance Co-ordinators and Officers from Acute Services, Older Persons and Primary Care, Children and Young Persons Services and Mental Health and Disability.

The Review of the Policy for the Management of Complaints was informed by focus groups held for service users and Trust staff. These discussions ensured that the reviewed Policy reflected the needs of Trust staff and service users.

7.1 *Approval*

The Policy for the Management of Complaints was presented in final draft and approved by SMT

7.2 *Review*

The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.
The Policy for the Management of Complaints will be reviewed bi-annually.

7.3 *Policy Implementation*

Following approval this policy will be circulated to all Trust staff via Global email.
A copy of the Policy for the Management of Complaints will be placed on the Trust's intranet.

7.3.1 Training and Education

All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

Appendix 1

Complaints *Process*

Complaints at Point of Service

Complaint is raised by or on behalf of a service

Member of staff who first learns of complaint should respond immediately & directly in an attempt to resolve the matter informally, speedily & appropriately.

IS THE MATTER **RESOLVED**?

YES

If a member of staff has resolved a complaint 'at point of service delivery' they should complete and return all sections on the *Complaints at Point of Source Delivery form. (Trust Intranet >Policies & Procedures>Clinical & Social Care Governance)*

NO

Formal Complaints Process

The **Formal Complaints** process is instigated. This is also the starting point for anyone who approaches the Corporate Complaints Office directly with their complaint.
The Corporate Complaints Officer will aim to de-escalate and resolve all complaints/enquires at first point of contact with the Corporate Complaints Office.

The Corporate Complaints Officer, Southern Health & Social Care Trust, Trust Headquarters, Craigavon Area Hospital, Portadown, BT63 5QQ
Telephone:
(028) 3756 4600
Email: complaints@southerntrust.hscni.net

DAY 1: Complaint is sent to the relevant Governance Co-ordinator's office.

DAY 2: Governance Co-ordinator's office to send **ACKNOWLEDGEMENT** of the complaint to the complainant.

INVESTIGATION

DAY 20: Governance Co-ordinator will issue a **RESPONSE** to the complainant.

Complainant Satisfied?

YES

Complaint file is closed.

NO

Assistant Director to consider the following measures: ***Further written response*** to outstanding issues (within 20 days of complaint being re-opened); ***meeting with the complaint*** (within 30 days); enhanced local resolution ***investigation by a second team***; c***onciliation***; use of ***Lay people to assist***; or the use of ***independent experts***.

Complainant Satisfied?

YES

Complaint file is closed.

NO

Where the Trust has exhausted all options available to it and there is no resolution to a complaint the complainant is advised of the procedures for contacting the ***Ombudsman's office.***

Appendix 2

Frequently Asked Questions

"Will my services/care be hindered in making a complaint?"	*No, making a complaint does not affect your rights and will not result in the loss of any services you have been assessed as requiring.*
"Who can make a complaint?"	*Any person can complain about any matter connected with the provision of Trust services. Complaints may be made by:* • *a patient or client;* • *former patients, clients or visitors using Trust services and facilities;* • *someone acting on behalf of existing or former patients/clients (providing they have obtained the patient/client's consent;* • *parents (or persons with parental responsibility) on behalf of a child; and* • *any appropriate person in respect of a patient/client unable by reason of physical or mental capacity to make the complainant himself or who has died, e.g. next of kin.*
"How can I make a complaint?"	*For the Trust it is important that we work closely with service users to find an early resolution to complaints when they arise.* *Initially you may wish to express your concerns to the person who is providing the care/services, or to other members of staff, such as receptionists, clinical/care staff. Every opportunity will be taken to resolve a complaint as close to the source as possible through discussion and negotiation.* *If you do this and are still not satisfied you may wish to express your concerns to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, the Trust advises complainants to address their complaint to the Trust's Corporate Complaints Officer. Complaints may be made verbally or in writing, and will also be accepted via other methods, for example the telephone or electronically (e-mail).*

	Corporate Complaints Officer, ***Southern Health & Social Care Trust,*** ***Trust Headquarter,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone:*** ***(028) 3756 4600*** ***Email: complaints@southerntrust.hscni.net*** *When making a complaint it is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint.*
"Why is consent needed?"	*By law confidentiality must be respected at all times and it is for this reason that complaints made by a third party require the consent of the individual involved. Consent is required as the response to the complainant will include personal details about the individual involved.*
"How long does it take until I receive a response to my complaint?"	*The relevant Governance Office will acknowledge receipt of the complaint within 2 working days. This acknowledgement will express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the Trust's attention to the issue.* *After an investigation has been carried out by the relevant Directorate the Trust aims to issue a final response to the complainant within 20 working days of the Trust's receipt of the complaint.* *In the event of the Trust being unable to meet the 20 working day target, which can be due to the complexity of a complaint, the Trust will issue a holding letter to the complainant. If this happens the Trust will remain in contact with the complainant and advise them as to when they should expect a final response in regards to the investigation of their complaint.*

"Who will investigate my complaint?"	*The complaint will be investigated by an investigating team made up of members of staff from within the Directorate where the complaint arose.*
"What if I am not satisfied with my response?"	*Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain, consideration needs to be given to providing enhanced local resolution where practicable. All complainants will be advised that if they should be advised that if they remain unhappy with the Trust's response they should contact the relevant Governance Office to discuss options available. At this point all complainants should be asked to state clearly which aspect(s) of their complaint that they feel remain unresolved. On receipt of this documentation, options may include one or a number of the following:* • *Further written response to outstanding issues;* • *Meeting with the complainant;* • *Enhanced local resolution investigation by a second team;* • *Conciliation;* • *Use of Lay people to assist;* • *Use of independent experts.* *If you are not happy with our response to your complaint, you can contact us again. We will discuss the options available which may assist in resolving any outstanding issues.* *If after this you remain unhappy, you can refer your complaint to the Northern Ireland Commissioner for Complaints (the Ombudsman). The Ombudsman will consider your complaint to determine whether it warrants investigation by the Ombudsman's office.* ***The Ombudsman,*** ***Freepost BEL 1478,*** ***Belfast,*** ***BT1 6BR*** ***Telephone: 0800 34 34 24*** ***Email: ombudsman@ni-ombudsman.org.uk*** ***Website: www.ni-ombudsman.org.uk***

"What if I don't want to make a formal complaint?"	*The Southern Trust is committed to providing a high quality service to all its users. You can help us improve our services by telling us of your experiences. Your views are much appreciated and will be treated in confidence.* *If you do not wish to make a formal complaint you can also make a comment or suggestion, which can be done by completing the 'We Value Your Views' leaflet.* *An Informal complaint can also be made by speaking to a member of staff at the point of service delivery, or by speaking to the Trust's Corporate Complaints Officer.* ***Corporate Complaints Officer,*** ***Southern Health & Social Care Trust,*** ***Trust Headquarters,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone:*** ***(028) 3756 4600*** ***Email: complaints@southerntrust.hscni.net***

Appendix 3

Useful Contacts

Southern Trust Contacts	
Corporate Complaints Officer	**Southern Health and Social Care Trust,** **Trust Headquarters,** **Craigavon Area Hospital,** **Portadown,** **BT63 5QQ** **Telephone:** **(028) 3756 4600** **Email:complaints@southerntrust.hscni.net**
Acute Services Clinical & Social Care Governance Office	**Telephone: (028) 3756 1056**
Children & Young People's Services Clinical & Social Care Governance Office	**Telephone: (028) 3756 3345**
Mental Health & Disability Directorate Clinical & Social Care Governance Office	**Telephone: (028) 3756 3366**
Older People & Primary Care Directorate Clinical & Social Care Governance Office	**Telephone: (028) 3756 3367**
Support & Advocacy Services	
Disability Action	**Human Rights Advocate,** **Disability Action's Centre on Human Rights,** **Disability Action,** **Portside Business Park,** **189 Airport Road West,** **Belfast,**

	BT3 9ED **Telephone: (028) 9029 7880** **Textphone: (028) 9029 7882** **Email:humanrights@disabilityaction.org**
Inspire NI	Central Office Lombard House 10-20 Lombard Street Belfast BT1 1RD **Telephone:** (028) 9032 8474 **Email:** hello@inspirewellbeing.org
VOYPIC	**Voice of Young People In Care** **Flat 12, Mount Zion House** **Edward Street** **Lurgan** **BT66 6DB** **Telephone: (028) 3831 3380** **Website: www.voypic.org**
NICCY (Northern Ireland Commissioner for Children and Young People)	**Legal and Investigations Team** **NICCY** **Equality House** **7-9 Shaftesbury Square** **Belfast** **BT2 7DP** **Telephone: (028) 9031 1616** (Monday – Friday: 9:00am to 5:00pm) **Email: listening2u@niccy.org** **Website: www.niccy.org**
Age NI	**Age NI** **3 Lower Crescent** **Belfast** **BT7 1NR**

	Telephone: 0808 808 7575 (8:00am to 7:00pm, 7 days a week) **Email: advice@ageni.org** **Website: www.ageni.org/advice**
Patient & Client Council	**Telephone: 0800 917 0222** **Website:www.patientclientcouncil.hscni.net**
Carecall (*Mental Wellbeing at Work*)	**Telephone: 0808 800 002** **Website: www.carecallwellbeing.com**
What to do if you're still not happy?	
Northern Ireland Commissioner for Complaints (the Ombudsman)	**The Ombudsman,** **Freepost BEL 1478,** **Belfast,** **BT1 6BR** **Telephone: 0800 34 34 24** **Email: ombudsman@ni-ombudsman.org.uk** **Website: www.ni-ombudsman.org.uk**
Complaints about Regulated Establishments	
The Regulation & Quality Improvement Authority (RQIA)	**The Regulation & Improvement Authority,** **9th Floor Riverside Tower,** **5 Lanyon Place,** **Belfast,** **BT1 3BT** **Telephone: (028) 9051 7500** **Fax: (028) 9051 7501** **Email: info@rqia.org.uk** **Website: www.rqia.org.uk**

Complaints about Family Practitioner Services **(family doctors, dentists, pharmacists, opticians)**	
HSC Board **Complaints Manager**	**Southern LCG,** **Tower Hill,** **Armagh,** **BT61 9DR** **Email: Complaints.hscb@hscni.net**

Southern Health and Social Care Trust

Quality Care - for you, with you

REPORT SUMMARY SHEET

Meeting Date	Governance Committee 6th September 2018
Title	SHSCT Clinical Audit Strategy, June 2018
Lead Director	Dr Ahmed Khan, Medical Director (Interim)
Corporate Objective:	Safe, high quality care
Purpose:	To provide a strategy for delivering on clinical audit within the Southern Trust

Summary of key issues for SMT

Key issues

This paper describes:

- a strategy and structure for overseeing clinical audit processes to provide an assurance to SMT and Trust Board that clinical audit is being appropriately managed and delivered;
- the arrangements for presenting the Trust's consolidated annual clinical audit work programme to SMT for assurance and approval;
- the clinical audit reporting arrangements to SMT, Governance Committee and Trust Board.

Key issues / risks for discussion:

- Ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance
- Ensuring there is a sufficient number of staff in the corporate clinical audit team and operational directorates to support delivery of the approved clinical audit work programme.

Summary of SMT challenge/discussion:

- The Clinical Audit Strategy was approved, for onward referral to Governance Committee
- The strengthened interface between clinical audit and quality improvement was endorsed.
- Further work is required to review the resources to support clinical audit/M&M and QI.
- An extension was granted until 31 July 2018, to facilitate two Operational Directorates in compiling their clinical audit work programmes 2018/19.

Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT Clinical Audit Strategy

June 2018

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Executive statement

The Southern Health & Social Care Trust is committed to delivering effective clinical audit in the clinical services it provides. The Trust sees clinical audit as a cornerstone of its arrangements for developing and maintaining high quality patient-centred care.

This strategy outlines the arrangements for defining, prioritising, approving, supporting, monitoring and reporting on the Trust's annual national, regional and local clinical audit work programme. The strategy also strengthens the assurance processes, as the foundation of our quality improvement efforts underpinning the Trust's Quality Improvement Strategy.

It is expected this one year clinical audit strategy, in line with the Trust's wider governance and assurance mechanisms, will inform and enhance the process of improving clinical services.

Dr A Khan
Medical Director (Interim)

1.0 Organisational context

Clinical audit forms an integral part of the clinical and social care governance framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit.

This strategy seeks to establish a common framework across the Trust to ensure clinical audit activity follows best practice guidance, and strengthens the assurance processes as the foundation of our quality improvement efforts underpinning the Trust's Quality Improvement Strategy. The value of audit projects is realised within the clinical assurance process and in terms of the improvements arising as result of clinical audit outcomes.

Effective national, regional and local clinical audit activities contribute to the delivery of the Trust's corporate objectives. It is important therefore that clinical audit is not seen as an isolated quality improvement activity, but as one of a set of tools which teams and services can use to improve the quality of care that is delivered to service users.

In developing an annual clinical audit work programme, it is essential to consider the links to wider quality and governance frameworks such as recommendations arising from serious adverse incidents, risk management processes, NICE standards and guidelines, etc.

HQIP advocates that if organisations are to gain the greatest benefit from clinical audit, certain pre-requisites must be in place (Appendix A).

2.0 Definition of clinical audit

For the purposes of this Strategy, HQIP's definition of clinical audit will be used, as follows:

> *"clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes"*

3.0 Aims

The aims of this strategy are to:

- Use clinical audit as a process to embed and measure clinical quality at all levels within the Trust, demonstrating the benefits of audit through assurance, and highlighting areas for improvement in the quality of care and services to the patient/service user.

- Identify and develop a prioritised annual national, regional and clinical audit programme, which reflects organisational need.

- Ensure a consistent approach to prioritising, developing, monitoring and reporting on clinical audit activity throughout the Trust.

- Ensure effective and timely reporting on the outcomes of audit activity

- Incorporate the recommendations arising from the internal audit of clinical audit (Appendix B).

4.0 Scope

This strategy is intended to inform, support and apply to all staff working in the SHSCT who have an interest in and responsibility for contributing to and overseeing the development, direction and delivery of national, regional and local clinical audit activity.

5.0 Developing and prioritising operational directorate national, regional and local draft clinical audit work programmes

This strategy describes the processes of developing and prioritising the Trust's clinical audit programme which reflects key national, regional and local drivers for clinical audit ("top-down" requirements), balanced against directorate/division/service priorities and the interests of clinicians ("bottom-up" initiatives).

The first step in developing a comprehensive annual work programme is the identification of all the clinical audit projects which must be undertaken in order to meet external monitoring requirements. HQIP propose clinical audit programmes be categorised into 4 distinct elements, with "external must do" audits being assigned the highest priority as Level 1 projects.

The HQIP defined priority levels for clinical audits are as follows:

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Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

The Trust's paper, *National Clinical and Social Care Audits and Clinical Outcome Review Programmes*' endorsed by SMT on 2 March 2016, highlighted a list of national audits for 2016/17 approved *by NHS England Quality Accounts*. These projects are identified as Level 1 in the table above.

The *NHS England Quality Accounts* List of national audits will be circulated annually to operational directors, Associate Medical Directors and Assistant Directors for identification of audits relevant to their areas of responsibility and inclusion in the directorate's "Level 1" annual clinical audit work programme.

HQIP propose internal 'must-do' clinical audits, which emanate from governance issues or high profile local initiatives, be classified as Level 2 audits.

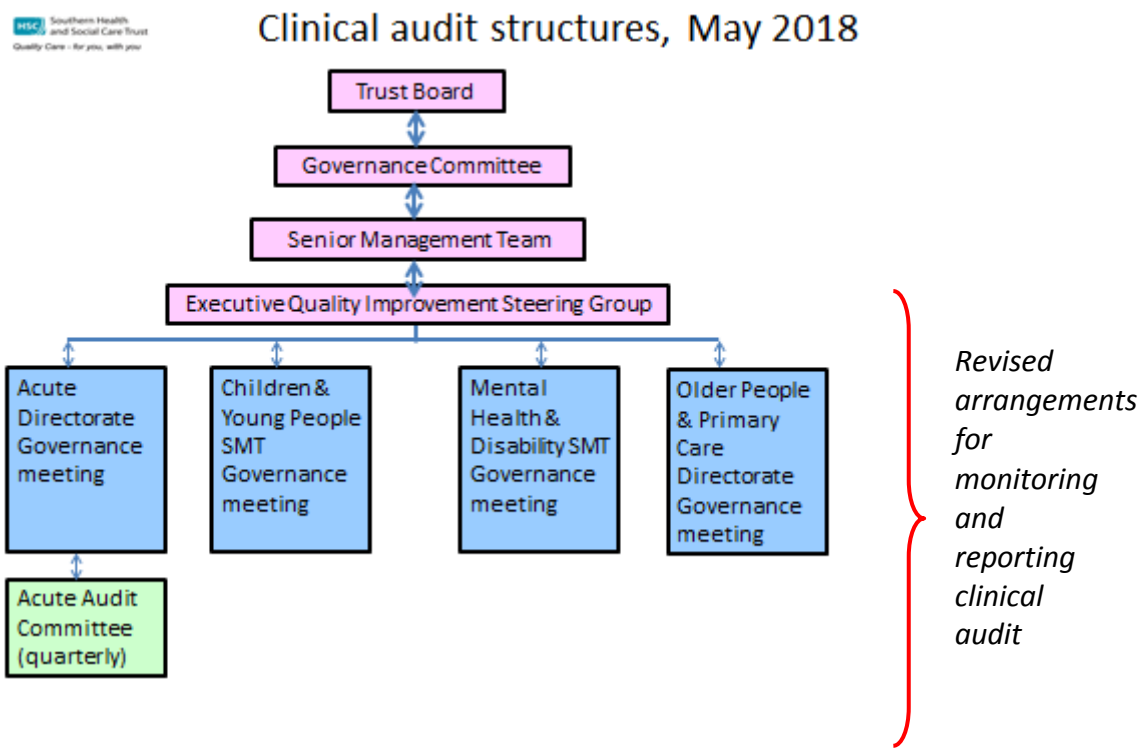
When the 'must-do' Levels 1 and 2 audits have been identified, directorates should, where appropriate, propose projects they believe would be of benefit to patients, service users, clinicians and managers. These audits should be classified as Level 3 and Level 4 audits, as determined by the operational directorates.

Taking the 4 levels of audit into consideration as appropriate, operational directorate's should agree their draft clinical audit work programme within the operational structures outlined in 6.0 below, The work programme should be forwarded to [redacted] for collation in the Trust's draft annual clinical audit work programme, which the Medical Director will take forward for review and approval. The draft clinical audit work programme 2018/19 is outlined in Appendices D and E below.

The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures.

6.0 Approval of the annual clinical audit work programme

The Medical Director will present the Trust's draft annual clinical audit work programme to Executive Quality Improvement Steering Group / SMT for review and approval. Following approval, the work programme will be forwarded to Governance Committee and Trust Board for information.



7.0 Additions to the annual clinical audit work programme

On occasion new audits may be identified throughout the year. Compiling and prioritising the annual clinical audit work programme should not stifle projects that emerge during the year that will contribute to improvements in care.

Some of these projects might be new 'must-do' audits which could not be determined when the work programme was being developed, while others may represent innovative ideas from clinicians which are as valid and important as ideas proposed when the programme was originally developed. Existing quality improvement work may also identify emerging work areas for clinical audit

New projects identified within year will be highlighted to the Executive Quality Improvement Steering Group / SMT by Operational Directors.

These audits should also be highlighted to [redacted] for registration on the Trust's centralised clinical audit database.

8.0 Registration of clinical audits

All clinical audit projects must be notified to [redacted], for recording on the Trust's centralised clinical audit database.

9.0 Monitoring and reporting schedule

Audit findings and recommendations should be discussed within the appropriate operational directorate structures.

For corporate reporting purposes, a standardised reporting template to assist directorates in summarising the audit findings and areas for improvement, for inclusion in the 6 monthly audit assurance report to Senior Management Team, is outlined in Appendix C. These audit summaries should be approved within operational directorate structures and forwarded to [redacted] for inclusion in the 6 monthly audit assurance report.

The reporting schedule is outlined below:

Audit activity should be included as a standing agenda item within the appropriate **sub-committee structures** as determined by each operational directorate	Monthly
Monitoring of national, regional and local clinical audit should be discussed within the appropriate **operational directorate** structures (Table 6.0 above)	Quarterly as a minimum
The Trust's Audit Assurance Report should be presented to the Executive Quality Improvement Steering Group, and following approval will be forwarded to the Senior Management Team, Governance Committee and Trust Board for information.	6 monthly

10.0 Quality assurance processes for data submission to external host organisations

The nominated Consultant Audit Lead/Supervisor will ensure data being submitted to an external host organisation is in keeping with Data Protection Act, Caldicott Guidance and the Trust's Information Governance protocols.

He/she will liaise with the relevant Associate Medical Director, Assistant Director and Operational Director to approve data prior to submission to an external host organisation and will be supported in this role by the Clinical Audit Facilitators, as required.

11.0 Resources to support the clinical audit work programme

The current staffing level in the corporate clinical audit and M&M team and operational directorates is insufficient to support and deliver the draft clinical audit work programme, 2018/19.

There may be potential to consider the resource requirements jointly with admin support for M&M, in light of the Hyponatraemia Inquiry recommendations, as M&M and clinical audit are intrinsically linked.

12.0 Review arrangements

This strategy will be reviewed in 1 year's time.

June 2018

SHSCT Clinical Audit Strategy

Action Plan, February 2018 (updated June 2018)

	Proposed action	Lead	Timescale
1	Directorates should ensure clinical audit structures exist to support the promotion, development, monitoring, reporting and quality assurance of clinical audit activity at operational level	Operational Directors	March 2018
2	The NHS England Quality Accounts List of national audits should be forwarded to operational directorates in February, for their review in developing a draft annual clinical audit work programme	Head of Service, clinical audit	Feb 2018
3	Operational directorates should develop and deliver their annual clinical audit work programme, in line with the prioritization criteria in the clinical audit strategy.	Operational Directors, AMDs & Assistant Directors, in consultation with service teams	March 2018 – extended to 31 July 2018
4	The Medical Director will present the Trust's consolidated annual clinical audit work programme to the Executive Quality Improvement Steering Group / SMT for assurance and approval	Medical Director	April 2018 –extended to 31 July 2018
5	The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures	Operational Directors, AMDs & ADs	Sept 2018
6	Clinical audit projects agreed within year should be highlighted to the Executive Quality Improvement Steering Group / SMT, and registered [redacted]	Operational Directors	prn
7	Following corporate approval, the clinical audit strategy should be launched within operational directorates	Head of Service, clinical audit	asap after approval
8	Operational Directorates should encourage the registration of all approved clinical audit activity. Details of audits to be registered on the Trust's centralised audit database should be forwarded to [redacted]	operational directorate "approval arrangements"	Ongoing
9	**Operational level:** Audit findings should be discussed within the appropriate operational directorate structures. **Corporate reporting:** Completed audit templates (Appendix C) should be approved within operational directorate arrangements and forwarded to [redacted] for inclusion in the 6 monthly audit assurance report.	Clinical Audit Leads Audit Committee arrangements at operational level	Ongoing 6 monthly

10	The Medical Director will present the 6 monthly audit report to the Executive Quality Improvement Steering Group / SMT, and following approval submit to Governance Committee and Trust Board for information.	Medical Director	May, Nov. May 2018 report - extension to 31 July2018
11	Clinical audit presentation to Governance Committee, including progress on outstanding recommendations from the Internal Audit of clinical audit	Head of Service, AD, Medical Director's team	Autumn 2018
12	Consider the potential to review clinical audit and M&M resources in light of the Hyponatraemia Inquiry recommendations and the interface between M&M and clinical audit	Medical Director	tba

HQIP Clinical audit best practice criteria		Appendix A
	Theme	**Reference source**
1.	Clinical audit is a quality improvement activity and therefore it functions best as part of a planned programme of quality improvement that has been approved by the Board and/or senior management of the organisation.	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001
2.	The Board should have dedicated time set aside to review both the clinical audit programme and the outcomes of individual projects	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001
3	An effective clinical audit programme will cover the requirements and needs of a number of stakeholders including the Board, clinicians, service users and commissioning bodies. The programme should be developed in accordance with clear policy and agreed following consultation with clinicians, managers and patient representatives. The programme should be closely monitored and progress reported regularly at Board and service delivery level. An annual report, linked where appropriate to the Trust quality account, should be presented to both the Board and patient groups for scrutiny before publication.	HQIP, Clinical audit policy and strategy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/N{PCA/2016-007
4	Service user and public involvement in clinical audit should be embedded in the organisation's Personal & Public Involvement (PPI) strategy. The clinical audit programme should include patient-focused projects, and the roles played by service users and lay representatives should be acknowledged in clinical audit reporting at all levels.	HQIP, Patient and Public Involvement (PPI) Strategy: www.hqip.org.uk/BPCA2016-003 HQIP,Patient and Public Invovement in Quality Improvement: www.hqip.org.uk/BPCA/2016-004 HQIP, Developing a patient and public involvement panel for quality improvement: www.hqip.org.uk/BPCA2016-005 HQIP, Introductin to quality improvement for pateints and public: www.hqip.org.uk/BPCA2016-006

5	In deciding which clinical audits should be undertaken, the following factors should be considered: Clinical priorities, including clinical risks, adverse incidents and patient safety Organisational priorities, including service redesign and development Patient and service user prioritiesCommissioner priorities and specifications, including Commissioning for Quality and Innovation Frameworks (CQUINs) and NHS Standard Contract requirements The outputs from the national Clinical Auidt and Patient Outcomes Programme (NCAPOP) and other national clinical audits Professional revalidation, appraisal and training needs	HQIP, Developing a clinical audit programme: www. Hqip.org.uk/BPCA2016-007 Using clinical audit in commissioning: www.hqip.org.uk/BPCA2016-008 HQIP, Srtatutory and mandatory requirements for clinical audit: www.hqip.org.uk/BPCA2016-009 HQIP, Guide to involving junior doctors in clinical audit: http://www.hqip.org.uk/rsources/involving -junio-doctors-in-clinical-audit/ GMC, Guidance on revalidation: http://www.gmc-uk.org/doctors/revalidatin.asp
6	Clinical audit is only one of a range of quality improvement methodologies and should not be used if another is more appropriate.	HQIP, Guide to quality improvement methods: www.hqip.org.uk/BPCA2016-010
7	Organisations must have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. The findings from clinical auidts may be used as part of the Board Assurance Framework, but full assurance can only be obtained if the quality improvement aims of the project have been achieved. Governance plans should include arrangements for participation in local and regional cross-organisational audits	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001 HQIP, Clinical audit policy and strategy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007
8	Policies and procedures must be in place to ensure that clinical audit (and all other quality improvement activities) are undertaken in a way that complies fully with current information governance legislation and guidance, and in consultation with local information governance leads and Caldicott guardians	HQIP, Information governance for local quality improvement: www.hqip.org.uk/BPCA2016-011

9	All staff within an organisation should be made aware of, and comply with, the governance arrangements in place, including local policy and protocols on proposing, registering, undertaking and reporting on clinical audits	HQIP, Clinical audit policy and stratgegy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007 HQIP, Guide for clinical audit leads: www.hqip.org.uk/BPCA2016-012
10	The organisation must enable the conduct of good quality clinical audit by providing appropriate resources to support the process. This includes dedicated time for audit and an appropriate level of funding. Organisations should have in place: A senior clinician able to lead on clinical audit across the whole organisation Clinical leads for quality improvement at service delivery level Clinical audit practitioners who can manage the audit programme and support the process A programme for supporting doctors in training to ensure that the clinical audit and quality improvement activities they undertake as part of their training to deliver benefits to the organisation.	HQIP, Developing a clinical audit programme: ww.hqip.org.uk/BPCA2016-007 HQIP, Guide for clinical audit leads: www.hqip.org.uk/BPCA/2016-012 HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014
11	The organisation should seek to improve the knowledge and skills of all staff in quality improvement. Training in clinical audit should be available for all staff and where appropriate for lay representatives. All staff should be encouraged to participate in clinical and other networks that provide knowledge sharing and opportunities for staff development	A promise to learn – a commitment to act: improving the safety of pateitns in England (the Berwick report): htpps:/www.gov.uk/government/publications/Berwick-review-into-patient-safety HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014 HQIP, Developing a patient and public involvement panel for quality improvement: www.hqip.org.uk/BPCA2016-005

Internal Audit recommendations on Clinical Audit (as at Feb 2018)	Appendix B