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. David Cardwell
Patient Client Liaison Manager
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

5 July 2023

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.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference. The Inquiry is of the

view that in your roles you will have an in-depth knowledge of matters that fall within our 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 detail 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 may be aware the Trust has 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 your 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 an 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 the USI.

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 16 of 2023]

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. David Cardwell
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 16th August 2023.**

APPLICATION TO VARY OR REVOKE THE NOTICE

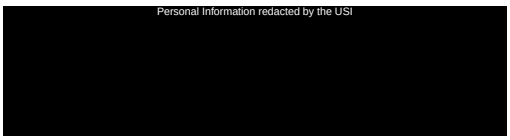
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

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 9th August 2023**.

Issued by the Urology Services Inquiry on 05/07/2023. Annotated by the Urology Services Inquiry.

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 5th day of July 2023

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

SCHEDULE

[No 16 of 2023]

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:

   (i) an explanation of your role, responsibilities and duties within the Southern Health and Social Care Trust ("the Trust"), and

   (ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.

   It would greatly assist the inquiry if you would provide the above 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"). 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. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

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.

Datix, Incident Report, Screening and SAIs

7. With reference to specific policies and procedures where appropriate, please provide an outline of the steps to be followed when an incident is reported within the Trust and, in particular, address the following:

    a. How are incidents to be reported and is there a requirement for all incidents to be reported in a specific manner?

    b. Outline the procedure to be followed when an incident is reported which has the potential to meet the threshold for an SAI and, in particular, address the following:

        i. Who is responsible for identifying that the incident may potentially meet the threshold for an SAI and requires "Screening"?
        ii. On identifying an incident that may potentially meet the threshold for an SAI, what process is to be followed?

iii. Who is responsible for making the decision that the threshold for an SAI is met?
iv. Who else is involved in the "Screening" process?
v. How is any decision at the "Screening" stage recorded?
vi. What, if any, documentation is produced during this "Screening" process?
vii. How, if at all, is the outcome of that "Screening" process audited or quality assured?
viii. How is the outcome of that "Screening" process communicated to relevant individuals or organisations, including the Health and Social Care Board, as it was during the period relevant to the Inquiry's Terms of Reference.

c. Who is responsible for ensuring that incidents, including those which potentially meet the threshold for an SAI, are investigated in a prompt and thorough manner?

d. What tools, processes or procedures are available for ensuring prompt and thorough investigation?

e. Who is responsible for ensuring that learning from incidents is identified, disseminated and implemented?

f. What procedures exist within the Trust to ensure that learning from incidents is implemented and, if applicable, explain how these procedures have evolved over time.

8. Please consider the following extracts from Ms Trudy Reid's evidence to the Inquiry and address questions (a) – (b):

Extracts from Ms Trudy Reid's Response to Section 21 Notice:

> …**WIT-95223 paragraph 3.82.** On 07/02/2017 the development of dashboards on Datix was noted I progressed this work with David Cardwell in the Acute Clinical Governance team – this work was challenging to take forward due to staffing resources and the Datix system, however, some

dashboards were developed. Datix software has dashboard infrastructure, at the time there was no Datix manager and the Acute Directorate had limited capacity to progress dashboards. Dashboards are information from the Datix system which allows graphical monitoring of incidents. This was not sophisticated enough to identify fine detail but would have allowed monitoring of incidents open and closed or specific results on for example violence and aggression trends. As different Datix version were in use triangulation of data remained challenging.

a. Considering the evidence from Ms Trudy Reid above, explain:

   i. What the issue was?
   ii. What steps, if any, were taken to address same?
   iii. Whether or not, in your opinion, the issue was successfully addressed?

b. Considering the Datix system in general, please address:

   i. To what extent, if any, did you consider that there were any limitations in the system which impacted upon incident reporting and patient safety?
   ii. What steps, if any, were taken to address those limitations?
   iii. Whether or not, in your opinion, those limitations were successfully addressed?

9. Please consider the following extracts from Dr Tracey Boyce's evidence to the Inquiry and address questions (a) – (E):

Extracts from Dr Tracey Boyce's oral evidence to the Inquiry on 24 May 2023:

TRA-05835-05836
Dr Boyce: I also then realised that there was no real reporting coming out of the Governance team to try and make it easier for the other Assistant Directors. One of the first things I did was work with the admin support. They were excellent, they were really good staff, David Cardwell and so on, who really understand the Datix system. I asked them to come up with a report to show the Assistant Directors how many ones they have, what hadn't been opened, that sort of thing; how SAIs were running. Very quickly we got weekly reports set up for the Assistant Directors. We were doing that sort of thing.

a. As well as Assistant Directors, was this information contained on the Datix system communicated or reported to anyone else?

b. Outline how information contained on the Datix system was communicated or reported to Assistant Directors and others, if applicable, and explain how this communication or reporting evolved over time.

c. Explain how these communications or reports were created.

d. What actions were Assistant Directors and others, if applicable, expected to take on receipt of these communications or reports?

e. Who was responsible for following up and ensuring that incidents, SAIs or issues identified in these reports or communications were addressed?

f. What steps would you take to ensure that incidents, SAIs or issues identified in these reports or communications were addressed?

Issues arising from specific Incidents and SAIs

10. Please consider **WIT-54874-54881**, a SHSCT Adverse Incident Reporting (IR2) Form – December 2020 for Patient 102. Provide a detailed overview of your involvement with the incident relating to Patient 102, from the date it was reported on 21 October 2015 to the last time it was updated by you on 17 June 2016, and, in particular, address the following:

    a. Please consider **TRU-277904** which is an email from Heather Trouton to Martina Corrigan and Eamon Mackle dated 22 October 2015 with regard to the incident concerning Patient 102 in which Mrs Trouton asks *"Does this need screened?"* and address the following:

i. Was this incident screened with a view to deciding whether or not it met the threshold to be classed as an SAI?
ii. If so, confirm the date of that screening process, the outcome and provide any documentation relating to that screening process.
iii. If not, confirm why you this incident was not screened.

b. Further to the above, explain why this incident was never declared an SAI. In addressing same, please outline the nature of any discussions regarding this incident being treated as an SAI and the name, and roles within the Trust, of anyone involved in those discussions.

c. Confirm whether a direct referral for radical radiotherapy was ever sent following the Urology MDM on 20 November 2014 and address the following:

i. If a referral was sent, please explain why Patient 102 did not receive any timely appointments from oncology.
ii. If a referral was not sent, please explain why.

d. Why was there a delay from 21 October 2015 when the incident was reported to 18 November 2015 when it was *"opened"*?

e. Consider the entry dated 11/12/2015 14:55:26 at **WIT-54879** where it is stated that you were asked by Helen Forde to send this incident form to Martina Corrigan for her "*to discuss with consultan*t". As available, please provide the email exchange from Helen Forde and address the following questions:

i. Why this matter was being sent back to Martina Corrigan to discuss with Aidan O'Brien?

ii. Who was involved in that decision and how was that decision reached?
iii. What action was to be taken to address the issues raised by the incident concerning Patient 102?
iv. Did you receive any response from Martina Corrigan to your message? If so, please detail or provide that response.
v. If you did not receive a response, did you take any further action to follow up that Martina Corrigan had received your message and actioned the outcome as expected by speaking to the consultant?
vi. If the actions at (ii) above did not fall within your responsibility, who was responsible for ensuring that actions anticipated were in fact completed?
vii. Does your message at WIT-54879 to Martina Corrigan via Helen Forde mean that this incident form was now deemed "closed" from your perspective or were further steps anticipated or undertaken by you regarding this incident after this message? If so, please provide full details.
viii. Was this the last message regarding this issue particular incident form? If not, please provide full details.

f. Outline the circumstances and explain the decision making which led to the closure of this incident on 17 June 2016.

11. Please consider **TRU-274729-274730** and **TRU-274751-274753**, a series of emails from August and September 2016 regarding an incident concerning Patient 93. Provide a detailed overview of your involvement with the incident relating to Patient 93 and, in particular, address the following:

a. Please address the following questions concerning whether the incident concerning Patient 93 should have been considered an SAI:

i. Was this incident screened with a view to deciding whether or not it met the threshold to be classed as an SAI?

ii. If so, confirm the date of that screening process, the outcome and provide any documentation relating to that screening process.
iii. If not, confirm why you understand the incident was not screened.

b. Confirm whether or not a Datix was ever received concerning the incident involving Patient 93. If so, please disclose all documentation and records relevant to same.

12. Please consider **TRU-01366-01371**, a series of emails dated 22-23 December 2016 regarding a complaint concerning Patient 16. Provide a detailed overview of your involvement with the incident relating to Patient 16 from the date the complaint was received by the Trust on 21 December 2016 to the reporting of the SAI on 27 January 2020, and, in particular, address the following:

a. How did the complaint concerning Patient 16 come to your attention?

b. Concerning your email to Trudy Reid on 22 December 2016 at 11:08, what features of this case did you consider merited potential screening to see if it met the threshold for an SAI?

c. Who was responsible for determining whether or not the complaint concerning Patient 16 met the threshold for an SAI?

d. When was the decision taken that the complaint concerning Patient 16 met the threshold for an SAI? Provide any documentation relating to that screening process.

e. Were you aware of extant issues concerning Aidan O'Brien being handled at or around that time by the Oversight Committee? If not aware at that time, when did you become aware?

f. Outline the extent of your involvement once it was determined that an SAI was to take place in relation to Patient 16.

g. Outline your understanding of the delay which took place between the complaint being received by the Trust on 21 December 2016 and the final SAI report dated 27 January 2020.

Complaints

13. With reference to specific policies and procedures where appropriate, please provide an outline of the steps which must be followed when the Trust receives a complaint and please address the following:

    a. Explain your specific role concerning the handling of complaints.

    b. Explain who is responsible for investigating the substance of complaints and what steps are to be undertaking in the investigation of complaints.

    c. Outline any key performance indicators or standards against which the handling of complaints was judged or performance managed.

    d. Outline what issues, if any, in your opinion, you considered there to be with the handling of complaints within the Trust.

    e. Further to (d) above, outline what, if any, steps you took to address any issues with the handling of complaints within the Trust.

14. With reference to specific examples where appropriate, outline what, if any, trends you identified from complaints you were involved in concerning both urology services in general and specifically Aidan O'Brien and address the following:

    a. What, if any, trends, issues or concerns you identified?

b. What, if any, action you took to escalate or address any tends, issues or concerns?

c. Whether or not, in your opinion, the trends, issues or concerns were successfully addressed?

15. Please provide any further details which you consider may be relevant to the Inquiry's Terms of Reference.

NOTE:

By virtue of section 43(1) of the Inquires 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 recording. 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 Inquires 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.

Martina Corrigan

SHSCT Adverse Incident Reporting (IR2) Form -December 2020

The new Regional CCS2 codes which will replace 'Type', 'Category', 'Subcategory', and 'Detail' have been updated.

A full list of these codes can be found here for review.

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	20:25

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	20/11/2014
Time (hh:mm)	17:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Patient 102 Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr Pe for Radical Radiotherapy. For OP Review with Mr O'B.' Was reviewed by Mr O'B in OP on 28th November 2014. No correspondance created from this appointment. Referral letter from GP received 16th October 2015 stating that Patient 102 had not received any appointments from oncology.
Action taken Enter action taken at the time of the incident	Patient 102 has now been referred to Oncology. This has been done by email and letter. Investigation with MDM team, direct referral was generated at CAH but no record of being received in Belfast.
Learning Initial	
Reported (dd/MM/yyyy)	21/10/2015
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	18/11/2015
Last updated	David Cardwell 06/17/2016 09:17:40
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 102

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery

Speciality / Team Urology Surgery

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job title	Originated from
No details found for the contact with ID Personal Information redacted by the	sharon.kennedy Personal Information redacted by the USI	21/10/2015 20:26:07	Personal Information redacted by the USI			Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	Eamon.Mackle Personal Information redacted by the USI	21/10/2015 20:26:07				Level 1 Form
Connolly, Connie	Personal Information redacted by USI	21/10/2015 20:26:06			Acting Acute Governance Co-Ordinator	Level 1 Form
Mackin, Dawn	Personal Information redacted by the USI	21/10/2015 20:26:06			Nursing Governance CoOrdinator	Level 1 Form
Young, Michael	Personal Information redacted by USI	21/10/2015 20:26:05			Consultant	Level 1 Form
Smyth, Paul	Personal Information redacted by USI	21/10/2015 20:26:05			Head of Unscheduled Care	Level 1 Form
Trouton, Heather	Personal Information redacted by USI	21/10/2015 20:26:05			Assistant Director of Acute Services	Level 1 Form
Glenny, Sharon	Personal Information redacted by USI	21/10/2015 20:26:04			Operational Support Lead	Level 1 Form
Nelson, Amie	Personal Information redacted by USI	21/10/2015 20:26:04			Head of Service	Level 1 Form
Corrigan, Martina	Personal Information redacted by USI	21/10/2015 20:26:03			Head of ENT and Urology	Level 1 Form

Management of Incident

Handler
Enter the manager who is handling the review of the incident

Martina Corrigan

Additional/dual handler
If it is practice within your team for two managers to review incidents together use this field to record the second handler

Escalate
You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the

incident has been escalated to them.	
Date of final approval (closed date) (dd/MM/yyyy)	17/06/2016

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	
Sub Category	
Detail	

Datix CCS2

Type	
Category	
Sub-Category	
Detail	
Is this a Haemovigilance /Blood Transfusion or Labs-related Incident?	No
Is this an incident relating to confidentiality? This may include inappropriate access / disclosure, loss or theft of records etc	No

SAI / RIDDOR / NIAIC?
Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI? Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.	
Is this incident RIDDOR reportable? Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition): 1. Employee or self-employed person working on Trust premises is killed or suffers a major injury 2. A member of the public on Trust premises is killed or taken to hospital 3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive	

days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)

4. Dangerous Occurence attributable to the work of the Trust

5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

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Is this a NIAIC Incident
NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;

- design or manufacturing problems

- inadequate servicing and maintenance

- inappropriate local modifications

- unsuitable storage and use conditions

- selection of the incorrect device for the purpose

- inappropriate management procedures

- poor user instructions or training (which may result in incorrect user practice

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Investigation

Investigator	Andrea Cunningham
Date started (dd/MM/yyyy)	18/11/2015
Actual Impact/Harm This has been populated by the reporter. To be quality assured by the investigating manager.	Major

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Risk grading
Click here

When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incident happening again under similar circumstances. (Likelihood) and multiply that by the potential

	Consequence				
Likelihood of recurrence	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible	○	○	○	○	○

impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:	**(Expected to occur monthly)**					
	Unlikely (Expected to occur annually)	○	○	○	○	○
	Rare (NOT expected to occur for years)	○	○	○	○	○
		Grade:				

Action taken on review Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)	181115cc- preliminary review by FSS established that there was no dictation done on this patient. Incident returned to SEC and will be escalated to HOS and AMD
Action Plan Required? A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.	

Action Plan

No actions

Lessons learned

Lessons learned If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".	
Date investigation completed (dd/MM/yyyy)	
Was any person involved in the incident?	No
Was any equipment involved in the incident?	No

Notepad

Notes Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information	

Communication

Recipients

Message

Message history

Date/Time	Sender	Recipient	Body of Message	Attachments
22/03/2016 12:08:10	Kerr, Vivienne	martina.corrigan Personal Information redacted by	This is a feedback message from Vivienne Kerr. Incident form reference is Personal Information The feedback is: Please see Datix which is now coded under urology. Please go to Personal Information redacted by USI Personal Information redacted by USI	
11/12/2015 14:55:26	Cardwell, David	martina.corrigan Personal Information redacted by the	This is a feedback message from David Cardwell. Incident form reference is Personal Information The feedback is: Hi Martina, Helen Forde has asked me to send this to you with the following message: Personal Information – I think it should go to Martina Corrigan as it says there was no correspondence for the appointment – so it wasn't that the secretary didn't type it – I think it was that it wasn't dictated so that would need to go to Head of Service for urology to discuss with consultant. Regards David Cardwell Please go to Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 14:29:44	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident form reference is Personal Information The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 14:29:44	Connolly, Connie	Mark.Haynes Personal Information redacted by	This is a feedback message from Connie Connolly. Incident form reference is The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 14:29:43	Connolly, Connie	Corrigan, Martina	This is a feedback message from Connie Connolly. Incident form reference is The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 14:29:43	Connolly, Connie	Robinson, Katherine	This is a feedback message from Connie Connolly. Incident form reference is Personal Information The feedback is: Martina- i have taken this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if needed. Connie Please go to Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 11:41:44	Connolly, Connie	Mark.Haynes Personal Information redacted by the	This is a feedback message from Connie Connolly. Incident form reference is Personal Information The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 11:41:43	Connolly, Connie	Robinson, Katherine	This is a feedback message from Connie Connolly. Incident form reference is Personal Information. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to http: Personal Information redacted by USI Personal Information redacted by USI	
18/11/2015 11:41:43	Connolly, Connie	Forde, Helen	This is a feedback message from Connie Connolly. Incident form reference is Personal Information The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to http Personal Information redacted by USI	

			Personal Information redacted by the USI	
18/11/2015 11:41:42	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident form reference is Personal information The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gave access to all. Moved to review Connie Please go to Personal Information redacted by the USI Personal Information redacted by the USI	

Medication details

Stage
Prescriber Name
Medication error
Medication involved If multiple medications involved enter the primary medication affecting the incident, and record the others in the description
Correct medication
Form administered
Correct form
Dose and strength involved
Correct dose
Route involved
Correct route

Falls Information
Please Quality Assure all information as part of your investigation

Did the fall occur in Hospital or Community Setting?
Specific Location of Fall
Exact location of Fall Please describe in free-text exactly where the fall occurred
Injury Suspected?
Harm?
Buzzer / bell available within reach before fall?
Floor surface
Footwear suitable?
Walking aid in use / reach?
Mental State
First fall this admission or repeat?
Days since admission
Was the patient receiving medication which may affect the risk of falling?
Family informed of fall?
Outcome of Bedrails Assessment

Result

Pressure Ulcers

Was this incident in respect of a Pressure Ulcer?

Equipment details

Product type

Brand name

Serial no

Description of device

Current location

CE marking?

Description of defect

Model/size

Documents added

No documents.

People Affected

	ID	Title	Forenames	Surname	Type	Approval status
▶	Personal Information redacted by	Personal Informatio n	Personal Information redacted by	Personal Information redacted by the USI	Patient/Client/Service User	Approved

Employees

	ID	Title	Forenames	Surname	Type	Approval status
▶	Personal Information redacted by the USI	Mr	Mark	Haynes	Staff - Medical and Dental	Approved
▶			Marie	Dabbous	Staff - Administrative and Clerical	Approved
▶			Shauna	McVeigh	Staff - Administrative and Clerical	Approved
▶		Mr	Aidan	O Brien	EMPL	Approved

Other Contacts

No Other Contacts

Willis, Lisa

From: Trouton, Heather
Sent: 22 October 2015 09:01
To: Corrigan, Martina; Mackle, Eamon
Subject: RE: Fwd: Datix Incident Report Number [redacted]

Follow Up Flag: Follow up
Flag Status: Flagged

Eamon

Does this need screened ?

Heather

From: Corrigan, Martina
Sent: 21 October 2015 22:05
To: Mackle, Eamon; Trouton, Heather
Subject: Re: Fwd: Datix Incident Report Number [redacted]

I will check tomorrow. I don't think so but I will let you know.

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile [redacted]

From: Mackle, Eamon
Sent: Wednesday, October 21, 2015 09:56 PM
To: Corrigan, Martina; Trouton, Heather
Subject: Fwd: Datix Incident Report Number [redacted]

Please see below. Was this a missing chart patient?

Eamon

Sent from my iPad

Begin forwarded message:
From: Datix [redacted]
Date: 21 October 2015 20:26:07 BST
To: "Mackle, Eamon" [redacted]
Subject: Datix Incident Report Number [redacted] An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Corrigan, Martina

From: Corrigan, Martina
Sent: 02 September 2016 14:51
To: Young, Michael
Cc: Weir, Colin
Subject: Urgent for investigation please

Importance: High

Michael,

Please see email trail and Charlie's comments below.

Can you please discuss with Colin when you are back from Annual Leave and advise course of action ?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Personal Information redacted by the USI HCN Personal Information redacted by the USI
Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Personal Information redacted by the USI HCN Personal Information redacted by the USI

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Personal Information redacted by USI

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Personal Information redacted by USI
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Personal Information redacted by USI
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana <Personal Information redacted by USI>
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 16 September 2016 18:08
To: Weir, Colin
Subject: FW: Urgent for investigation please

Hi Colin

I am not sure if I had forwarded this to you already?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by USI

From: Young, Michael
Sent: 08 September 2016 17:32
To: Corrigan, Martina
Subject: RE: Urgent for investigation please

Few points
1/ GP probably should have referred as RF in first place. A PSA of 34 is well above normal
2/ if booking centre has not received a triage back then I agree that they follow the GP advice
3/ if recent scan had shown secondaries then they were present at referral. As such then this was at an advanced non curable stage even then.
4/ I think the point here is that although non-curable I would have thought that treatment would still have been offered in the form of anti-androgen therapy at some stage over the subsequent few months.
5/ So to follow this to the next step means that if still following our current Routine waiting time would have resulted in the patient not being seen for a year. Some clinicians would have regarded this as resulting in a delay in therapy.
6/ It is not clear if arrangements were made, but the triage letter was not returned ?
7/ The patient was in fact seen within a few months.
8/ The apparent delay of just a few months has however not impinged on prognosis.

My view

MY

From: Corrigan, Martina
Sent: 07 September 2016 12:14
To: Young, Michael
Subject: FW: Urgent for investigation please
Importance: High

As discussed this afternoon

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by USI

From: Corrigan, Martina
Sent: 02 September 2016 14:51
To: Young, Michael
Cc: Weir, Colin
Subject: Urgent for investigation please
Importance: High

Michael,

Please see email trail and Charlie's comments below.

Can you please discuss with Colin when you are back from Annual Leave and advise course of action ?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by USI

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Patient 93
Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Patient 93

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Patient 93

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Patient 93
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana Personal Information redacted by USI
Sent: Wednesday, 31 August 2016 08:34

From: Boyce, Tracey
Sent: 23 December 2016 12:30
To: Carroll, Ronan
Subject: FW: Complaint - ?SAI
Attachments: file.pdf; Patient 16 1.doc; Patient 16 .pdf

Importance: High

Hi Ronan
See below - David Escalated this complaint to Trudy yesterday for an opinion as to whether it might need to be considered under the SAI process. (David doesn't know anything about our other AOB concerns).

What do you think?

Would the delay in the stent issue be down to the urologist or is that a process under radiology's control?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

Learn more about mental health medicines and conditions on the Choiceandmedication website
http://www.choiceandmedication.org/hscni/

-----Original Message-----
From: Reid, Trudy
Sent: 22 December 2016 16:05
To: Boyce, Tracey
Subject: FW: Complaint - ?SAI

Tracey please see attached and below -, David has asked is this a potential SAI?

Episode Enquiry

Select Episode 22/12/16 13:56 CA

Name

Patient 16 *MRSA* 03/07/12 Casenote Personal Information redacted by USI

No Status Date Cons Spec Hosp Ward Cat Casenote WL-Cd A/P P
-- -------- -------- ------ ---- ---- ---- --- ---------- ----- --- -

1 IP ADM 09/12/16 JYG GSUR DHH FS NHS [redacted]
ZB001 RHSCB
2 DSCH INCPT 08/12/16 AOB URO CAH TDU [redacted] CURWL
ZB001 RHSCB
3 WL ACTV 02/12/16 AOB URO CAH 1WEA [redacted] CURWL
ZB001 RHSCB
4 DSCH CMPLT 01/09/16 AJG URO CAH 1WEA [redacted] CAJG
ZB001 RHSCB
5 DSCH CMPLT 12/08/16 AOB URO CAH 3ESU [redacted] CURWL
ZB001 RHSCB

E p i s o d e E n q u i r y

Select Episode 22/12/16 13:56 CAH
Name
[redacted] *MRSA* 03/07/12 Casenote [redacted]

No Status Date Cons Spec Hosp Ward Cat Casenote WL-Cd A/P PD
-- -------- -------- ------ ---- ---- ---- --- ---------- ----- --- --

1 DSCH CMPLT 10/07/16 AOB URO CAH 3ESU NHS [redacted] CURWL
ZB001 RHSCB
2 OP DSCH 24/06/16 PREAS NPOA CAH [redacted]
ZB001 RHSCB
3 OP DSCH 09/05/16 JOD URO CAH [redacted] (CJODNU
ZB001 RHSCB
4 WL CANC 29/10/15 RAH RT CAH CMU [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS
5 DSCH CMPLT 08/10/15 RAH RT CAH CMU [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS

E p i s o d e E n q u i r y

Select Episode 22/12/16 13:56 CAH
Name
[redacted] *MRSA* 03/07/12 Casenote [redacted]

No Status Date Cons Spec Hosp Ward Cat Casenote WL-Cd A/P PD
-- -------- -------- ------ ---- ---- ---- --- ---------- ----- --- --

1 DSCH CMPLT 17/09/15 RAH RT CAH CMU NHS [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS
2 DSCH CMPLT 27/08/15 RAH RT CAH CMU NHS [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS
3 DSCH CMPLT 19/08/15 RAH RT CAH CMU NHS [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS
4 DSCH CMPLT 30/07/15 RAH RT CAH CMU NHS [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS
5 DSCH CMPLT 02/07/15 RAH RT CAH CMU NHS [redacted] CRTRAH
CSRT6 CAHGT-SHSSB-R THERAPY-ALL EPS

Issued by the Urology Services Inquiry on 05/07/2023. Annotated by the Urology Services Inquiry.

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

<More available>
Select/Continue :

Regards,

Trudy

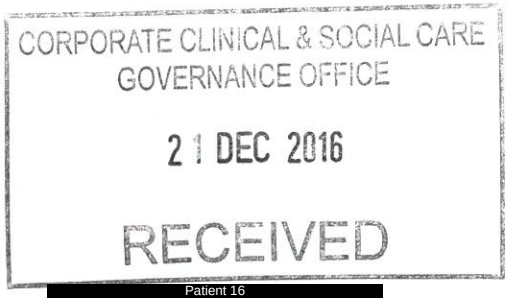
-----Original Message-----
From: ClientLiaison, AcutePatient
Sent: 22 December 2016 11:08
To: Reid, Trudy; Connolly, Connie
Subject: Complaint - ?SAI

Hi Trudy and Connie, I am sending this out for investigation as a complaint but copying to you also to see if it needs screened as an SAI.

Kind Regards

David.

Personal Information redacted by the USI



05/12/16

REF: Patient 16

Personal Information redacted by the USI

H&C: Personal Information redacted by the USI

To whom it may concern,

I am making this complaint, on behalf of my father, after much consideration and having discussed our concerns with involved personnel. It centres on the poor response to communication between the Oncology and Urology departments in Craigavon Hospital and the consequences of this which include; unnecessary suffering and denied access to a treatment option for cancer.

My father was diagnosed with bowel cancer in July 2012. He was referred to Oncology and in 2014 Chemotherapy was identified as a treatment option. Prior to the commencement of this treatment a stent was inserted into the left kidney in March 2015. We were informed at this point in time that the stent would be due for removal directly after the treatment ended as it's life span was 6 -9 months. Chemotherapy finished in November 2015 and my father was advised that arrangements would be made with Urology to have the stent removed. However, this did not happen and during follow-up reviews with the oncologists and surgical consultants the need for it to be removed was acknowledged and assurances given that letters would be written to various personnel in the Urology department. Meanwhile, for the next 6 months, my father suffered from a range of complications synonymous with a stent in place too long including; significant pain and persistent urinary tract infections. We continued to advise oncology personnel, our GP and the local Macmillian nurse of the increasing difficulties he was experiencing and again we were assured that these concerns had been passed on to Urology. In increasing desperation we began to ring Mr O'Brien's secretary in an effort to have the procedure completed.

In April 2016 during a review appointment in oncology the option of a short course of radiotherapy was raised. My father agreed to proceed with this but was made aware that first the stent would

need to be removed. In June 2016 dad received a phone call from the oncologist stating that he had viewed the latest scan results and radiotherapy was definitely a way forward. On the same day dad received a phone call from the urologist informing him of the arrangements for the removal of the stent three days later. We were bewildered about the apparent urgency, after such a long wait and wondered had something shown up on the scan. Dad attended Craigavon on the 28th June 2016 for the procedure; at this point the stent was in place for 15 months.

The procedure, which we understand generally takes about 30 minutes, took over two hours. The kidney was significant distended and the stent was encrusted and dislocated. Indeed I am aware that research suggests that the amount of stent encrustment is directly related to how long it has been in place. The aftermath was horrendous. Dad was very ill due to septicaemia and had to remain in hospital for 12 days. We were extremely upset and discussed our concerns with personnel in urology. We decided not to proceed with a formal complaint at the time, as we hoped that communication between the two departments would improve. Three weeks later there was further telephone correspondence from another oncologist advising dad that he was about to a make arrangements for him to attend the radiology department in the City Hospital to have initial measurements taken. It seems that this course of action was to be delayed for a short period, following consultation between the urologist and the oncologist, as a new stent would first have to be inserted. This happened in August 2016 and we immediately advised oncology that the stent was in place and we were on course again for radiotherapy. The next meeting with oncology was in September 2016. Dad was advised that it was deemed appropriate for a further scan to take place and he agreed to the deferral of the treatment until this was secured. It was with utter dismay at the next meeting on 1st December (13 weeks later) we learnt that this course of treatment was no longer an option as the disease had progressed. At that meeting I asked why the radiotherapy did not take place as planned in June, when the scan at that time indicated that it was feasible. I do not believe that I was given any clarification on this issue. In addition, when the oncologist was asked about the time delay between the scan and the review appointment he apologised but said it was 'out of his control'.

In summary, I believe that the delay in the removal of the original ureteral stent is undeniably linked to the removal of cancer treatment options for my father. I know that he has suffered unnecessarily as a result of the lack of response to communication from various sources to urology. Finally as a family we had the unenviable experience of dealing with a mother and father diagnosed and undergoing treatment for cancer at the same time. Ironically the experience of both parents is startlingly different. My mother suffered from mouth cancer and was under the care of the South Eastern Trust. There were a number of departments involved in her surgery and aftercare, both within the trust and outside it. The co-ordination of services was seamless and communication between departments immediate and transparent. She receives regular follow up review appointments where both oncology and her surgical consultant are present and she has access to a superb advocacy service provided by the Head and Neck nurse.

The expected outcomes of this complaint are as follows;

a) Details of all correspondence to the Urology department from all sources regarding the removal of the stent.
b) A review of protocols for communication between two departments in the same hospital. It seems incredulous, that there is a reliance on the social etiquette of writing to a colleague in the same hospital rather than emailing or using another system on the intranet.
c) Provision of a clear explanation for the delay in carrying out the procedure of removing the ureteral stent, clarification on the Urology department's policy for the time frame of insertion and removal of kidney stents, the name of the manufacture of the stent and their guidelines regarding the length of time the stent can safely remain in place.
d) Consideration of the cost to the National Health Service of dealing with the aftermath of not completing a procedure within a reasonable time frame.
e) An examination of the review arrangements for patients with cancer which is deemed to be progressive. Cancer does not wait for scans or lengthy periods between appointments!
f) A direct explanation as to why radiotherapy did not proceed as planned in June 2016.
g) Reflection on examples of good practice in other trusts.
h) Consideration given to setting up an advocacy service for patients who are undergoing treatment for cancer. Within the Southern trust this is ad hoc and seems to be left to the local Macmillan nurses, who cannot cope with the demands placed on their service.

In essence, we are a family who are dismayed and disillusioned! We are requesting answers to questions posed, seeking recognition of the unnecessary suffering endured by my father due to neglect and the subsequent lack of ability to access an appropriate cancer treatment; which may have increased his life span a little and given us more time to spend with a wonderful man!

Yours faithfully,

Urology Services Inquiry

Note: An addendum amending this statement was received by the Inquiry on 8 September 2023 and can be found at WIT-100354 to WIT-100366. Annotated by the Urology Services Inquiry.

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 16 of 2023
Date of Notice: 6th July 2023

Witness Statement of: David Cardwell

I, David Cardwell, will say as follows:-

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:

(i) an explanation of your role, responsibilities and duties within the Southern Health and Social Care Trust ("the Trust"), and

1.1 I began working in the NHS in August 1993 and held a number of administrative posts, which are set out in my response to question 4, before being appointed to the post of Administration and Complaints Manager with the then Craigavon Area Hospital Group Trust in February 2004. My employment transferred to the Southern Health and Social Care Trust on its formation in April 2007 and I remained in my role as Administration and Complaints Manager until the Governance Structures were agreed and staffed in October 2008. From then until July 2011, my role as a Patient Client Liaison Manager primarily involved the management of complaints (receiving complaints by phone, in writing or in person, allocating to an operational team for investigation, co-ordinating and drafting a response for approval by the Assistant Director of Acute Services and signature by the Director) for the Directorate of Acute Services and leading a team of complaints staff. Thereafter my role broadened, as a result of a 2010/2011 Clinical Governance review, to a Governance Officer assisting the newly appointed role of Directorate Governance Co-Ordinator, Mrs Margaret Marshall, with the administration of the Datix system for reporting of incidents, running reports and keeping risk registers up to date on the Datix system.

1.2 Prior to appointment to my current post of Band 7 Clinical Governance Manager in April 2019, which primarily involves the management of Serious Adverse Incidents, (to include the screening of incidents, notification of SAI's to

SPPG, co-ordination of SAI review teams, assisting chairs with the drafting of reports and facilitating family engagement) I was provided with training in March 2019 by an external provider, Clinical Leadership Solutions, on the management of Serious Adverse Incident Reviews using the root cause analysis process.

(ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.

1.3 Complaints and SAI's are patient specific. As part of my workload I dealt with complaints regarding urology services and these were passed to the relevant Consultant and Mrs Corrigan for investigation. The number of complaints in relation to urology were not excessive and were usually in relation to the length of time that patients had to wait for an appointment. There were no complaints regarding urology which stood out. Outside this, I do not recall any specific issues being raised with me or by me in relation to any broad governance issues that arose. My role was to manage individual cases and had there been a need to escalate any aspect of an investigation to an Assistant Director or the Directorate Governance Co-Ordinator, this would have been carried out. An example would be if there was a long delay in receiving a response from a Clinician. This would have been highlighted to the Assistant Director and Head of Service. Additionally if I felt a question to a complaint was not addressed fully, I would have sent it back to the Assistant Director for more information.

It would greatly assist the inquiry if you would provide the above 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"). 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. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

2.1 Please see:

1. Patient/Client Liaison Manager, Directorate of Acute Services, Band 6, Job Description.
2. Governance Officer, Job Description.
3. Senior Governance Officer, Job Description.
4. Clinical Governance Manager Job Description.
5. Line Management, Roles and Reporting Arrangements.
6. Management of Adverse Incidents 2008.
7. Filling out an IR1 Form Online.
8. Process for the Reporting of Serious Adverse Incident (SAI) and Reporting Early Alert December 2017.
9. Sample Screening Sheet.
10. Sample Screening Template.
11. Sample Notification Form.
12. Information Sessions.
13. Incidents, Risks and Complaints – What do they mean for you and your team?
14. Governance Management.
15. Incident Management.
16. Acute Services Incidents.
17. Incident Reporting: An Investigator's Guide.
18. Policy for Shared Learning.
19. Email re Datix Dashboards.
20. Directorate of Acute Services Incident Position.
21. Surgery and Elective Care Governance Report.
22. Trust Procedure for the Sharing/Moving of incidents.
23. Email from Mrs Forde.
24. Major Catastrophic Incident Checklist.
25. Policy for the Management of Complaints 2010.
26. Policy for the Management of Complaints 2013.
27. Policy for the Management of Complaints 2018.
28. Investigating Complaints – Advice Sheet.
29. Investigating Complaints & User Views – Advice Toolkit for Staff.
30. Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009.
31. Weekly report on current complaints.
32. Acute Complaints Summary.

3. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your position(s) within the SHSCT

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

4.1 In June 1993, I obtained a London Chamber of Commerce and Industry Private Secretary's Certificate and a NVQ Level II in Business Administration. I obtained 7 GCSE's in 1991. These were my qualifications prior to taking up a post as a Grade II Audio Typist with the Southern Health and Social Services Board (Craigavon and Banbridge Unit of Management) on 31 August 1993, working in Craigavon Area Hospital with the Area Ambulance Service. In November 1994, I was seconded to the role of Higher Clerical Officer Grade III until 31 March 1995. On 1 April 1995, at the formation of the Northern Ireland Ambulance Service HSS Trust, I was appointed to the role of Personal Secretary to the Director of Operations Grade IV. I remained in this post until I took up a secondment, to cover a maternity leave, as Personal Assistant to the Chief Executive and Chairman in April 1998. After this, I returned to my substantive post in October 1999 until I ceased employment with the Northern Ireland Ambulance Service Trust on 13 February 2004. On 14 February 2004, I commenced employment with the Craigavon Area Hospital Group Trust as Administration and Complaints Manager for the Directorate of Nursing and Quality Grade VI (subsequently re-banded under Agenda for Change to a Band 7). I remained in that post until the formation of the Southern Health and Social Care Trust on 1 April 2007.

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 At the formation of the Southern Health and Social Care Trust on 1 April 2007, until the Clinical Governance structures were agreed in 2008, I remained in the post of Administration and Complaints Manager.

5.2 Under the 2006 review of public administration, the old post of Administration and Complaints Manager no longer existed in the new SHSCT structures so I was allocated the closest matched post (with pay protection) which was the Band 6 Patient/Client Liaison Manager (*please see 1. Patient/Client Liaison Manager, Directorate of Acute Services, Band 6, Job Description*) on 1 November 2008. I was responsible for the management of patient/client complaints, user views and patient/client liaison for the Directorate of Acute Services. I led a team of complaints staff for the Directorate of Acute Services and ensured that best practice was adopted with regard to the management of

patient/client complaints, ensuring that the complaints process was managed in an open and responsive manner. I remained in this post until June 2011 at which point the review of Clinical and Social Care Governance moved the day to day responsibility for Governance from the Medical Directorate to the Operational Directorates.

5.3 As detailed at point 6, in the 2010/11 review of clinical governance there was no dedicated Patient/Client Liaison Manager role in the revised structures so I was allocated the closest matched post (with further pay protection) which was Governance Officer Band 5 in Acute Services which I started on 1 July 2011 *(please see 2. Governance Officer, Job Description).* I was responsible for the provision of a high quality clinical and social care administrative service to the Directorate. This included management of administrative staff within the Directorate Clinical and Social Care Governance (CSCG) office, the administrative system management of Directorate complaints, incidents and other sensitive CSCG issues and the monitoring and management of the Directorate information system to support CSCG. I provided significant support to the Directorate Governance Coordinator in the management of the incidents and complaints process, including tracking of responses, liaising with clinical teams, patients, clients and their families. My role also incorporated production and analysis of reports from the CSCG information system, report composition for various audiences of clinical and non-clinical staff, monitoring key CSCG performance indicators and providing an early warning alert to the Directorate Coordinator in relation to exceptions and the organisation and delivery of Directorate specific training. This post was re-banded to a Band 6 in March 2016 when I became Senior Governance Officer Band 6 in Acute Services *(please see 3. Senior Governance Officer, Job Description)*. At this time I was responsible for the management of complaints within Acute Services ensuring complaints were investigated within set timescales. My role was to co-ordinate investigations and draft responses for the approval of the Director. I was to ensure that best practice was adopted with regards to the management of patient/client complaints, ensuring that the process was managed in an open and responsive manner. In addition I provided significant support to the Lead Governance Nurses in the management of incidents and Serious Adverse Incidents and Heads of Service in relation to risk registers. I was also responsible for the production of a suite of reports from the CSCG reporting system, monitoring key performance indicators and providing early alerts regarding exceptions. The role also included the management of administrative staff and the provision of training to staff in relation to incidents, risks and complaints.

5.4 I remained in the Senior Governance Officer Band 6 post until I took up the post of Clinical Governance Manager Band 7 in Acute Services on 29 April 2019 *(please see 4. Clinical Governance Manager Job Description).* I became responsible for monitoring and improving the delivery of patient care services within the SHSCT, supporting the clinical governance agenda within the Acute Directorate, in Medicine and Unscheduled Care and/or Surgery and Elective Care and ATICS which includes the management of complaints, clinical audit, clinical effectiveness and multi-disciplinary education and training. The post holder will effectively support the implementation of principles and practice of clinical governance and risk management, in the clinical setting within a framework which uses information to guide reflection, leading to action and outcomes monitoring. This remains my current post. In May 2023, I was successful at interview for the post of Acting Clinical Governance Co-Ordinator Band 8b for the Medicine and Unscheduled Care Directorate, however I choose to decline this offer of employment.

5.5 Reflecting on the content of the job descriptions, I do not consider these are an accurate reflection of the duties and responsibilities. There were a lot of duties in these and given the volume of work within the Directorate, it was not possible, without a workable structure below the level I was at, to have completed all of the duties listed. I consider this remains the current situation, especially with my current post which does not detail the day to day responsibilities that I have. I consider that I was and still am frequently working above the level that was described in the job descriptions.

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 In my Role of Patient/Client Liaison Manager I reported to Ms Gill Smith, Senior Manager Medical Directorate. I had two staff reporting to me, Mrs Vivienne Kerr (Band 4) and Mrs Roisin Farrell (Band 3). In my role as Governance Officer I reported to Mrs Margaret Marshall, Directorate Governance Co-Ordinator and when her post was not replaced, Dr Tracey Boyce, Director of Pharmacy. I had three staff reporting to me who were Mrs Roisin Farrell, Miss Lynn McKenzie and Mrs Pamela Truesdale (all Band 3). In my role of Senior Governance Officer I reported to Mrs Trudy Reid, Directorate Governance Co-Ordinator and I had five staff reporting to me, Mrs Vivienne Kerr, Mrs Roisin Farrell and Mrs Barbara Joyce (all band 5), Mrs Pamela Truesdale Band 4 and Miss Danielle Canning Band 2). In my current role I have reported to Mrs Patricia Kingsnorth, Mr Chris Wamsley and now to Mrs Clair Quin and Ms Lisa

Polland O'Hare, all of whom have been or are currently Directorate Governance Co-Ordinators. I have no staff reporting to me currently. Please refer to *(please see 5. Line Management, Roles and Reporting Arrangements*). I have listed this information in tabular format for ease of reference.

Datix, Incident Report, Screening and SAIs

7. With reference to specific policies and procedures where appropriate, please provide an outline of the steps to be followed when an incident is reported within the Trust and, in particular, address the following:

a. How are incidents to be reported and is there a requirement for all incidents to be reported in a specific manner?

7.1 From 2007 to 2011 I would not have been involved in Datix, incident reporting, screening or SAI's. I was only involved in Datix incident reporting from 2011 until 2019. It was at this point I became involved with screening and SAI's. Prior to 2011 the reporting of incidents was done using a paper based system. Staff would have completed a paper incident form, retained a copy, given their line manager a copy and sent a copy to the Central Reporting Point, which was staffed by three Band 3 Staff whose job it was to enter these incidents onto a computer based system. It is my understanding that incidents should have been reported in line with the Trust's Procedure on the Management of Adverse Incidents November 2008 *(please see 6. Management of Adverse Incidents 2008)* and now currently reported in line with the Procedure on Incident Management October 2014 *(please see TRU-02708 – 02743).* I am not aware of a more recent version of this procedure. This document states at section 3.2 (Reporting an Incident) that:

Where: All incidents must be recorded electronically via the Datix Web based form (IR1 incident reporting form).
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 incident reporting 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. They are to be reported electronically via the Datix Risk Management System. A Datix User Guide was appended to this Procedure to assist staff with the completion of reporting *(please see 7. Filling out an IR1 Form Online).*

b. Outline the procedure to be followed when an incident is reported which has the potential to meet the threshold for an SAI and, in particular, address the following:

7.2 Prior to commencing my current post in April 2019, I was not involved in the screening of incidents which were reported and had the potential to meet the threshold for an SAI. This role would have been carried out by Mrs Trudy Reid, Directorate Clinical and Social Care Governance Co-Ordinator (2016 – 2019) and prior to her appointment, Mrs Connie Connolly and Mr Paul Smyth (2014 – 2016) when they were in the Lead Nurse Governance role and prior to that Mrs Margaret Marshall (2012 – 2014). I am aware, since commencing my current post of a document entitled, *(please see 8. Process for the Reporting of Serious Adverse Incident (SAI) and Reporting Early Alert – December 2017).* It is my understanding this document was developed to help staff gain an understanding of the SAI process and point 1 refers to "When a Serious Adverse Incident (SAI) occurs."

i. Who is responsible for identifying that the incident may potentially meet the threshold for an SAI and requires "Screening"?

7.3 I cannot comment on what the arrangements were for the screening of incidents prior to commencing my current post in April 2019. Since 2019 all Datix incidents, within Acute Services, are reviewed on a daily basis by a Band 7 Clinical Governance Manager (Mrs Carly Connolly and/or myself. We were joined in 2022 by Mrs Joanne Bell who came to us as a redeployed member of staff). Those which are graded as major and catastrophic by the reporter of the incident are automatically added to a weekly screening sheet which is then shared with the relevant screening team. There are other incidents which may be graded insignificant, minor or moderate, by the reporter of the incident, which on review do not reflect a good standard of care or outcome for the patient, and these can be added to the list for screening following consultation with either an Assistant Director, Divisional Medical Director or Clinical Director.

ii. On identifying an incident that may potentially meet the threshold for an SAI, what process is to be followed?

7.4 I cannot comment on what process was followed on identifying that an incident may potentially meet the threshold for an SAI prior to April 2019 but I understand, from what I have been told and the documentation available, that

the screening process was formalised in the Autumn of 2018. Since appointment to my current post in April 2019 there are weekly screening meetings held for each Division within Acute Services. These are attended by the Assistant Director, Divisional Medical Director and Clinical Directors along with the Directorate Governance Co-Ordinator and a Band 7 Clinical Governance Manager who will facilitate the meeting. At these meetings, each new incident, which is listed for screening, is discussed and the medical notes are provided to the clinicians in attendance who will review them. A discussion will then ensue in relation to whether or not the incident meets the threshold of an SAI. If it does then a Review Team Chairperson and panel members are nominated. If it does not meet the criteria of an SAI then the rationale for this decision is noted and uploaded to Datix so that the investigator can close off the incident.

iii. **Who is responsible for making the decision that the threshold for an SAI is met?**

7.5 I cannot comment on who was responsible for making the decision that the threshold for an SAI was met prior to April 2019. Since April 2019 it is the multi-disciplinary screening team listed at my response to point 15 above, who are responsible for making the decision that the threshold for an SAI is met. It would be normal practice for clinicians review the medical notes and benchmark the care on what is an accepted standard and recognised guidelines.

iv. Who else is involved in the "Screening" process?

7.6 There is no one else that is involved in the screening process.

v. How is any decision at the "Screening" stage recorded?

7.7 Since the establishment of the formal screening process in 2018 each incident for discussion is listed on a screening sheet (a list of all patients to be discussed). A Clinical Governance Manager will be in attendance and make a note of all discussions. They will then document these on the screening sheet and also on a specific screening template for each patient. *(please see 9. Sample Screening Sheet).*

vi. What, if any, documentation is produced during this "Screening" process?

7.8 The screening sheet referred to above is an excel document. Embedded in this document will be all relevant patient notes and/or emails relating to each specific case.

7.9 There is also a screening template for each incident. *(please see 10. Sample Screening Template).* This is a word document which records the date of screening, who was in attendance and the outcome of the screening. For those incidents which do not meet the criteria of a SAI, the screening template should record a clear rationale as to why the incident did not meet the criteria of an SAI.

vii. How, if at all, is the outcome of that "Screening" process audited or quality assured?

7.10 Screening cannot take place unless the meeting is quorate. There must be two clinicians, a member of the governance team and an operational manager in attendance for the meeting to proceed. Whilst at these meetings there will be challenge between the multi-disciplinary team, to be best of my knowledge, there is no formal process of auditing or quality assurance of decisions that are made by the screening team.

viii. How is the outcome of that "Screening" process communicated to relevant individuals or organisations, including the Health and Social Care Board, as it was during the period relevant to the Inquiry's Terms of Reference.

7.11 I cannot comment on how the outcome of the screening process was communicated to relevant individuals or organisations, prior to commencing my current post in 2019 other than to say if an incident was screened as an SAI, then a notification would have been completed and submitted to the then Health and Social Care Board (HSCB). This continues to the present day and where necessary, other agencies such as the Coroner is informed. *(please see 11. Sample Notification Form)*

7.12 In relation to the outcome of those incidents that are screened and deemed not to meet the criteria of an SAI, a copy of the completed screening template is uploaded to Datix. Staff responsible for investigation can see the outcome of the screening meeting. There is however no automated mechanism to alert

the staff responsible for the investigation of the incident, that this has been done. This is a manual task which is reliant on administrative staff in the Governance Team. At this time there is no process in place for advising the staff who were involved in the incident of the outcome of screening unless the incident is declared an SAI in which case they receive notification when the draft report is complete (or sooner if they are to be interviewed).

c. Who is responsible for ensuring that incidents, including those which potentially meet the threshold for an SAI, are investigated in a prompt and thorough manner?

7.13 The Trust's Procedure on Incident Management October 2014 document section 2.4 states that:

(a) "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."

(b) I consider it is the responsibility of the Operational Teams (those responsible for the running of the service (Assistant Director/Head of Service/Lead Nurse and Clinical Director) to ensure incidents are investigated in a prompt and thorough manner.

(c) It is the responsibility of the Directorate Governance Co-Ordinator to ensure that Serious Adverse Incidents are investigated in a prompt and thorough manner. The current Directorate Governance Co-Ordinators are Mrs Clair Quin and Ms Lisa Polland-O'Hare (May and August 2023 respectively – present). They were preceded by Mr Chris Wamsley (2021 – 2023) and Mrs Patricia Kingsnorth (2019 – 2021). Those who carried out this role before I commenced my Clinical Governance Manager role in 2019 are listed at point 13.

d. What tools, processes or procedures are available for ensuring prompt and thorough investigation?

7.14 To aid thorough investigation, in 2012/13 there was the roll out of generic Incident, Risk and Complaints Training *(please see 12. Information Sessions)* under the direction of the then Directorate Clinical and Social Care Governance Co-Ordinator, Mrs Margaret Marshall. The content of the training

is provided. *(please see 13. Incidents, Risks and Complaints – What do they mean for you and your team?).* The training presentation was updated in 2016 *(14. Governance Management)* by the then Directorate Clinical and Social Care Governance Co-Ordinator, Mrs Trudy Reid. In 2018 a number of specific training sessions *(15. Incident Management)* were organised and delivered for staff who had responsibility for the investigation of incidents. Staff who attended the generic Incident, Risk and Complaints Training, post 2016 would also have access to a prompt sheet *(16. Acute Services Incidents)* which they could use as an aide memoir to investigation. However, I consider there were no tools as such to ensure prompt investigation. This relied on the availability of staff to log onto Datix and investigate the incidents to which they were assigned. There are no timescales set in the October 2014 Incident Management Procedure for the processing of incidents. What staff are advised at training is, if there is a delay in investigation, they should clearly document the reason on the Datix notepad, however this is not common practice in the Acute setting.

7.15 Since 2019 there has been very limited capacity due to the workload of the Band 7 Clinical Governance Managers to deliver regular Incident Management Training to staff within the Acute Services Directorate. In light of that, I developed a document entitled *(please see 17. Incident Reporting: An Investigator's Guide").* This is available to staff who request it and are tasked with responsibility for investigating incidents. Ad-hoc training on the use of the Datix system can be provided on request.

e. Who is responsible for ensuring that learning from incidents is identified, disseminated and implemented?

7.16 The Trust's Procedure on Incident Management October 2014 document section 2.4 and 2.5 (bullet point 1) states that Assistant Directors, Associate Medical Directors, Heads of Services and Team Managers all have a 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.

7.17 Section 2.7 of the Incident Management Procedure October 2014 states that the Directorate Governance Co-Ordinator will ensure that processes are in place for the recording, review, monitoring and learning from incidents and will provide timely and appropriate information on incidents to the Directorate and also on action plans and learning arising from incidents and SAI's and the progression of these action plans.

f. What procedures exist within the Trust to ensure that learning from incidents is implemented and, if applicable, explain how these procedures have evolved over time.

7.18 My understanding is that learning from specific incidents, reported on Datix, would have been shared at the Morbidity and Mortality Meetings for medical staff or the Patient Safety Briefings for nursing staff. Specifically in relation to Serious Adverse Incidents, since 2019 a recommendation in each SAI report is that the report be shared at Morbidity and Mortality Meetings for learning. The Medical Directorate have issued at *(please see 18. Policy for Shared Learning)* in July 2022. Further information on this policy can be obtained from the policy author, Mrs Stacey Hetherington, Corporate Clinical and Social Care Governance Co-Ordinator.

8. Please consider the following extracts from Ms Trudy Reid's evidence to the Inquiry and address questions (a) – (b):

Extracts from Ms Trudy Reid's Response to Section 21 Notice: …WIT-95223 paragraph 3.82. On 07/02/2017 the development of dashboards on Datix was noted I progressed this work with David Cardwell in the Acute Clinical Governance team – this work was challenging to take forward due to staffing resources and the Datix system, however, some dashboards were developed. Datix software has dashboard infrastructure, at the time there was no Datix manager and the Acute Directorate had limited capacity to progress dashboards. Dashboards are information from the Datix system which allows graphical monitoring of incidents. This was not sophisticated enough to identify fine detail but would have allowed monitoring of incidents open and closed or specific results on for example violence and aggression trends. As different Datix version were in use triangulation of data remained challenging.

a. Considering the evidence from Ms Trudy Reid above, explain:

i. What the issue was?

8.1 The main issue was the availability of myself to progress the development of dashboards on Datix. Datix dashboards would have allowed real-time statistical information for Managers in relation to incidents within their area. At this time, I was responsible for the management of complaints, MLA enquiries

and general queries for the Acute Services Directorate. This role would have taken up at least 80% of my time. I was also required to provide governance training, referenced in point 28, (circulating dates of training, keeping an attendance register, delivering a 2 hour training session, follow up with staff afterwards and circulation of training material) to staff and ensure that regular reports in relation to complaints, incidents and risks were being produced. This was on top of the management of a team of staff.

8.2 A secondary issue was that to physically set up a dashboard, I had to have two Datix accounts. I would log onto the Acute Governance account and set up the dashboard, log out of the first account. After this, I then needed to log onto my own personal account to grant the Datix user permission to access the dashboard that I had created on the Acute Governance account. This process took at least 20 minutes per user and there were almost 100 users of the system which had to be worked through. No formal training was provided by the provider of the Datix system on the establishment of dashboards and I had to pick this up myself as I went along. Every time a member of staff, who had access to Datix, moved post, manual changes to the system were required (If a member of staff moved from one ward to another, then their permissions need changed on Datix so that they had access to the right incidents and the right time and received the appropriate notifications). This was a very time consuming and laborious task. All staff have access to reporting an incident using the IR1 form on line, but not all staff have a Datix account. It is only those who have responsibility for investigating incidents that have a Datix account.

ii. What steps, if any, were taken to address same?

8.3 A limited amount of protected time was set aside to allow me to focus on the development of the dashboards. I cannot recall exactly how much time was allocated but it would have been in and around the start of 2018. There would have been no more than 5 days set aside due to the volume of work on the complaints side. Issues in relation to the capabilities of the system (specifically how many staff could have access to one dashboard) were escalated to the IT team in May 2018 *(please see 19. Email re Datix Dashboards)* but there was no solution available which meant that I had to create individual dashboards for each division and then a separate dashboard for the entirety of Acute Services.

iii. Whether or not, in your opinion, the issue was successfully addressed?

8.4 In my opinion, I do not consider the issue was successfully addressed or the dashboards developed to their full potential for the reasons outlined at point 34 above.

b. Considering the Datix system in general, please address:

i. To what extent, if any, did you consider that there were any limitations in the system which impacted upon incident reporting and patient safety?

8.5 From its inception in 2011, all staff who had access to a Trust PC could report an incident using the online IR1 form. Informal feedback from staff would have indicated that the process of completing a Datix was cumbersome, so when staff were completing it, it was not straightforward. This feedback would have been sporadic, after training and in conversation with staff at ward level. The Directorate Governance Co-Ordinators would have been aware of this also and this remains the case.

8.6 Formal training on the submission of a Datix, and formal training on the investigation of a Datix was not, and still is not mandatory. I consider that in some instances, it took a long time for investigators to investigate and close off incidents and that those staff responsible for doing so were unaware of their responsibilities in relation to same. My perceptions would have been confirmed when delivering training as staff would have said they did not know how to manage Datix incident reports. The weekly report provided to the Directorate on Incident Position would have indicated that incidents were outstanding for long periods of time.

8.7 I am also aware of issues surrounding the ownership of the Datix system. Whilst I would not have been involved in discussions at a higher level or privy to any documentation that may exist, there was always “chat” about whose responsibility it was for this IT system. The IT Department considered it was a Governance system, so Governance should maintain and update the system as well as provide training. The IT Training Team have not at any point provided any input into the Datix training given to staff but I consider that that this would be beneficial.

ii. What steps, if any, were taken to address those limitations?

8.8 In 2018, a number of training sessions were organised for Acute Services Staff. This continued into 2019 until training stopped at the start of Covid-19. This included information on how to report an incident *(please see 15. Incident Management).*

8.9 There was also a Datix Users Forum in existence in 2012, 2014 and 2015 which could discuss Datix issues, but this had its limitations as the user group. None of the decision makers used Datix operationally and often Datix users were not involved in decision making. In early 2023 the Governance Officers Forum was reinstated by the Corporate Governance Team and there now is an opportunity to raise issues about Datix at this meeting.

8.10 In order that Divisions were aware of how many incidents were at what stage in the process, a weekly report *(please see 20. Directorate of Acute Services Incident Position)* was developed in 2015 and issued to all Assistant Directors. This report was to show (a) how many incidents there were and (b) at what stage each incident was at. This report covered incidents that had been reported since 1 January 2014.

iii. Whether or not, in your opinion, those limitations were successfully addressed?

8.11 In my opinion, I do not consider the limitations were successfully addressed. I believe the management of Datix and all that it entailed, was not greatly understood by the operational teams, and would have required a dedicated member of staff to assist with this. At this point there is no training in relation to the management of incidents and it is evident that this is required, however given the competing demands placed on the Band 7 Clinical Governance Managers it is not possible to deliver all tasks detailed in the job description. I consider that people identified me as a point of contact, as I had (self-taught) experience with the system, and this continues until the point at which I am writing this response. I have been in governance for a long time and am most likely to be recognised by staff if they need help or information. As an example I have just recently received a request from a Midwifery Manager asking me to show her how to run a Datix report. Whilst there is now a Datix Manager in post corporately since late 2021, the Directorate of Acute Services, could benefit from a member of staff within its area to actively manage Datix and queries about it. The Band 7 Clinical Governance Managers are still getting up to 15-20 requests per week to provide assistance with Datix queries.

Urology Services Inquiry

9. Please consider the following extracts from Dr Tracey Boyce's evidence to the Inquiry and address questions (a) – (E):

Extracts from Dr Tracey Boyce's oral evidence to the Inquiry on 24 May 2023:
TRA-05835-05836
Dr Boyce: I also then realised that there was no real reporting coming out of the Governance team to try and make it easier for the other Assistant Directors. One of the first things I did was work with the admin support. They were excellent, they were really good staff, David Cardwell and so on, who really understand the Datix system. I asked them to come up with a report to show the Assistant Directors how many ones they have, what hadn't been opened, that sort of thing; how SAIs were running. Very quickly we got weekly reports set up for the Assistant Directors. We were doing that sort of thing.

9.1 I note Dr Boyce's comments regarding reporting. In 2012, in conjunction with Mrs Margaret Marshall, Mrs Vivienne Kerr (Band 5 Governance Officer) and I developed a report for each Division within the Directorate of Acute Services. The origin of this information was from Datix. *(please see 21. Surgery and Elective Care Governance Report).* This included information on the Directorate Risk Register, Divisional Risk Register, Major and Catastrophic Incidents, Insignificant – Moderate Incidents, Serious Adverse Incidents and Formal Complaints.

9.2 When Mrs Trudy Reid was appointed to the post of Directorate Governance Co-Ordinator in April 2016, the style of this report changed to be more pictorial in nature *(please see TRU-81833 -81837).* It no longer included a listing of the major and catastrophic incidents, although the Director and Assistant Directors continued to receive a weekly report on Major and Catastrophic incidents.

a. As well as Assistant Directors, was this information contained on the Datix system communicated or reported to anyone else?

9.3 There were weekly reports on the incident position and major and catastrophic incidents commenced in March 2015. These were circulated every Tuesday to the Director of Acute Services and their Assistant Directors with a copy to the Directorate Governance Co-Ordinator and Lead Governance Nurses when they were in post. I am not aware of the arrangements that Assistant Directors had in place to cascade this information to their service teams, if any.

9.4 The monthly reports described at 44, 45, and 46 were circulated to the Director and all Assistant Directors and these would have been the subject of discussion at the monthly Directorate Governance Meeting.

b. Outline how information contained on the Datix system was communicated or reported to Assistant Directors and others, if applicable, and explain how this communication or reporting evolved over time.

9.5 Each Assistant Director had a Datix account and would have received automatic email notification of all incidents for their service area that were either major or catastrophic, so they would have had real time reporting. Assistant Directors would have had access to insignificant, minor and moderate incidents, though they would not have had an automatic email alert about these. Figures and trends would have been listed on the monthly reports if there were any.

9.6 Information was extracted from the Datix system and reports formulated. The weekly and monthly reports noted at 44, 45 and 46, were communicated by email. This continued until I took up my current post in April 2019 and it is my understanding that this reporting mechanism remains in place today.

c. Explain how these communications or reports were created.

9.7 To create a report from information held on the Datix system I would have carried out a search on the system using specific “fields” to obtain the information that I required (e.g. date range, division, service area, CCS code). This information would then have been “exported” into an excel spreadsheet and saved as the report. These reports would then have been communicated via email.

d. What actions were Assistant Directors and others, if applicable, expected to take on receipt of these communications or reports?

9.8 I do not know what the Directors’ expectations were of Assistant Directors on receipt of these reports, however I consider that Assistant Directors should have reviewed the content of these reports and shared these with their Heads of Service for appropriate action.

e. Who was responsible for following up and ensuring that incidents, SAIs or issues identified in these reports or communications were addressed?

9.9 I consider that the following up of issues identified in these reports would have been the role of the Assistant Directors and their Heads of Service as outlined in section 2.4 of the Incident Management Procedure October 2014.

f. What steps would you take to ensure that incidents, SAIs or issues identified in these reports or communications were addressed?

9.10 This was not my role. My task was to extract information from the Datix system and prepare a report. I consider it was the role of the Directorate Governance Co-Ordinator to highlight the pertinent issues to secure an assurance that appropriate action was being taken by the operational teams.

Issues arising from specific Incidents and SAIs

10. Please consider WIT-54874-54881, a SHSCT Adverse Incident Reporting (IR2) Form – December 2020 for Patient 102. Provide a detailed overview of your involvement with the incident relating to Patient 102, from the date it was reported on 21 October 2015 to the last time it was updated by you on 17 June 2016, and, in particular, address the following:

10.1 At the time of this incident being reported, I would not have been in receipt of a notification email for every Datix that was reported in Acute Services. At that time the notification would have gone to Mrs Connie Connolly who was the Lead Nurse for Governance. The daily reviewing of incidents only became part of my duties when I commenced my current role in April 2019.

10.2 An audit trail of the incident on Datix indicates that I logged onto the incident on 26 November 2015 and moved it from the Surgery and Elective Care Division to the Functional Support Services Division to allow Mrs Forde, Head of Health Records, to investigate it as she would not have had access to this Datix. On receipt of information from Mrs Forde, Head of Service, I then logged onto the incident on 11 December 2015 and moved it back to the Surgery and Elective Care Division for investigation.

10.3 There was in place *(please see 22. Trust procedure for the Sharing/Moving of incidents).* Often this was not followed by the operational teams and I would have received an email asking me to move and incident from one area to another for investigation.

10.4 On 17 June 2016 I moved this incident from "being reviewed" to "finally approved". From a search of my email archives, I cannot find any documentation to justify this action but can only say I would not have moved an incident to "finally approved" without being asked to do so as I am conscious that this is a decision which should be made by the operational team. I cannot recall who would have asked me to close this Datix.

a. Please consider TRU-277904 which is an email from Heather Trouton to Martina Corrigan and Eamon Mackle dated 22 October 2015 with regard to the incident concerning Patient 102 in which Mrs Trouton asks *"Does this need screened?"* and address the following:

i. Was this incident screened with a view to deciding whether or not it met the threshold to be classed as an SAI?

10.5 At the time of the incident being reported, my Band 5 Governance Officer role would not have extended to the screening of incidents. Now having access to information in my current role, I understand this incident was not screened.

ii. If so, confirm the date of that screening process, the outcome and provide any documentation relating to that screening process.

10.6 Not applicable given response to point i above.

iii. If not, confirm why you this incident was not screened.

10.7 At the time of the incident being reported, my role would not have extended to the screening of incidents so unfortunately, I cannot answer this question. This question should be directed to Mrs Heather Trouton, Mr Eamon Mackle and Mrs Martina Corrigan.

b. Further to the above, explain why this incident was never declared an SAI. In addressing same, please outline the nature of any discussions regarding this incident being treated as an SAI and the name, and roles within the Trust, of anyone involved in those discussions.

10.8 At the time of the incident being reported, my role would not have extended to the screening of incidents so unfortunately, I cannot answer this question. This question should be directed to Mrs Heather Trouton, Mr Eamon Mackle and Mrs Martina Corrigan.

c. Confirm whether a direct referral for radical radiotherapy was ever sent following the Urology MDM on 20 November 2014 and address the following:

10.9 It is my understanding from accessing NIECR, that a direct referral for radical radiotherapy was not sent following the Urology MDM on 20 November 2014. This is the reason why a Datix was submitted when Mr Haynes became aware of the patient. NIECR indicates that Mr Haynes made a referral to the Northern Ireland Cancer Centre on 22 October 2015.

i. If a referral was sent, please explain why Patient 102 did not receive any timely appointments from oncology.

10.10 Not applicable in light of the response to c above.

ii. If a referral was not sent, please explain why.

10.11 Unfortunately I am not in a position to respond to this question. It would have to be addressed by Mr O'Brien.

d. Why was there a delay from 21 October 2015 when the incident was reported to 18 November 2015 when it was *"opened"*?

10.12 An audit trail of the Datix system relating to the incident indicates that Mrs Connie Connolly, Lead Nurse Governance, logged onto the incident on 18 November 2015 and moved it from the "In holding area awaiting review" to the "being reviewed" section.

10.13 Unfortunately I cannot explain why there was a delay from 21 October 2015 until 18 November 2015. This question should be redirected to Mrs Connolly, however TRU-277904 records that Mr Mackle alerted Mrs Heather Trouton and Mrs Martina Corrigan to the incident on the same day that it was reported. This arose from the fact that they were on the circulation list for the incident.

e. Consider the entry dated 11/12/2015 14:55:26 at WIT-54879 where it is stated that you were asked by Helen Forde to send this incident form to Martina Corrigan for her "*to discuss with consultant*". As available, please provide the email exchange from Helen Forde and address the following questions:

10.14 The email from Mrs Forde giving me the instruction to send this incident to Mrs Corrigan is at *(please see 23. Email from Mrs Forde).*

i. Why this matter was being sent back to Martina Corrigan to discuss with Aidan O'Brien?

10.15 My understanding is that Mrs Forde had investigated the incident and found that there was no correspondence for the appointment. In essence the problem was not that the secretary had not typed the letter (for which Mrs Forde would have been responsible) but it was a case that the referral letter had not been dictated by Mr O'Brien for processing. Therefore, the incident needed to be sent back to Mrs Corrigan as Head of Service for Urology so that she could discuss this with the consultant involved. I was involved in moving the incident from one area to another as the Process for the Moving/Sharing of Incidents was not followed. The process set out the steps for giving access to or sharing an incident for investigation and also for moving responsibility for investigation. Had the process been followed by Mrs Corrigan and Mrs Forde I would not have been involved.

ii. Who was involved in that decision and how was that decision reached?

10.16 The decision was reached by Mrs Forde as a result of her investigation into the incident.

iii. What action was to be taken to address the issues raised by the incident concerning Patient 102?

10.17 I am not aware of what action was taken to address the issues raised by the incident concerning patient 102. This question should be redirected to Mrs Martina Corrigan.

iv. Did you receive any response from Martina Corrigan to your message? If so, please detail or provide that response.

10.18 Having examined my emails and archives, to the best of my knowledge, I did not receive a response from Mrs Martina Corrigan.

v. If you did not receive a response, did you take any further action to follow up that Martina Corrigan had received your message and actioned the outcome as expected by speaking to the consultant?

10.19 It would not have been my role to follow up on specific incidents. The Datix system records that the message was delivered to Mrs Martina Corrigan at 14:55 on 11 December 2015. I did not take any further action to follow up that Mrs Martina Corrigan had actioned the email. However I now know that according to TRU-277904 Mrs Corrigan was aware of the incident before I moved the incident to her on 11 December 2015.

vi. If the actions at (ii) above did not fall within your responsibility, who was responsible for ensuring that actions anticipated were in fact completed?

10.20 I consider it would have been the responsibility of Mrs Martina Corrigan to ensure that actions anticipated were in fact completed.

vii. Does your message at WIT-54879 to Martina Corrigan via Helen Forde mean that this incident form was now deemed "closed" from your perspective or were further steps anticipated or undertaken by you regarding this incident after this message? If so, please provide full details.

10.21 No, I do not consider that my message detailed at WIT-54879 "closed" the incident from my perspective. It is clear the message from Mrs Forde, via myself, noted that there needed to be a discussion with the Consultant. I would have expected this conversation to have taken place in order that (i) the patient could be followed up and (ii) that the Datix could be closed.

viii. Was this the last message regarding this issue particular incident form? If not, please provide full details.

10.22 There was a subsequent message on 22 March 2016 from Mrs Vivienne Kerr, Band 5 Governance Officer, to Mrs Martina Corrigan reminding her that the incident had been coded under urology for investigation. The last message I was involved with regarding this particular issue was on 11 December 2015.

f. Outline the circumstances and explain the decision making which led to the closure of this incident on 17 June 2016.

10.23 As explained in my response to question 10, on 17 June 2016 I moved this incident from “being reviewed” to “finally approved”. I cannot find any documentation to justify this action but can only say I would not have moved an incident to “finally approved” without being asked to do so as I am conscious that this is a decision, which should be made by the operational team, but I cannot recall who asked me to close this Datix incident.

11. Please consider TRU-274729-274730 and TRU-274751-274753, a series of emails from August and September 2016 regarding an incident concerning Patient 93. Provide a detailed overview of your involvement with the incident relating to Patient 93 and, in particular, address the following:

11.1 To the best of my knowledge I was not aware of an incident relating to patient 93 until I was provided with TRU-274729-274730 and TRU-274751-274753. Up until April 2019 I would not have been receiving email notification of incidents that had been reported.

a. Please address the following questions concerning whether the incident concerning Patient 93 should have been considered an SAI:

i. Was this incident screened with a view to deciding whether or not it met the threshold to be classed as an SAI?

11.2 After being notified of patient 93 on receipt of the request to complete this section 21, I conducted a search of the Datix system and can find no incident having been reported. I can find no evidence that this patient’s care was screened with a view to deciding whether or not it met the threshold to be classed as an SAI.

ii. If so, confirm the date of that screening process, the outcome and provide any documentation relating to that screening process.

11.3 I am unable to answer this question given my response at point 78.

iii. If not, confirm why you understand the incident was not screened.

11.4 I am unable to answer this question given that my role in 2016 did not involve the review of incidents and/or screening of same. As noted in my response at paragraph number 77, to the best of my knowledge I was not aware of an incident relating to patient 93 until I was provided with TRU-274729-274730 and TRU-274751-274753.

b. Confirm whether or not a Datix was ever received concerning the incident involving Patient 93. If so, please disclose all documentation and records relevant to same.

11.5 I have conducted a search of the Datix system and can find no incident having been reported.

12. Please consider TRU-01366-01371, a series of emails dated 22-23 December 2016 regarding a complaint concerning Patient 16. Provide a detailed overview of your involvement with the incident relating to Patient 16 from the date the complaint was received by the Trust on 21 December 2016 to the reporting of the SAI on 27 January 2020, and, in particular, address the following:

12.1 The complaint regarding Patient 16 was received by the Corporate Clinical and Social Care Governance Team on 21 December 2016 and passed to the Acute Complaints Team that day. On reading the complaint on 22 December 2016, I escalated it, TRU-01368, to the Directorate Governance Co-Ordinator and Lead Nurse Governance, to ascertain if it needed screened as an SAI. In the meantime, the complaint was acknowledged on 23 December 2016 by the Acute Complaints Team and forwarded to the operational team for investigation. On 3 February 2017 and 27 March 2017, a holding letter was issued by the Acute Complaints Team to Patient 16's family whilst the case was being prepared for screening. On 19 April 2017, the Director of Acute Services sent a letter to the family advising that an SAI was going to be carried out. After this point, I had no involvement with this SAI investigation.

a. How did the complaint concerning Patient 16 come to your attention?

12.2 The complaint regarding patient 16 came to my attention via the Corporate Clinical and Social Care Governance Team after it was received by them. It was sent to me, as the Acute Complaints lead, for processing.

b. Concerning your email to Trudy Reid on 22 December 2016 at 11:08, what features of this case did you consider merited potential screening to see if it met the threshold for an SAI?

12.3 My concern was that patient 16 had come to harm. The letter of complaint described a number of delays followed by a period of urgency in delivering care and then a surgery which appears to have lasted longer than it should. This was followed by a poor outcome and prolonged recovery which reduced the options available to the patient.

c. Who was responsible for determining whether or not the complaint concerning Patient 16 met the threshold for an SAI?

12.4 I consider it was the surgical screening team (Mr Ronan Carroll, Mr Colin Weir and Mrs Trudy Reid) who had responsibility for determining whether or not the complaint concerning patient 16 met the threshold for an SAI.

d. When was the decision taken that the complaint concerning Patient 16 met the threshold for an SAI? Provide any documentation relating to that screening process.

12.5 It is my understanding that the decision was made on 5 April 2017. A copy of the screening form is attached at *(please see 24. Major Catastrophic Incident Checklist).*

e. Were you aware of extant issues concerning Aidan O'Brien being handled at or around that time by the Oversight Committee? If not aware at that time, when did you become aware?

12.6 No. I was not aware of the extant issues concerning Aidan O'Brien being handled at or around that time by the Oversight Committee. An email from Dr Boyce dated 23 December 2016 noted at TRU-01366 confirms this. I remained in the post of Senior Governance Officer until April 2019 and then moved to work on SAI's in my current role as Band 7 Clinical Governance Manager. The SAI regarding patient 16 was not one that I was involved in facilitating, so up until the point that an inquiry was announced, I was not aware of the extant issues.

f. Outline the extent of your involvement once it was determined that an SAI was to take place in relation to Patient 16.

12.7 I was not involved in the management of the SAI relating to patient 16. This was facilitated by my line Manager, Mrs Patricia Kingsnorth, Directorate Governance Co-Ordinator.

g. Outline your understanding of the delay which took place between the complaint being received by the Trust on 21 December 2016 and the final SAI report dated 27 January 2020.

12.8 Not having been involved in this SAI, unfortunately I cannot answer this question. It should be directed to Mrs Patricia Kingsnorth, Directorate Governance Co-Ordinator.

Complaints
13. With reference to specific policies and procedures where appropriate, please provide an outline of the steps which must be followed when the Trust receives a complaint and please address the following:

13.1 I am no longer in a complaints role therefore I can only describe the process that was followed when the management of complaints was a part of my roles from 2004 until April 2019. During this time when a complaint was received by the Trust it was acknowledged within 2 working days and sent to the Head of Service and Consultant responsible for the patient's care for investigation. The complaint was copied to the Director of Acute Services and the Assistant Directors responsible for the service area complained about. Each complaint was registered onto the Datix system. The investigators were asked for a full written draft response within 10 working days. The information provided was then transcribed into a draft response template which was left with the Assistant Director for approval by day 17. When the Assistant Director approved the draft response to the complaint it was left with the Director for signature. When signed, the response was posted to the complainant and the complaint was closed and Datix updated accordingly.

13.2 I attach the relevant policies and procedures which were in place at that time *(please see 25. Policy for the Management of Complaints 2010), (26. Policy for the Management of Complaints 2013), (27. Policy for the Management of Complaints 2018) and (TRU 154995 - 155008).* For a response in relation to how the complaints process operates now, information can be obtained from Mrs Caroline Doyle, Acting Assistant Director for Clinical and Social Care Governance.

a. Explain your specific role concerning the handling of complaints.

13.3 As detailed in my response at paragraph 6, in my role as Patient/Client Liaison Manager Band 6 in 2008, I was responsible for the management of patient/client complaints, user views and patient/client liaison for the

Directorate of Acute Services. I led a team of complaints staff for the Directorate of Acute Services.

13.4 My role was to ensure that best practice was adopted with regard to the management of patient/client complaints, ensuring that the complaints process was managed in an open and responsive manner.

13.5 At this time I was also responsible for the introduction of the then new 2009 HSC Complaints Guidance across the entire Trust.

13.6 As explained in my response to question 5 above, my role changed in July 2011. The role changed from the management of complaints to being responsible for the administrative system management of Directorate complaints. My role was to provide significant support to the Directorate Governance Coordinator in the management of complaints, including tracking of responses, liaising with clinical teams, patients, clients and their families. The role included the provision of reports in relation to complaints. The responsibility for the management of complaints moved from me to the Directorate Governance Co-Ordinator.

13.7 In April 2019, I moved from the Complaints role to my current Serious Adverse Incident role.

b. Explain who is responsible for investigating the substance of complaints and what steps are to be undertaking in the investigation of complaints.

13.8 Section 6.4 of *(please see 25. Policy for the Management of Complaints 2010)* outlines the role of Operational Directors, Assistant Directors and Heads of Service. It states at 6.4.1 that, “All Operational Directors are responsible and accountable for the proper management of, and accurate, effective timely responses to complaints in received in relation to the services they manage. This responsibility should also include the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.” It goes on to say at 6.4.2, “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.”

13.9 To support staff who were investigating complaints, I developed (*please see 28. Investigating Complaints – Advice Sheet).* This was subsequently adopted Trust wide by the Corporate Governance Team and updated in 2015 *(29. Investigating Complaints & User Views – Advice Toolkit for Staff).*

c. Outline any key performance indicators or standards against which the handling of complaints was judged or performance managed.

13.10 The *(please see 30. - Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009)* states at point 12 (1) that "The Complaints Manager shall send to the complainant a written acknowledgement of the complaint within 2 working days of the date on which the complaint was made." The PFA target for acknowledgement of complaints was 100% within 2 working days.

13.11 In respect of response, it goes on to say at point 14 (4), "The response must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, the complainant must be notified of the delay and the full response issued as soon as possible." The PFA target for response to complaints, set by the Department of Health, was 72% within 20 working days.

d. Outline what issues, if any, in your opinion, you considered there to be with the handling of complaints within the Trust.

13.12 The only issue that I considered at the time with the handling of complaints was the length of time it took for investigations to conclude and response letters to be issued. Operational staff found it difficult to get the time to respond to complaints and clinicians were no different, with competing clinical priorities. At times, there could also have been delays at the approval stages of the response between the Assistant Directors and Director.

e. Further to (d) above, outline what, if any, steps you took to address any issues with the handling of complaints within the Trust.

13.13 In an attempt to address the length of time it took to respond to complaints, from March 2015, Assistant Directors were provided with a *(please see 31. Weekly report on current complaints)* each week. Complaints that were overdue were highlighted in red and those which were due for response within the upcoming 10 days were highlighted in amber. Timely reminders were issued to Heads of Service, which were copied to Assistant Directors, in relation to complaints which were outstanding. This information was also

escalated to the Director and discussed at the Directorate Governance Meetings, where Assistant Directors would have been held to account for response timeframes. Any concerns about delays with specific complaint responses would also have been escalated by myself or Mrs Kerr, Band 5 Governance Officer to the Directorate Governance Co-Ordinator.

14. With reference to specific examples where appropriate, outline what, if any, trends you identified from complaints you were involved in concerning both urology services in general and specifically Aidan O'Brien and address the following:

a. What, if any, trends, issues or concerns you identified?

14.1 To the best of my knowledge the only trend arising from urology complaints was the length of time it took to get a urology appointment, however this was no different from the dissatisfaction expressed by complainants in relation to numerous other specialties.

b. What, if any, action you took to escalate or address any tends, issues or concerns?

14.2 Each complaint was categorised by subject matter on receipt and the number of complaints regarding waiting times were detailed on the reports produced for the Acute Senior Management Team *(please 32. Acute Complaints Summary)*. These reports would have then been presented by the Directorate Governance Co-Ordinator who would have been responsible for identification of trends and the escalation of same.

c. Whether or not, in your opinion, the trends, issues or concerns were successfully addressed?

14.3 As I was not involved in the escalation process, I cannot provide a response to this question but to the best of my knowledge there remains an issue with the length of time that patients have to wait for urology appointments.

15. Please provide any further details which you consider may be relevant to the Inquiry's Terms of Reference.

15.1 Having a knowledge of all the roles and responsibilities, duties and tasks required of a governance role, I consider that Clinical Governance has been under resourced. I have previously outlined that not all duties on job

descriptions could be carried out. This is due to the volume of work within the Governance Team at that point within the Acute Services Directorate. Within Acute Services there was 0.6 WTE more of a Band 5 and 0.6 WTE of a Band 3 in the structure compared to that of the other three operational directorates, however within Acute the workload was more than that of the other three directorates put together. It is my personal opinion that the 2011 review of Clinical Governance diluted the importance of this critical process within the Acute Services Directorate. A middle management tier was abolished. The structure within Acute Services was 1 WTE band 8b, 1.6 WTE Band 5 and 1.6 WTE Band 3. The 1.0 WTE Band 7 (Risk Manager) and 1.0 WTE (Patient/Client Liaison Manager) Band 6 posts in existence prior to this review were done away with.

15.2 In respect of point (b) of the Terms of Reference for the Inquiry, having worked in a clinical governance role for almost 20 years I wish to offer a general personal observation. Since the inception of the Trust, I consider that there could be what is described as an element of "instability" within the Acute Governance Team. I will further clarify this by stating that since 2012 until now, there have been 6 Directorate Governance Co-Ordinators and an extended period when there was no Directorate Governance Co-Ordinator in place. On top of this, the Team was frequently resourced with staff from a re-deployment list whose skills and experience may not be best suited to the governance role. It is my opinion that these factors can create an environment of inconsistency. It also creates an environment where there is no corporate memory of governance within the acute setting.

15.3 Given the volume of work associated with clinical governance within the acute setting, the nature of it is usually reactive rather than proactive. I consider the role of clinical governance should be promoted in a more positive light and that there should be greater opportunity to raise the profile of this essential patient safety work, which in turn could change the balance of reactive vs. proactive.

15.4 Other than that, I have no further details that I consider may be relevant to the Inquiry's Terms of Reference.

NOTE:
By virtue of section 43(1) of the Inquires 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.

Urology Services Inquiry

It will also include electronic documents such as emails, text communications and recording. 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 Inquires 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

Signed Personal Information redacted by the USI

Dated: 15 August 2023

S21 16 of 2023

Witness statement of: David Cardwell

Table of Attachments

Attachment	Document Name
1	Patient/Client Liaison Manager, Directorate of Acute Services, Band 6, Job Description
2	Governance Officer, Job Description
3	Senior Governance Officer, Job Description
4	Clinical Governance Manager Job Description
5	Line Management, Roles and Reporting Arrangements
6	Management of Adverse incidents 2008
7	Filling out an IR1 Form Online
8	Process for the Reporting of Serious Adverse Incident (SAI) and Reporting Early Alert December 2017
9	Sample Screening Sheet
10	Sample Screening Template
11	Sample notification form
12	Information Sessions
13	Incidents, Risks and Complaints – What do they mean for you and your team
14	Governance Management
15	Incident Management
16	Acute Services Incidents
17	Incident Reporting: An Investigator's Guide
18	Policy for Shared Learning
19	Email re Datix Dashboards

20	Directorate of Acute Services Incident Position
21	Surgery and Elective Care Governance Report
22	Trust Procedure for the Sharing/Moving of incidents
23	Email from Mrs Forde
24	Major Catastrophic Incident Checklist
25	Policy for the Management of Complaints 2010
26	Policy for the Management of Complaints 2013
27	Policy for the Management of Complaints 2018
28	Investigating Complaints – Advice Sheet
29	Investigating Complaints & User Views – Advice Toolkit for Staff
30	Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009
31	Weekly report on current complaints
32	Acute Complaints Summary

Southern Health and Social Care Trust

Patient/Client Liaison Manager, Directorate of Acute Services
Band 6

JOB DESCRIPTION

Job Summary

The post holder will be responsible to the Senior Manager-Patient & Client Safety, Medical Directorate for the management of patient/client complaints, user views and patient/client liaison for the Directorate of Acute Services. The post holder will lead a team of complaints staff for the Directorate of Acute Services.

The post holder will ensure that best practice is adopted with regard to the management of patient/client complaints, ensuring that the complaints process is managed in an open and responsive manner. The post holder will also manage the implementation and administration of the Southern HSC Trust 'Being Open' policy for the Directorate of Acute Services and the processes associated with the collation and actioning of user views.

The job is likely to be full time, although other arrangements will be considered.

KEY RESPONSIBILITIES

Complaints Management

- In conjunction with the Senior Manager-Patient & Client Safety, Medical Directorate develop and implement processes and systems to support complaints management.
- Ensure compliance with HPSS and statutory requirements in relation to the management of complaints.
- Manage the investigation processes associated with complaints, liaising as appropriate with other multi-disciplinary staff.
- In conjunction with other clinical and social care governance leads oversee the preparation of written responses to complaints.
- Ensure that all complainants receive an accurate and timely response.
- Identify and implement best practice in respect of complaints management.
- Manage the coding of complaints in line with Trust guidance, ensuring the appropriate categorisation and investigation of complaints.
- Provide an effective patient/client liaison service to support the management of complaints.
- Share the learning from complaints in line with the processes outlined in the Trust Learning Lessons model.
- Plan and oversee the training of Directorate staff in respect of complaints management/patient/client liaison.
- Ensure effective communication and liaison between the Patient/Client liaison function of Directorate and the functions of patient/client safety, risk

management, litigation, effectiveness and evaluation, performance management and service planning.
- Develop appropriate links with other HPSS and NHS complaints/user views staff.
- Build and sustain relationships with external bodies that refer complaints and complainants (in particular Health and Social Services Councils).

Being Open and User Views
- In conjunction with the Senior Manager-Patient & Client Safety, Medical Directorate, support the development of the Trust 'Being Open' policy and associated procedures.
- Support the implementation the Trust 'Being Open' policy, providing training, advice and guidance to multi-disciplinary stakeholders as required.
- Monitor the implementation and effectiveness of the Trust 'Being Open' policy in the Directorate, including identification of patterns/trends ensuring action plans are developed as appropriate.
- Share the learning from 'Being Open' investigations in line with the processes outlined in the Trust Learning Lessons model.
- In conjunction with the Senior Manager-Patient & Client Safety, Medical Director establish appropriate mechanisms and processes to elicit and act upon user views.
- Promote user involvement at all levels across the Directorate.

Corporate Management
- Attend clinical and social care governance meetings as required to provide high quality support and information concerning those areas for which he/she is responsible.
- Develop and maintain working relationships with senior colleagues to ensure achievement of directorate and corporate objectives.
- Contribute to the Trust's overall corporate governance processes to assure safe and effective care for patients and clients and compliance with public sector values and code of conduct.
- Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS managers.

Financial and Resource Management
- Ensure the effective implementation of all Trust financial policies and procedures as appropriate.
- Implement arrangements to ensure strong financial management of all budgets within the remit of responsibility ensuring financial viability is maintained, best value achieved and all financial targets are met.
- Ensure the effective management, use and maintenance of all physical assets as appropriate.

Information Management
- Support the effective implementation of Trust information management policies and procedures.
- Ensure that information recording associated with complaints/user views and the Being Open policy is accurate, timely and up to date.
- Ensure that all reports emanating from the Patient/Client liaison function of Directorate are timely, accurate and of the appropriate standard.

- Monitor the pattern of complaints/Being Open investigations, identifying areas of concern/trends and ensuring action plans are developed as appropriate.
- Benchmark the Trust's complaints management processes/outcomes with suitable peers.
- Provide complaints/Being Open/user views related information to support the management of integrated governance within the Southern HSC Trust.
- Support the development and monitoring of corporate Key Performance Indicators related to complaints management/Being Open/user views.

General Management Responsibilities

- Participate in the Trust's Staff Development and Performance Review scheme.
- Maintain good staff relationships and morale amongst the staff reporting to him/her.
- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

This job description is 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 Patient/Client Liaison Manager works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Senior Manager-Patient & Client Safety, Medical Directorate.

General Responsibilities

Employees of the Trust will be required to promote and support the mission and vision of the organisation and:

- At all times provide a caring service and to treat those with whom they come in contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking policy
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision
- Comply with the HPSS Code of Conduct

October 2007

Draft Personal Specification

Knowledge, skills and experience required:

Essential Criteria
Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

- A university degree or a recognised professional qualification plus a minimum of 2 years middle/senior management experience in a *major complex organisation

OR

- 5 years middle/senior management experience in a *major complex organisation with five GCSE's including English and Maths

AND

- At least 2 years experience in a complaint management/patient liaison role
- At least 2 years experience of managing people
- Proven ability to communicate effectively with other multi-professional staff
- Proven ability to work with minimum supervision
- Have worked with a diverse range of stakeholders, both internal and external to the organisation, to realise successful outcomes.
- Have excellent communication skills, both verbally and in writing

* Major complex organisation is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

Job Title	Governance Officer
Band	Band 5
Directorate / Location	Service Directorates – Acute Services, Mental Health & Disability, Children and Young People and Older People and Primary Care
Reports to	Directorate Governance Coordinator
Accountable to	Service Director

JOB SUMMARY

The post holder will be responsible for the provision of a high quality clinical and social care administrative service to the Directorate. This will include management of administrative staff within the Directorate Clinical and Social Care Governance (CSCG) office, the administrative system management of Directorate complaints, incidents and other sensitive CSCG issues and the monitoring and management of the Directorate information system to support CSCG. The post holder will also provide significant support to the Directorate Governance Coordinator in the management of the incidents and complaints process, including tracking of responses, liaising with clinical teams, patients, clients and their families. The role will also incorporate production and analysis of reports from the CSCG information system, report composition for various audiences of clinical and non clinical staff, monitoring key CSCG performance indicators and providing an early warning alert to the Directorate Coordinator re exceptions and the organisation and delivery of Directorate specific training.

Key Duties / Responsibilities

1. The development and maintenance of a CSCG administrative office which will support this key agenda within a Service Directorate. This will include the management of administrative staff within this office and all other aspects of office management.

2. Assist with the development of, and be responsible for managing and maintaining the Directorate system for complaints management, in collaboration and alignment with the organisational system and ensure regional response time targets are met.

3. Liaise with clinical staff of all levels, patients, clients and their families in relation to complaints in a sensitive, confidential and appropriate manner.

4. Assist the Directorate teams in the administrative and information management system for all aspects of the CSCG agenda and specifically incident reporting, investigation and learning, using excellent communication and empathetic skills in this sensitive and complex area.

5. Manage and monitor the Directorate use of the CSCG information system, liaising with the systems manager and the corporate CSCG office to ensure standardisation, high quality information and data accuracy.

6. Produce a suite of complex reports for target audiences in relation to CSCG key performance indicators, trends in incidents, complaints and risk and tailor reports in response to ad hoc requests for specific analysis of information.

7. Validate and analyse Directorate, Divisional and team reports, highlight and escalate exceptions and trends to the Directorate Governance coordinator in a timely way.

8. Be the Directorate focal point for the coordination of Directorate Serious Adverse Incidents (SAI's) and subsequent Root Cause Analysis reports that the Regional Board request.

9. Liaise with all clinical staff and the corporate CSCG office to ensure timeframes for the SAI process are met, a standard process is completed and a high quality report is produced. This will require sensitivity and good communication.

10. Inform the Directorate Governance Coordinator if any of the above CSCG processes are sub optimal within the Directorate and assist with designing and implementing an improvement plan.

11. Plan and coordinate various CSCG workshops and training days within the Directorate as required and identify areas of procedure and teams which require targeted training on any aspect of CSCG.

12. Assist the Directorate CSCG coordinator to develop and embed procedures within the Directorate to assist with the CSCG agenda, and facilitate service teams to implement these procedures.

13. Audit and report on the implementation of CSCG procedures within the Directorate to the CSCG coordinator.

14. On a daily basis operationally manage the CSCG Directorate office and the above processes. Meet weekly and as appropriate with the Coordinator to highlight issues of concern and escalate exceptions and trends.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

4. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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. 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.

5. 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.

6. 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.

7. 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.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

Job Title	Governance Officer
Band	Band 5
Directorate / Location	Service Directorates – Acute Services, Mental Health & Disability, Children and Young People and Older People and Primary Care
Salary	£21,176 to £27,625 per annum

For the purposes of the populating structures under the "Pools" process those wishing to express an interest in this post in the first round must:

a. hold a substantive Band 5 post within the SHSCT and

b. must be part of the Medical Directorate Pool

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE	Senior Governance Officer
BAND	Band 6
DIRECTORATE	Directorate of Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Pharmaceutical Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The post holder will be responsible for the management of complaints and enquiries within Acute Services ensuring complaints are investigated within set timescales. The post holder will co-ordinate the investigation and/or personally conduct an investigation as necessary, and draft responses, for the approval of the Director and/or Chief Executive based on the information provided by clinical reports and in clinical notes. The post holder will ensure that best practice is adopted with regard to the management of patient/client complaints, ensuring that the complaints process is managed in an open and responsive manner.

In addition the post holder will provide significant support to the Lead Governance Nurses in the management of incidents and Serious Adverse Incidents and Heads of Service in relation to Risk Registers.

The post holder will also produce a suite of reports from the Clinical and Social Care Governance reporting system, report composition for various audiences of clinical and non-clinical staff, monitoring key performance indicators and providing an early alert warning to the Assistant Director regarding exceptions.

The role will also include management of administrative staff within the Clinical and Social Care Governance Team and the overseeing of administrative systems.

The post holder will also be responsible for the provision of training to staff in relation to incidents, risks and complaints.

KEY DUTIES / RESPONSIBILITIES

Operational Delivery

1. To ensure all complaints, enquiries and other forms of service user feedback are handled in accordance with Trust Policies and Procedures.

2. To receive and instigate action regarding complaints from service users, their

relatives or representatives, dealing with these in a timely, courteous and sensitive manner, providing support when necessary.

3. To liaise with a range of staff including the Director of Acute Services, Assistant Directors, Consultant's, Heads of Service and other healthcare professionals during the investigation of complaints and ensure complaints are responded to appropriately including meeting the statutory timescales for producing complaints responses.

4. To draft and quality assure response letters to complaints based on information received from clinical and other staff or from patient records or other means and following up, when required to ensure all issues are adequately responded to.

5. To advise on the need for meetings with complainants to encourage and assist in local resolution to include facilitating and leading such meetings as appropriate.

6. To collate and produce information on individual complaints when requested by the Commissioner for Complaints and produce any necessary documents, information and responses within the deadline set.

7. To assist with the investigation of patient specific enquiries received from the DHSSPS, elected representatives, HSCB and Patient Client Council, producing and quality assuring responses to same.

8. To provide support to the Directorate, Divisions and Teams specifically relating to incident reporting, investigation and learning, using excellent communication and empathetic skills in this sensitive and complex area.

9. To assist with the development of systems and processes to support the efficient and effective operation of Directorate Risk Registers.

10. To act as the Directorate focal point for the co-ordination of Serious Adverse Incidents which includes provision of necessary information for investigations, preparing timelines, drafting communications to patients and their relatives, attending meetings and ensuring agreed processes for completion of reports and sharing of learning is followed.

11. To develop and maintain a Clinical and Social Care Governance administrative support service which will include the management of administrative staff and all other aspects of office management.

12. Attend Clinical and Social Care Governance meetings as required to provide high quality support and information concerning those areas for which the post holder is responsible.

Information Management

1. To attend the Directorate and Divisional Governance Meetings as required and report on incidents, risks and complaints.

2. To operate and manage the Datix database in relation to incidents, risks and complaints ensuring the maintenance of good record keeping for each incident, risk and complaint dealt with, ensuring that there is a paper trail of the investigation

process and all relevant information is stored in a sensitive and secure manner.

3. Manage and monitor the Directorate use of the Datix system, liaising with relevant Heads of Service and the Information Technology Team to ensure standardisation, high quality information and data accuracy.

4. Produce a suite of complex reports for target audiences in relation to trends in incidents, risk and complaints and tailor reports in response to ad hoc requests for specific analysis of information and validate all information as well as highlighting and escalating exceptions and trends to the Director of Acute Services in a timely way.

Key Working Relationships

1. To work closely with the Corporate Complaints Office and Corporate Governance Office at Trust Headquarters, communicating effectively regarding complaints, enquiries and Serious Adverse Incidents.

2. Liaise with clinical staff of all levels, patients and their families as well as those external to the Trust, including elected representatives, in a sensitive, confidential and appropriate manner.

3. Develop and maintain working relationships with senior colleagues to ensure achievement of directorate and corporate objectives.

4. Contribute to the Trust's overall governance processes to assure safe and effective care for patients and clients and compliance with public sector values and code of conduct.

Quality

1. Plan, co-ordinate and deliver governance training within the Directorate to specific teams.

2. To promote learning from complaints and liaise with services and management to ensure learning and other improvement measures are actioned.

3. Audit and report on the implementation of Clinical and Social Care Governance procedures within the Directorate.

4. Inform the Assistant Director if any of the Clinical and Social Care Governance processes are sub optimal within the Directorate and assist with designing and implementing an improvement plan.

Financial and Resource Management

1. Ensure the effective implementation of all Trust financial policies and procedures as appropriate.

2. To be an authorised signatory for the Acute Governance Team in respect of ordering of stock and authorisation of invoices.

3. Ensure the effective management of all staff reporting to the post holder and the

appropriate use of all physical assets available.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

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. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

10. 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 & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Governance Officer

DIRECTORATE Directorate of Acute Services

SALARY

HOURS

Ref No: **<Month & Year>**

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;

QUALIFICATIONS / EXPERIENCE

1. Relevant, Degree or recognised professional qualification or equivalent / Higher qualification AND 2 years' experience in a role involving dealing directly with patients and relatives and communicating with external stakeholders and/or risk and incident management.

2. **OR** HNC / HND or equivalent / higher qualification AND 3 years' experience in a role involving dealing directly with patients and relatives and communicating with external stakeholders and/or risk and incident management.

3. **OR** 5 years' experience in a role involving dealing directly with patients and relatives and communicating with external stakeholders and/or risk and incident management.

4. Experience in the use of Microsoft office products including Word, Excel, Outlook and PowerPoint.

5. Experience in staff management.

KNOWLEDGE & SKILLS

6. Hold a full current driving license valid for use in the UK and have access to a car on appointment.

7. Have an excellent understanding of Clinical and Social Care Governance within the Trust setting.

8. Effective Planning & Organisational skills with an ability to prioritise own workload.

9. Highly effective Communications skills to meet the needs of the post in full and the ability to deal with difficult and/or distressing situations.

10. Ability to constructively question and challenge existing practices.

11. Ability to effectively manage and lead a team.

12. Ability to identify solutions to problems and implement them effectively.

13. Ability to work to tight timescales whilst meeting targets.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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

Permanent.

Southern Health and Social Care Trust

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE	Clinical Governance Manager
BAND	Band 7
DIRECTORATE	Acute Services
REPORTS TO	Acute Clinical and Social Care Governance Coordinator

JOB SUMMARY

The post holder will be responsible for monitoring and improving the delivery of patient care services within the SHSCT. The post holder will support the Clinical Governance agenda within the Acute Directorate, in Medicine and Unscheduled care and/or Surgery & Elective Care and ATICS level which will include risk management, complaints, clinical audit, clinical effectiveness and multidisciplinary education and training. The post holder will effectively support the implementation of the principles and practice of clinical governance and risk management, in the clinical setting within a framework which uses information to guide reflection, leading to action and outcomes monitoring.

KEY DUTIES / RESPONSIBILITIES

Risk Management

1. To coordinate and support the risk management process across the patient care Divisions.

2. To ensure that the Divisional risk registers are effectively populated from investigations received, to analyse and identify trends and actions required, supporting Ward Managers throughout.

3. To work alongside clinical audit to develop and implement an audit programme that supports the needs of clinical risk management.

4. To ensure that investigations generated through the risk management process are multidisciplinary and, that findings are appropriately disseminated through established networks.

5. To collect data from serious incidents/investigations for the purpose of clinical audit

6. To attend the Governance Fora, supporting the Assistant Director, Heads of Service

and Lead Nurses with the maintenance of this group

7. To assist in any investigation required for Divisional complaints, working with the Complaints Manager to collate divisional responses.

Clinical Governance/Collaborative working

1. To support the development and implementation of a clinical governance programme, aimed at improving the quality of clinical acre in the division.

2. To collate information and statistics which assist clinicians to reflect on their practice

3. To work alongside the Clinical Governance Lead Clinicians in facilitating a rolling programme of audit and training, based on local policies and national guidelines

4. To compile reports and present findings as required to the Trust Clinical Governance Committee and risk management committee.

5. To coordinate the implementation of decisions taken by the Clinical Governance Committee within the Division/s

6. To assist and support the development of the Divisional Clinical Governance Strategy, revising and developing as required.

7. To be responsible for the efficient dissemination of clinical governance information across the division/s

8. To work alongside the Clinical Governance Lead Clinicians to investigate reported incident and prepare incident report and action plans in line with current Trust and regional clinical governance guidance

Educational Responsibilities/Communications

1. To identify training needs highlighted through the implementation of the risk management process and inform the Head of Service of these.

2. To assist senior nursing and medical teams in training and induction programmes regarding risk management and clinical governance for all staff as required.

3. To regularly attend and provide reports to the Divisional risk management meetings, Clinical Governance fora.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

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. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. 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

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

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

7. 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.

8. 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.

9. 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. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

10. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

This post may evolve over time and this Job Description will therefore 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

PERSONNEL SPECIFICATION

JOB TITLE & BAND Clinical Governance Manager, Band 7

DIRECTORATE Acute Services Directorate

SALARY

HOURS 37.5 hours per week

May 2018

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *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		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you 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.		
Factor	**Criteria**	**Method of Assessment**
Experience / Qualifications/ Registration	Relevant Degree or recognised professional qualification or equivalent AND 2 years experience at Band 6 or equivalent in a role involving patient safety and governance in a clinical setting **OR** HNC / HND or equivalent / higher qualification AND 3 years experience at Band 6 or	Shortlisting by Application Form

	equivalent in a role involving patient safety and governance in a clinical setting **OR** 5 years' experience at Band 6 or equivalent in a role involving patient safety and governance in a clinical setting Hold or be willing to undertake a patient safety or governance related module at Degree Level. Experience in delivering objectives which have led to a significant[4] Improvement in Service Have experience in working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant[4] change initiative. Have a minimum of 1 years experience in staff management[5] Experience in the use of Microsoft office products including Word, Excel, Powerpoint	
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	1. Have an excellent understanding of Clinical and Social Care Governance within the Trust setting. 2. Effective Planning & Organisational skills with an ability to prioritise own workload. 3. Highly effective Communications skills to	Interview

	meet the needs of the post in full and the ability to deal with difficult and/or distressing situations. 4. Ability to constructively question and challenge existing practices. 5. Ability to identify solutions to problems and implement them effectively. 6. Ability to work to tight timescales whilst meeting targets	

DESIRABLE CRITERIA		
SECTION 3: These will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted.		
Factor	**Criteria**	**Method of Assessment**
Experience	Experience of statistical analysis Experience of creating and using databases	Shortlisting by Application Form
Qualifications	*Include equivalencies where necessary*	Shortlisting by Application Form

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trust's Smoke Free Policy

19th April

20th June

16th August

Line Management, Roles and Reporting Arrangements

Role	To whom I reported	Departments, services, systems I whom I managed	Staff I had responsibility for
Patient/Client Liaison Manager	Ms Gill Smith Senior Manager – Medical Directorate	Responsible for the management of patient/client complaints, user views and patient/client liaison for the Directorate of Acute Services. The post holder will lead a team of complaints staff for the Directorate of Acute Services. The post holder will ensure that best practice is adopted with regard to the management of patient/client complaints, ensuring that the complaints process is managed in an open and responsive manner. The post holder will also manage the implementation and administration of the Southern HSC Trust 'Being Open' policy for the Directorate of Acute Services and the processes associated with the collation and actioning of user views.	Mrs Vivienne Kerr (Band 4) Mrs Roisin Farrell (Band 3)
Governance Officer	Mrs Margaret Marshall CSCG Co-Ordinator Dr Tracey Boyce Director of Pharmacy Services	Responsible for the provision of a high quality clinical and social care administrative service to the Directorate. This will include management of administrative staff within the Directorate Clinical and Social Care Governance (CSCG) office, the administrative system management of Directorate complaints, incidents and other sensitive CSCG issues and the monitoring and management of the Directorate information system to support CSCG. The post holder will also provide significant support to the Directorate Governance Coordinator in the management of the incidents and complaints process, including tracking of responses, liaising with clinical teams, patients, clients and their families. The role will also incorporate production and analysis of reports from the CSCG information system,	Mrs Roisin Farrell (Band 3) Miss Lynn McKenzie (Band 3) – replaced by Mrs Pamela Truesdale (Band 3)

		report composition for various audiences of clinical and non clinical staff, monitoring key CSCG performance indicators and providing an early warning alert to the Directorate Coordinator re exceptions and the organisation and delivery of Directorate specific training.	
Senior Governance Officer	Mrs Trudy Reid CSCG Co-Ordinator	Responsible for the management of complaints and enquiries within Acute Services ensuring complaints are investigated within set timescales. The post holder will co-ordinate the investigation and/or personally conduct an investigation as necessary, and draft responses, for the approval of the Director and/or Chief Executive based on the information provided by clinical reports and in clinical notes. The post holder will ensure that best practice is adopted with regard to the management of patient/client complaints, ensuring that the complaints process is managed in an open and responsive manner. In addition the post holder will provide significant support to the Lead Governance Nurses in the management of incidents and Serious Adverse Incidents and Heads of Service in relation to Risk Registers. The post holder will also produce a suite of reports from the Clinical and Social Care Governance reporting system, report composition for various audiences of clinical and non-clinical staff, monitoring key performance indicators and providing an early alert warning to the Assistant Director regarding exceptions. The role will also include management of administrative staff within the Clinical and Social	Mrs Vivienne Kerr (Band 5) Mrs Roisin Farrell (Band 5) Mrs Barbara Joyce (Band 5) Mrs Pamela Truesdale (Band 4) Miss Danielle Canning (Band 2)

		Care Governance Team and the overseeing of administrative systems. The post holder will also be responsible for the provision of training to staff in relation to incidents, risks and complaints.	
Clinical Governance Manager	Mrs Patricia Kingsnorth CSCG Co-Ordinator (April 19 – June 21) Mr Chris Wamsley CSCG Co-Ordinator (July 21 – May 23) Mrs C Quin CSCG Co-Ordinator (June 23 – present)	Responsible for monitoring and improving the delivery of patient care services within the SHSCT. The postholder will support the clinical governance agenda within the Acute Directorate, in Medicine and Unscheduled Care and/or Surgery and Elective Care and ATICS which will include the management of complaints, clinical audit, clinical effectiveness and multi-disciplinary education and training. The post holder will effectively support the implementation of principles and practice of clinical governance and risk management, in the clinical setting within a framework which uses information to guide reflection, leading to action and outcomes monitoring.	N/A.

Southern Health and Social Care Trust

Southern Health & Social Care Trust

Procedure for the Management of Adverse Incidents

7 November 2008

CONTENTS

1 PURPOSE AND FORMAT OF THIS PROCEDURE

This procedure sets out how adverse incidents are managed in the Southern Trust. It should be read in conjunction with the following documents:

- Southern Trust Risk Management Strategy (May 2008)
- Southern Trust Policy on the Management of Adverse Incidents (October 2007)
- Southern Trust Serious Adverse Incident Guidance (July 2008)
- Guidance on the Use of RCA Techniques for the Investigation of Adverse Incidents and Complaints (May 2008)

The format of this guidance is as follows:

- Section 2 – Definitions relevant to this procedure
- Section 3 - Process for the Management of Adverse Incidents
- Section 4 – Feedback, Staff Support and Learning from Adverse Incidents

2 DEFINITIONS RELEVANT TO PROCEDURE

This section of the procedure defines the terms adverse incident, serious adverse incident, RIDDOR reportable and root cause analysis.

2.1 Definition of Adverse Incident

An adverse incident is a circumstance or departure from acceptable standards of practice that could have or did lead to unintended harm, loss or damage to people, property, environment or reputation[1].

All adverse incidents which occur in the Southern Trust are categorised under the above definition. This includes the previous use of terms such as incident, non-clinical incident, untoward event, clinical incident, near miss etc.

It is the responsibility of all staff members to report adverse incidents to their line manager. The staff member directly involved, or the person who has detected the incident must complete the incident form (IR1). The specific processes for reporting adverse incidents are outlined in Section 3.2 of this procedure.

In the case of adverse incidents which arise during the work of domiciliary care workers, the incident form will be completed by the line manager of the domiciliary care worker in conjunction with the staff directly involved.

2.2 Definition of Serious Adverse Incident

A Serious Adverse Incident (SAI)[2] is an adverse incident with the added dimensions that the incident is likely to:

- Be serious enough to warrant regional action to improve safety or care within the broader HPSS;
- Be of major concern; and/or
- Require an independent review.

Such incidents may, for example:

- Involve a large number of patients/clients;
- Include poor clinical or management judgement;
- Involve a failed service, systems or piece of equipment;
- Contribute to the death of a patient or client under unusual circumstances; or
- A possibility or perception that any of these might have occurred.

AND the incident could have or did result in:

- Potential/serious harm to a patient/client, service user or the public e.g. disease outbreaks, clinical error;
- Serious implications for the patient/client, or staff safety; or
- Allegations/serious compromises in the proper delivery of health and social care services.

[1] Southern Trust Adverse Incident Policy, October 2007
[2] Southern Trust Serious Adverse Incident Guidance, May 2008

The following should be automatically reported as an SAI as required by DHSSPS:

- **All suspected suicides**
- **Under 18 year olds placed in an adult mental health or learning disability facility**
- **The transfer of a child from a Children's Home to Juvenile Justice**
- **Looked after Children absent without permission for more than 24 hrs**

Serious Adverse Incidents should be reported to the relevant Programme of Care Director/designated Assistant Director and to the appropriate Patient/Client Liaison, Safety and Risk Manager. The appropriate Patient/Client Liaison, Safety and Risk Manager is responsible for ensuring the onward reporting of the SAI to all relevant bodies.

2.3 Riddor Reportable Incidents

The term *'RIDDOR Incident.'* relates to any incident or dangerous occurrence that is defined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (N.I.) 1997. There are four main classifications which are:

- Major Injury Incidents/Conditions.
- Adverse incidents that result in more than three consecutive day's incapacity from work.
- Dangerous Occurrences.
- Occupational Diseases.

RIDDOR reportable incidents are firstly reported in the same manner as adverse incidents (see Section 2.1). Once the adverse incident is identified as RIDDOR reportable it is reported by the appropriate Health and Safety locality manager to the relevant enforcing authority.

2.4 Definition of Root Cause Analysis

Root Cause Analysis (RCA), is a retrospective investigation/review of a patient/client safety incident/complaint undertaken in order to identify what, how, and why it happened. Root causes are the fundamental issues which have caused the incident to happen. Root Cause Analysis is used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future[3].

[3] National Patient Safety Agency

3 PROCESS FOR THE MANAGEMENT OF ADVERSE INCIDENTS

This section of the procedure sets out the steps which apply in respect of the management of adverse incidents. This includes immediate actions associated with managing any harm/potential harm associated with an adverse incident, the steps to be taken in the reporting of the adverse incident, and the investigation processes and feedback related to reported incidents.

The processes outlined in this section are illustrated in the flowchart at Appendix 1.

3.1 Managing Harm

Depending on the nature of the adverse incident the first priority is to undertake an immediate assessment of the impact or potential impact of the incident on the patient/client/member of staff.

Where harm has occurred:

- Action must be taken to prevent further immediate harm. This should also include an assessment of the potential impact on other patients/clients, members of staff or the public.

- Any necessary first aid or medical treatment must be initiated.

In the event of an incident that did not reach the patient/client/member of staff/public or cause harm, an assessment should take place to ensure that any immediate steps required to remove or minimise risk to patients/clients/staff/public are taken.

If a **major or catastrophic incident** has occurred, immediately inform the Ward/Department/Facility Manager (or person in charge), Consultant responsible for the patient/client, Head of Service, Lead or Senior Nurse, Clinical Director, or other Director/Assistant Director. The Ward/Department Manager (or person in charge) and/or Consultant responsible for the patient/client must assess the on-going management of the patient/client to establish whether or not any further treatment or action is required.

If an **insignificant, minor** or **moderate** incident has occurred, inform relevant staff, for example the Ward/Department/Facility Manager, Consultant responsible for the patient/client as appropriate.

The categorisation of adverse incidents against insignificant, minor, moderate, major or catastrophic is made using the Risk Matrix overleaf.

Southern Trust - Risk Matrix *(Southern Trust Risk Management Strategy, May 2008)*

LIKELIHOOD	CONSEQUENCE (POTENTIAL IMPACT)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5) (will undoubtedly recur, a persistent issue)	5	10	15	20	25
Likely (4) (will probably recur, not a persistent issue)	4	8	12	16	20
Possible (3) (may recur occasionally)	3	6	9	12	15
Unlikely (2) (do not expect it to happen again)	2	4	6	8	10
Rare (1) (can't believe it will ever happen again)	1	2	3	4	5

VERY LOW (1 – 5)	LOW (6-11)	MODERATE (12-19)	HIGH (20 – 25)

An example of a risk rating using the risk matrix is:

Likelihood x Consequence(Potential Impact) = Risk Rating
e.g. Possible x Moderate = Yellow (9)

3.2 Identifying and Reporting Adverse Incidents

In order to promote the reporting of all adverse incidents, each Directorate/ department/facility should develop a 'trigger' list of examples of incidents that occur within their area. Some will be generic across the Trust i.e. medication incidents; others will be more specific to each specialty/area of work. The appropriate Patient/Client Liaison, Safety and Risk Manager/Risk Manager will provide advice and guidance to Directorates/department/facilities on the establishment of 'trigger lists' and ensure consistency of same across the Southern Trust.

All adverse incidents must be reported using the Southern Trust Incident Reporting Form (IR1 Form). Copies of the IR1 forms are available in all ward/department/facility areas. For those wards/departments/facilities which have access to electronic on-line adverse incident reporting this method should be applied to reporting of adverse incidents.

3.2.1 Who should complete the Incident Form?

It is the responsibility of all staff members to report adverse incidents to their line manager. The staff member directly involved, or the person who has detected the incident must complete the incident form (IR1). In the case of domiciliary care workers, they should report the adverse incident to their line manager and complete the incident form in conjunction with their line manager. A copy of the incident form

is illustrated at Appendix 2. Alternatively, for those wards/departments/facilities which have access to Datix electronic reporting the incident may be reported using this method. The individual most involved in the incident is best placed to complete the incident form, however there is a responsibility on all staff members aware of the incident, to ensure that a form has been completed and if not, to complete the incident form themselves. However, the greatest responsibility for reporting the incident rests with the individual who detected the incident.

All incident reports must be completed within 2 working days of the incident being discovered. The summary of the incident must document the sequence of events in an accurate, factual and objective manner, together with any immediate remedial action taken and treatment given to the patient/client/member of staff/public. In completing the incident form care should be taken to avoid being subjective or giving an opinion, and there must not be any attempt to apportion blame.

The incident form at Appendix 2 identifies specifically the information required.

3.2.2 Where does the Incident Form go to?

The Central Reporting Point of the Southern Trust is the single receipt point in the Trust for all incident forms. The contact details of the Central Reporting Point is:

Southern HSC Trust Central Reporting Point for Complaints & Incidents
Ground Floor
The Maples
Craigavon Area Hospital

Tel: Irrelevant information redacted by the USI
Fax: Irrelevant information redacted by the USI
Email: Irrelevant information redacted by the USI

In the case of all Datix electronically reported incidents these will be received automatically by the Central Point via the Datix IT system.

In cases were an incident form is completed the White Copy should be sent to the Central Point (either by post or fax). The Blue Copy should be filed in the patient/client chart/record or staff record, and the Pink Copy sent to the relevant Line Manager.

3.2.3 Identification of Serious Adverse Incidents and Riddor Reportable Incidents

Some additional actions are required in circumstances were the adverse incident reported is also reportable as a Serious Adverse Incident (SAI), a RIDDOR reportable incident or a health and safety related incident. The steps which should be taken in such cases are outlined below.[4]

[4] The steps outlined apply to SAI's and RIDDOR reportable incidents in both service and corporate directorates.

i) Serious Adverse Incidents

When an adverse incident occurs, which is also defined as a Serious Adverse Incident (see definition Section 2.2), staff should report the incident via the Southern Trust Interim Procedures for the Management of Adverse Incidents, May 2008. A copy of the flowchart summarising the processes associated with the management of Serious Adverse Incidents is included at Appendix 4.

ii) Riddor Reportable Incidents

As indicated above all adverse incidents are reviewed by the appropriate Patient/Client Liaison, Safety and Risk Manager/Risk Manager. In reviewing the incident and determining the incident grading using the Risk Matrix the Patient/Client Liaison, Safety and Risk Manager/Risk Manager will also identify if the incident is RIDDOR reportable to the relevant enforcing authority, in line with the RIDDOR reporting requirements outlined in Section 2.3.

If the incident is deemed to be RIDDOR reportable the appropriate Health and Safety Locality Manager will automatically be notified via the Datix IT system. Upon receipt of the incident notification the appropriate Health and Safety Locality Manager will undertake the notification of the RIDDOR incident to the relevant enforcing authority.

The Health and Safety Locality Manager is also responsible for investigating the incident, developing an action plan (and monitoring same) and updating details regarding actions taken directly onto the Datix IT system.

iii) Health and Safety Related Incidents

As indicated above all adverse incidents are reviewed by the appropriate Patient/Client Liaison, Safety and Risk Manager/Risk Manager. In reviewing the incident and determining the incident grading using the Risk Matrix the Patient/Client Liaison, Safety and Risk Manager/Risk Manager will also identify if the incident is a Health and Safety Category Adverse Incident (See Appendix 5 for Categorisation of Health and Safety Adverse Incidents).

If the incident is deemed to be a Health and Safety Category Adverse Incident, the Health and Safety Department will automatically be notified via the Datix IT system. Upon receipt of the incident notification the appropriate Health and Safety Locality Manager is responsible for investigating the incident, developing an action plan (and monitoring same) and updating details regarding actions taken directly onto the Datix IT system.

3.2.4 Investigation and Review of Incidents

On receipt of the incident form the Central Point will record all the relevant information on the Datix IT system. The appropriate Patient/Client Liaison, Safety and Risk Manager/Risk Manager will review the incident and grade it accordingly.

All adverse incidents (including Serious Adverse Incidents) in the Southern Trust are graded in a standardised manner using the Risk Matrix contained in the

Southern Trust Risk Management Strategy (May 2008). The Risk Matrix applies a grading to the adverse incident based on an analysis of consequence (impact) and likelihood. Adverse incidents can then be categorised into green (very low), yellow (low), amber (moderate) and red (high).

Adverse incidents which occur in the Southern Trust are subject to a standardised form of review based on Root Cause Analysis techniques. The depth of investigation and analysis undertaken will be determined by the level of review to be applied. The level of review undertaken is determined by the incident grading.

There are three levels of investigation/review which are adopted in respect of adverse incidents in the Southern Trust. All three levels of investigation/review apply RCA techniques and tools to find causation in respect of adverse incidents. The differentiating factors between levels are the depth of analysis, the leadership and composition of the review team, and the format and detail of the review report.

The levels are outlined in the sub-sections which follow.

It should also be noted that where there has been an incident, unexpected death, or other event that suggests the necessity for further investigation or enquiry, that **ALL** relevant notes, records and papers should be immediately secured and forwarded to the lead directorate Patient/Client Liaison, Safety and Risk Manager.

i) Level 1

Level 1 investigations/reviews are undertaken on repeating green and yellow adverse incidents where trends have been identified.

Level 1 is a local investigation and review by staff in the immediate vicinity of where the adverse incident occurred. It is recommended that repeating green and yellow adverse incidents are reviewed locally by key staff within departments/facilities or by local governance forums to identify those which should be subject to Level 1 review. Repeating green and yellow adverse incidents should be identified by the appropriate Directorate Patient/Client Liaison, Safety and Risk Manager, or in the case of Health and Safety incidents the Locality Health and Safety Manager.

In the case of investigations/reviews associated with adverse incidents an appropriate service manager should be assigned lead responsibility for the review. Depending upon the nature of the investigation/review it may be undertaken by 1 individual (ward sister/head of service) or 2-3 individuals.

During Level 1 investigations/reviews, RCA techniques are applied throughout the gathering of information, analyzing the problem(s), identifying the contributory factors and root causes and making recommendations/developing an action plan to seek to prevent the incident from reoccurring. Level 1 investigations/reviews do not require the full application of all aspects of the RCA methodology. The application of RCA techniques should be commensurate with the impact/consequence of the incident.

An investigation/review report is produced (this may be 1-2 pages long with key action points) and shared with the appropriate department/directorate managers, the relevant directorate Patient/Client Liaison, Safety and Risk Managers, relevant Health and Safety Locality Managers, and other staff as appropriate.

ii) Level 2

Level 2 investigations/reviews are conducted on amber adverse incidents. Investigations of Serious Adverse Incidents (SAI's) may also be included in Level 2 investigations/reviews depending upon the grading of the incident using the Risk Matrix.

A Level 2 investigation/review is also undertaken locally, but unlike Level 1 reviews is led by the directorate Patient/Client Liaison, Safety and Risk Manager in conjunction with relevant directorate Managers/Senior Nurses/Consultants/Social Workers etc. In the case of health and safety incidents the investigation will be led by the appropriate Locality Health and Safety Manager.

The Assistant Director and Patient/Client Liaison, Safety and Risk Manager in the lead directorate or the Locality Health and Safety Manager agree the composition of the small team that will undertake the investigation/review and the relevant expert(s) from the area(s) are involved.

Depending upon the nature and circumstances of the adverse incident external input to the team (i.e. from outside the immediate department/directorate but still within the Trust) may be included in the team. During Level 2 investigations/reviews RCA techniques are applied through the gathering of information, analyzing the problem(s), identifying the contributory factors and root causes and making recommendations to seek to prevent the incident from reoccurring. The application of RCA techniques should be commensurate with the impact/consequence of the incident.

The investigation/review team provide the directorate with a report which is anonymised and shared across other directorates and staff as appropriate. Reports generated from Level 2 investigations/reviews must follow the reporting format identified in Appendix 1. The output of level 2 investigations may (if appropriate) also be shared with the family of the patient/client involved in the adverse incident.

Reports of Level 2 investigations/reviews which are also SAI's are provided monthly to the SMT Governance Steering Group and quarterly to the Governance Committee.

iii) Level 3

Level 3 investigations/reviews are conducted for all red adverse incidents. Reviews of Serious Adverse Incidents (SAI's) may also be included in Level 3 investigations/reviews depending upon the grading of the incident using the Risk Matrix.

The decision to commence a Level 3 investigation/review should be taken within one working week of the adverse incident/SAI being reported. Level 3 investigations/reviews require the full application of RCA techniques. Additionally the Chief Executive may at any time request a Level 3 investigation/review in response to a reported adverse incident, SAI or complaint.

In respect of adverse incidents all Level 3 investigations/reviews must be chaired by a trained RCA facilitator. The terms of reference and review team for Level 3

investigations/reviews are agreed in conjunction with the Senior Manager, Patient/Client Safety (Medical Directorate), the relevant directorate Patient/Client Liaison, Safety and Risk Manager and the appropriate lead Director/Assistant Director. External input to the team i.e. from outside the immediate department/directorate or in some cases Trust (the latter should be considered in light of the nature of the incident and circumstances involved) is required.

Exceptions to the above process may be made in respect of suspected suicides. In such cases the appropriate Director/Assistant Director should review the circumstances of the suicide in conjunction with the Patient/Client Liaison, Safety and Risk Manager. Unless exceptional circumstances pertain (i.e. the suspected suicide is also linked with absconding from Trust premises) a Level 3 investigation/review will not be required. In these cases the well established processes of multi-disciplinary team review of the suspected suicide should be engaged and appropriate reporting mechanisms adopted.

With regard to Level 3 reviews of adverse incidents the terms of reference and proposed review team for Level 3 investigations/reviews should be submitted to the Trust Senior Management Team (SMT) for approval within two working weeks of the decision to commence a Level 3 investigation/review. SMT will sign off the proposed team and terms of reference (or make recommendations for change), and agree the investigation Chair. The Board Secretary will confirm the decisions of SMT in writing to the Lead Director/Assistant Director and Senior Manager, Patient and Client Safety, Medical Directorate. As above, exceptions to these processes may include suspected suicides.

The identified investigation team Chair for adverse incident investigations is responsible for bringing together the team and beginning the investigation process.

Level 3 investigation/review reports should be submitted to the Chief Executive within 10 working weeks of the adverse incident being reported. In line with DHSSPS guidance the investigation/review report should be completed within 12 weeks. As above, exceptions to these processes may include suspected suicides.

Level 3 investigation/review reports are sent to the Chief Executive's office and are co-ordinated and collated by the Board Secretary on behalf of the Chief Executive. Level 3 investigation/review reports for adverse incidents will also be shared as appropriate with other organisations i.e. Mental Health Commission, SHSSB etc.

Reports of Level 3 investigations/reviews which are also SAI's are provided monthly to the SMT Governance Steering Group and quarterly to the Governance Committee.

Level 3 investigation/review teams provide a report which is anonymised and shared across other directorates and staff as appropriate. Reports generated from Level 3 investigations/reviews must follow the reporting format identified in Appendix 1. In the case of adverse incidents the output of level 3 investigations should also be shared with the family of the patient/client involved. As above, exceptions to these processes may include suspected suicides.

3.2.5 Application of Root Cause Analysis Techniques

This sub-section outlines the techniques which should be applied (in varying degrees depending upon the level of investigation) to the investigation/review of adverse incidents in the Southern Trust. Level 1 investigations/reviews are not required to apply all aspects of the techniques outlined in this guidance, but should treat this guidance as best practice and apply the techniques in a manner which is commensurate with the adverse incident under review.

The methodology outlined in this guidance is in line with the National Patient Safety Agency recommended approach to undertaking Root Cause Analysis. As identified, the depth of investigation/review conducted is dependant upon the level of investigation/review to be undertaken.

There are eight stages in the application of RCA techniques. These are:

- Stage 1 - Setting up the team
- Stage 2 - Scoping the adverse incident/complaint
- Stage 3 - Data gathering
- Stage 4 - Information mapping
- Stage 5 - Identifying problems
- Stage 6 - Analysing problems and contributory factors
- Stage 7 - Agreeing the root causes
- Stage 8 - Recommendations and reporting

Each of these stages is described in the sub-sections which follow and illustrated by the flow chart at Appendix 2.

i) Stage 1 - Setting up the Investigation/Review Team

The size of the investigation/review team and composition of interests will reflect the nature/circumstances of the adverse incident/complaint under investigation/review and the level of investigation/review (Level 1-3) to be undertaken.

For all Level 3 investigations/reviews in the Southern Trust the Chair of the investigation/review team must be a trained RCA facilitator who will be agreed with the Senior Management Team of the Trust. Whilst it is advantageous, it is not essential that all other members of the investigation/review team are RCA trained.

With regard to Level 2 and 3 investigations/reviews of adverse incidents the team should include relevant clinical/social care knowledge experts. Those directly involved in the incident should be invited to work with the investigation/review team to identify and prioritise problem issues and undertake the analysis process for contributory factors and causes. This will be facilitated by invitation to participate in meetings with the investigation/review team. Staff involved may also avail of appropriate support mechanisms as required i.e. be accompanied by a colleague for peer support or by the representative of their professional body.

External input to the team i.e. from outside the immediate department/directorate or in some cases Trust (the latter should be considered in light of the nature of the

incident and circumstances involved) is required for all Level 3 reviews of adverse incidents. External input to the team may also be considered for Level 2 reviews depending upon the nature/circumstances of the incident.

In investigation/review of some Level 1 incidents it may be appropriate that the investigation/review is conducted by a single individual (ward manager, head of service etc).

ii) Stage 2 - Scoping the Adverse Incident

The scoping of the adverse incident refers to how far back in time from the adverse incident the team must explore in order to understand what happened and why. The individual factors which are relevant to each adverse incident under review will guide the scoping of the incident/complaint. However, the following 'rule of thumb' should be applied to the scoping process:

a) Acute Care Episodes
In the case of an adverse incident in the acute setting the complete episode of care/outpatient episode should be examined.

b) Community and Primary Care (including those in environments of long-term care)
Data collection should start from the time of the adverse incident and work backwards until the team agree enough information has been gathered to enable the issues to be identified and explored fully. It should be noted that the time period with data collection will also be influenced by the time parameters for the investigation/review agreed in the terms of reference for the investigation/review.

iii) Stage 3 - Data Gathering

This stage involves gathering the relevant data for the investigation/review and developing a chronology of events. The time expended on this stage of the investigation/review process normally represents 60%. The investigation/review team Chair in conjunction with other team members should decide what data should be gathered for the investigation/review. Potential sources of information include:

- People – the team should identify which people (i.e. staff/other agencies etc.) they need to gather information from and in what format i.e. statements or interviews
- Site – visiting the site at an early stage is important and can be used to generate sketches, photographs etc.
- Policies and procedures – identify the current policies and procedures at the time of the incident/complaint and establish if they were followed
- Patient/client notes
- Others – maintenance records (relevant in the case of incidents/complaints related to equipment/devices), incident forms, staff rotas, training records etc.

iv) Stage 4 – Information Mapping

This stage involves ordering the information gathered in a useful way. A number of techniques can be applied to this process. These are:

a) Narrative Chronology – An account of what happened in date/time order. This provides one account of the incident under investigation.
b) Timeline – This is a chronology of 'what' information, giving precise dates and times as appropriate according to the nature of the incident/complaint. Each step in the critical path related to the incident is written in a box. Each box is linked by an arrow indicating the direction of time.
c) Tabular Timeline – Similar to above, but recorded in a table. For each event as well as nature, date and time information can be recorded related to good practice, care and service delivery problems and supplementary information. This tool supports the discipline of chronology but also provides more information that a) and b).
d) Time Person Grid – This facilitates close analysis of concentrated time periods when the investigating team need to understand who was doing what and where.

More detail on the above tools can be accessed via the National Patient Safety Agency website www.npsa.nhs.uk.

The number and type of information mapping techniques applied to the investigation/review is at the discretion of the investigation/review team, taking into consideration the information generated and level of investigation/review. However, the tabular timeline is recommended as a minimum standard of information recording for Level 2 and 3 investigations/reviews in the Southern Trust.

v) Stage 5 – Identifying Problems

During and after Stage 4 the precise points at which things went wrong need to be identified. Problems should be categorised into Care Delivery Problems (CDPs) and/or Service Delivery Problems (SDPs). There are a number of tools which can be used to help the team identify CDPs and SDPs. The tools used in the investigation/review should be agreed by consensus in the investigation/review team and will depend upon the type of incident under investigation/review, its context and complexity and the team dynamics of the investigation/review team. Tools which may be applied at this stage are:

- Brainstorming – Each participant produces ideas openly
- Brainwriting – Similar to one but participants offer ideas anonymously
- Nominal Group Technique – The group achieve consensus on the priority issues they wish to subject to causal analysis and improvement strategies
- Change Analysis – Evaluates differences between good and poor performance. Compares and analyses what was expected to happen with what actually happened
- Barrier Analysis – Identifies what barriers, defences or controls should have been in place to prevent the incident/complaint arising or could be installed to increase safety

The number and type of methods applied to identify problems is at the discretion of the investigation team, taking into consideration the information to be categorised.

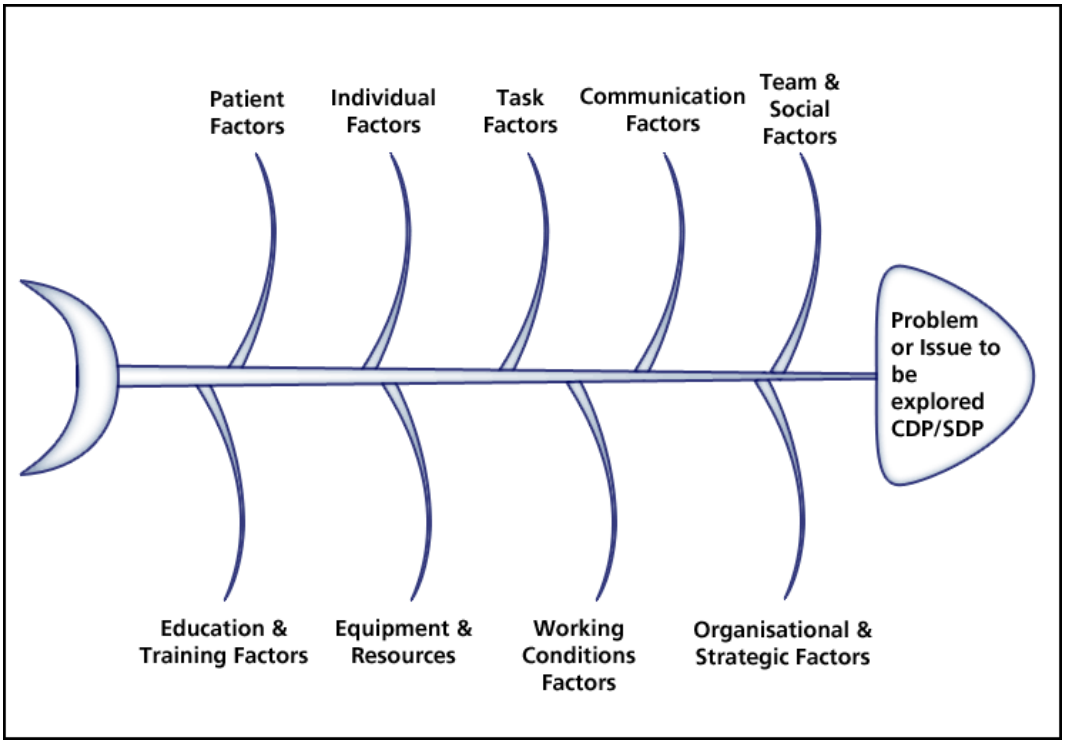
vi) Stage 6 – Analysing Problems and Contributory Factors

During Stage 6 the investigation/review team will:

- Agree and prioritise the problems identified to date
- Confirm that no critical issue has been overlooked
- Analyse the problems and issues that have been identified
- Establish their root causes (fundamental issues)

In order to undertake the above the investigation/review team should group problems together to identify emerging themes, and then decide which problems require further exploration. The key part of the analysis at this stage is to identify the key contributory factors lying behind each of the problems. There are a number of categories and components relating to exploring contributory factors.

The NPSA 'fish bone' diagram illustrates each of the categories which should be explored (though not all categories will be relevant to each CDP/SDP to be examined). See fishbone diagram below.



The components associated with each category are as follows:

- Patient – Clinical condition, social factors, physical factors, mental and psychological factors and interpersonal relationships.
- Individual – Physical, psychological and personality
- Task – Guidelines and policies, decision making aids, task design
- Communications – Verbal, written, non-verbal
- Team and Social – Role congruence, leadership, support and cultural factors
- Education and Training – Appropriateness, supervision, availability

- Equipment and Resources – Equipment and supplies, visual display, integrity, positioning, usability
- Working Conditions – Administrative, design of physical equipment, staffing, time
- Organisational and Strategic – Organisational structure, policy/standards/goals, externally imported risks, safety culture, priorities

The investigation/review team should identify if the contributory factors are highly specific to the incident or commonly present within the system. The team should also identify if contributory factors are influencing (i.e. very busy ward with seriously ill patients) or causal (i.e. specific instructions not given to undertake a necessary task).

Where appropriate and possible, careful consideration should be given to facilitating the involvement of patients/clients/carers in the processes associated with Stage 6 of investigation/review.

vii) Stage 7 – Identifying the Root Causes

The contributory factors identified in Stage 6 should now be analysed to identify which of these are root causes. There are a number of tools that can be applied at this point. These are:

- Brain storming
- Brain writing
- Fishbone
- The 5 w's -What happened?, Why did it happen?, What can we learn from this and what changes should be make?, What training need is identified, if any?, What good practice is evident?
- Barrier Analysis – Review of all the barriers (controls) that were in place and which should have stopped the problem occurring or mitigated its impact.

The tool(s) to be applied should be agreed by consensus in the investigation team.

The root causes (or fundamental issues) are the earliest points at which action could have been taken to:

- Strengthen the appropriate systems to enable appropriate care to be delivered
- Avert the course of the incident or prevent is occurrence altogether
- Significantly reduce the impact of the incident in the event or reoccurrence

viii) Stage 8 – Recommendations and Reporting

Once the issues and problems have been analysed and their root causes established the recommendations should be developed to prevent/mitigate another incident of the same kind reoccurring. During this stage the team should develop recommendations and associated action plans – this should include identifying at which level in the organisation responsibility lies for the actions required.

The report generated from the review should contain the appropriate information associated with the incident including background, analysis of issues/problems,

recommendations and associated actions. The depth and content of the investigation/review report will be influenced by the level of review undertaken.

For all Level 2 and 3 investigations the report template attached at Appendix 3 must be adopted.

The findings and actions of Level 1 reviews will be shared with appropriate department/directorate managers and the relevant directorate Patient/Client Liaison, Safety and Risk Managers. With regard to Level 2 and 3 investigations, the team will provide the directorate with a report which is anonymised and shared across other directorates if appropriate and with the Litigation Manager of the Trust. Reports for Level 3 reviews must be forwarded to the Chief Executive's Office within 10 weeks of commencing the investigation. Where such reports relate to SAI's these will also be shared (in line with agreed SAI processes) with the SHSSB and DHSSPS and the Mental Health Commission (if appropriate) within 12 weeks of commencement of the review. In the case of adverse incidents the output of level 3 investigations should also be shared with the family of the patient/client involved.

4 FEEDBACK, LEARNING FROM INCIDENTS AND STAFF SUPPORT

This section of the procedure outlines the mechanisms which relate to the feedback on adverse incidents, the support mechanisms available to staff in the event of an adverse incident and how the Southern Trust seeks to learn from adverse incidents.

4.1 Feedback and Learning Lessons

At an individual department/ward/facility/Directorate head of service/department and managers are responsible for feedback information on adverse incidents reported. This will be facilitated by the provision of regular information to departments/wards/facilities and directorates via the appropriate Patient/Client Liaison, Safety and Risk Manager/Risk Manager.

Action plans developed as a result of investigations into adverse incidents should be appropriately disseminated and shared in order to support learning. Stage 8 of the RCA process above outlines how the recommendations and action plans from investigations should be shared according to the level of the investigation undertaken.

Directorate governance fora should ensure that review of adverse incident trends and lessons learned from same is a standing item on meeting agendas. A quarterly Patient/Client Safety Report is also provided by the Medical Directorate to the Trust Governance Committee. This report includes Trust-wide analysis of adverse incident trends and lessons learned.

4.2 Staff Support

Depending upon the nature and circumstances of the adverse incident there may be a requirement for support to staff. Staff support is available via a number of sources by contacting the Health and Safety Department or Human Resources.

In circumstances were staff are required to participate in investigations associated with adverse incidents they may request the presence of a peer or professional representative to accompany them. In some instances staff statements may be required as part of the data gathering processes associated with investigation of an adverse incident. Where this is the case support for development of such statements may be provided by the appropriate Patient/Client Liaison, Safety and Risk Manager/Risk Manager, the Litigation Department of the Southern Trust, Southern Trust legal service advisors or via appropriate professional bodies.

Appendix 1 – Flowchart of Management of Adverse Incident Procedures

APPENDIX 2

IR1 FORM

APPENDIX 3

LEVEL 2 AND 3 INVESTIGATION REPORT FORMAT

Template Title Page

Date of Incident

Trust Unique Case Identifier (for tracking purposes)

Introduction

The introduction should outline the purpose of the report and include details of the commissioning Executive or Trust Committee.

Team Membership

List names and designation of the members of the Investigation team. Investigation teams 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. However, best practice would indicate that investigation / 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. There may be specific guidance for certain categories of adverse incidents, such as, the Mental Health Commission guidance

http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf

Terms of Reference of Investigation/Review Team

The following is a sample list of statements of purpose that should be included in the terms of reference:

- To undertake an initial investigation/review of the incident
- To consider any other relevant factors raised by the incident
- To agree the remit of the investigation/review
- To review the outcome of the investigation/review, agreeing recommendations, actions and lessons learned.
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the investigation.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

Summary of Incident/Case

Write a summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

This list is not exhaustive

Methodology for Investigation

This section should provide an outline of the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety" is a useful guide for deciding on methodology.

- Review of patient/ service user records (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
- Engagement with patients/service users / carers / family members
- Review of Trust and local departmental policies and procedures
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

Analysis

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 provided.

Analysis can include the use of root cause and other analysis techniques. 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
- 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

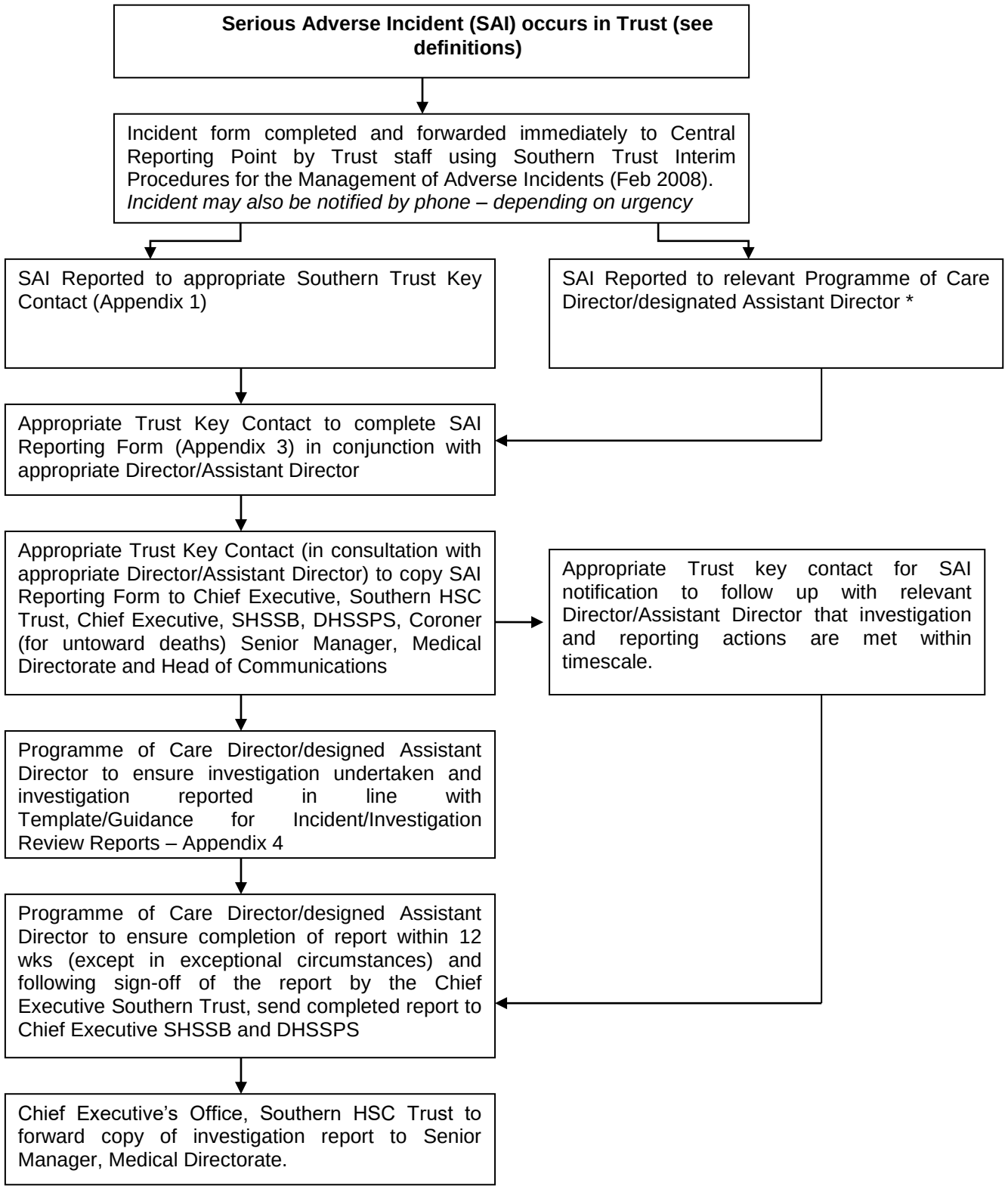
As a framework for organising the contributory factors investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. www.npsa.nhs.uk/health/resources/7steps

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within

this process .
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 ongoing engagement / contact with family members or carers.
Involvement with Patients/Service Users/ Carers and Family Members Where possible and appropriate careful consideration should be made to facilitate the involvement of patients/service users / carers / family members.
Recommendations List the improvement strategies or recommendations for addressing the issues above. Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions. Recommendations should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions. • Local recommendations • Regional recommendations • National recommendations
Learning In this final section it is important that any learning is clearly identified. Reports should indicate to whom learning should be communicated and copied to the Committee with responsibility for governance.

- Stage 1 - Setting up the team
- Stage 2 - Scoping the adverse incident/complaint
- Stage 3 - Data gathering
- Stage 4 - Information mapping
- Stage 5 - Identifying problems
- Stage 6 - Analysing problems and contributory factors
- Stage 7 - Agreeing the root causes
- Stage 8 - Recommendations and reporting

Appendix 4 – Flow Chart for the Management of Serious Adverse Incidents



* In instances were the SAI is notified to a Director/designated Assistant Director out of hours, the Director/designated Assistant Director should ensure that the appropriate Southern Trust Key Contact has also been informed.

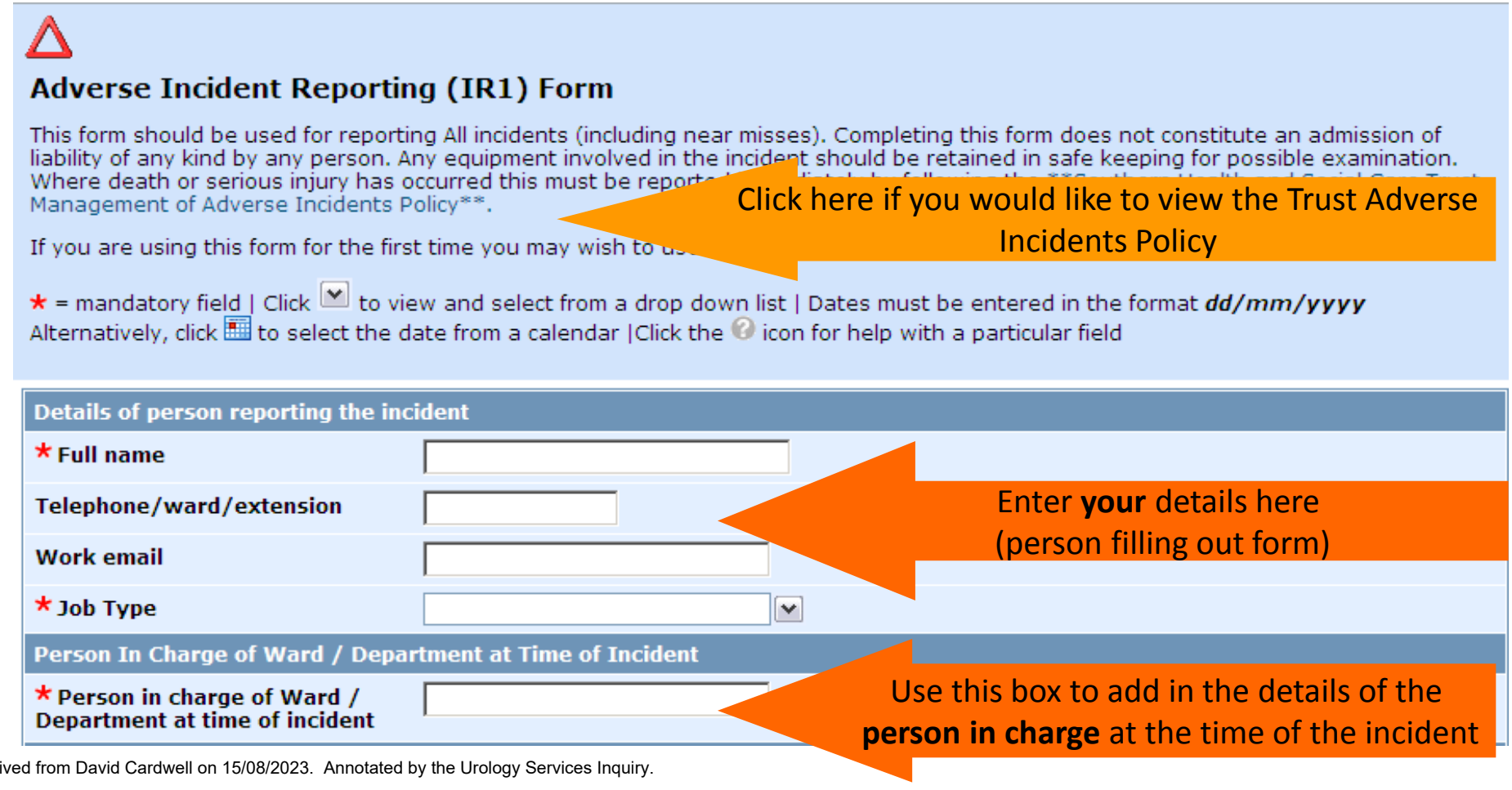
Appendix 5

Incident Mapping - Agreed Health & Safety Incident Categories

Filling out an IR1 Form Online

Go to: Trust Intranet / Useful Links / Other Useful Links and scroll down to click on “Datix Web”

You don’t need log in details to report an incident, you can input incident information directly into this form



Adverse Incident Reporting (IR1) Form

This form should be used for reporting All incidents (including near misses). Completing this form does not constitute an admission of liability of any kind by any person. Any equipment involved in the incident should be retained in safe keeping for possible examination. Where death or serious injury has occurred this must be report… Management of Adverse Incidents Policy**.

If you are using this form for the first time you may wish to u…

Click here if you would like to view the Trust Adverse Incidents Policy

* = mandatory field | Click to view and select from a drop down list | Dates must be entered in the format ***dd/mm/yyyy***
Alternatively, click to select the date from a calendar |Click the icon for help with a particular field

Details of person reporting the incident

* Full name	
Telephone/ward/extension	
Work email	
* Job Type	

Enter **your** details here (person filling out form)

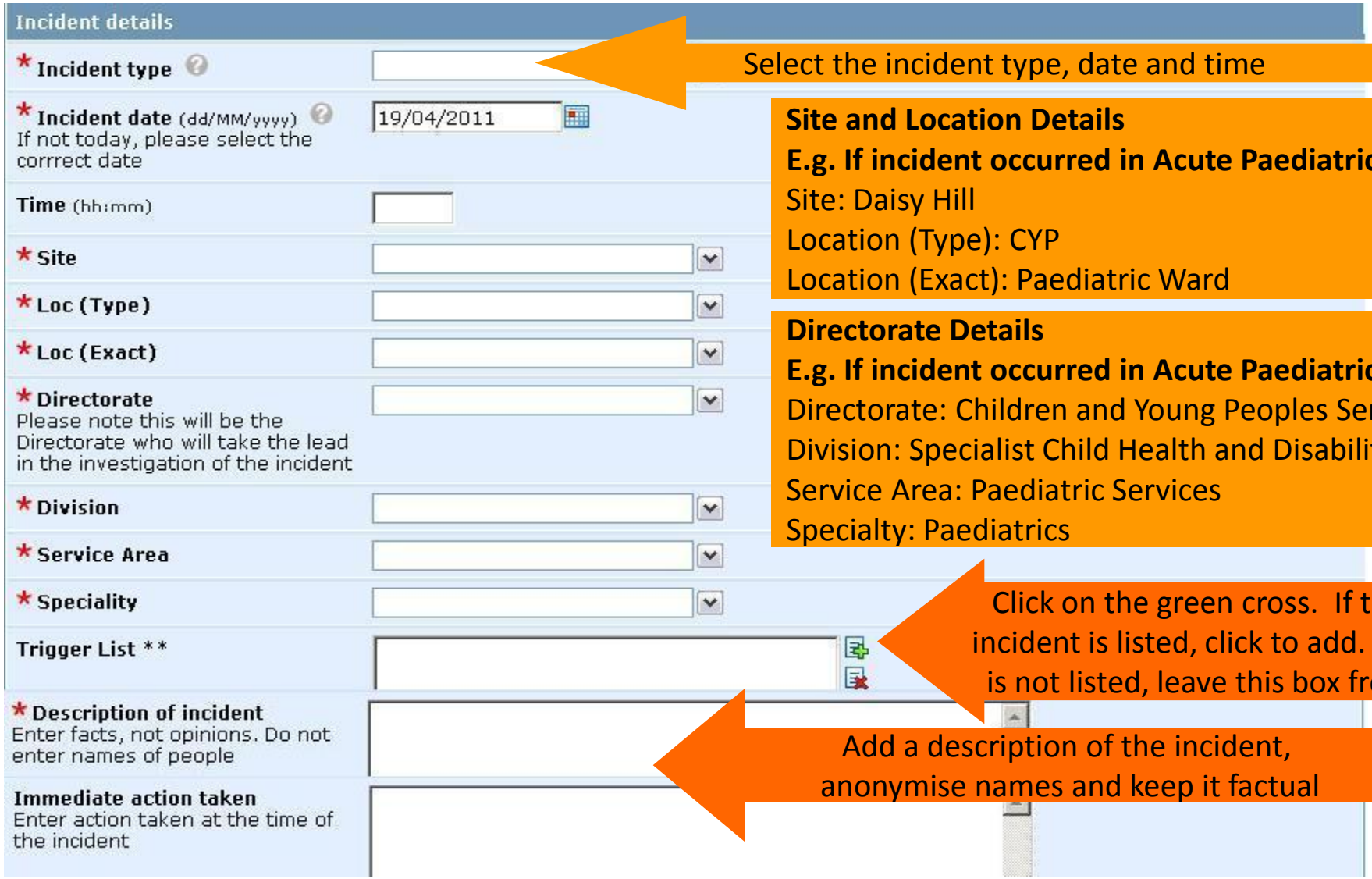
Person In Charge of Ward / Department at Time of Incident

* Person in charge of Ward / Department at time of incident	

Use this box to add in the details of the **person in charge** at the time of the incident

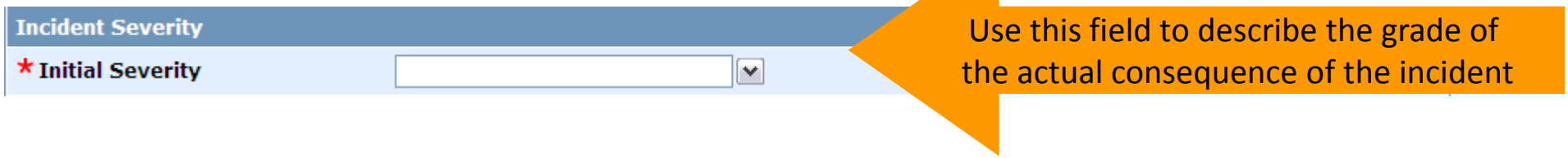
Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Incident Details, Location, Description and Action Taken

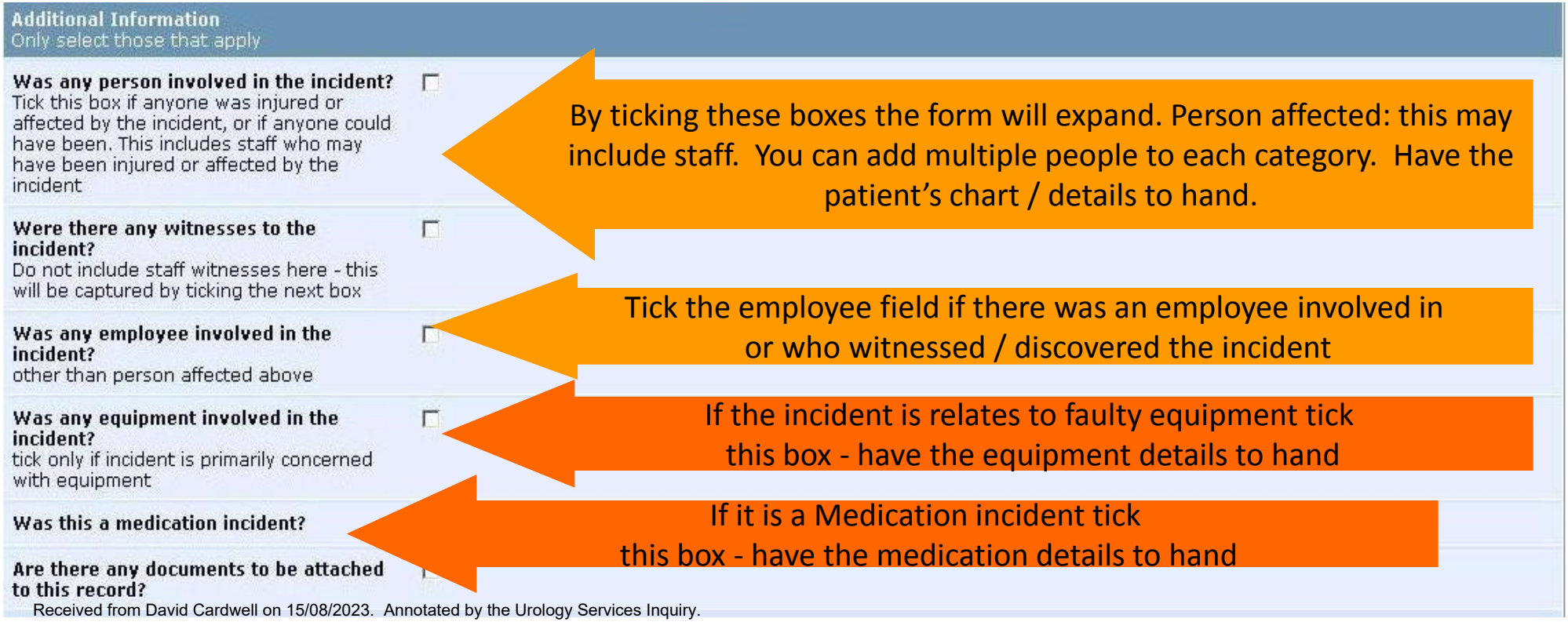


Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Severity



Tick Boxes: People Involved? Equipment? Medication?



Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Person(s) Affected

People Affected

Person Affected — Clear Section

Title	
First names	
* **Surname**	
Address if this is a member of staff please use work address here	
Postcode	
Telephone No:	
Mobile:	
E-mail	
H&C No/Hospital No HC No. should be used here with the exception of New Born	
MHA Section	
Ethnicity	
Language	
Date of birth (dd/MM/yyyy)	
Deceased?	
Date of death (dd/MM/yyyy) Fill this in for a patient who has died	
Staff No	
Was any injury apparent?	☐

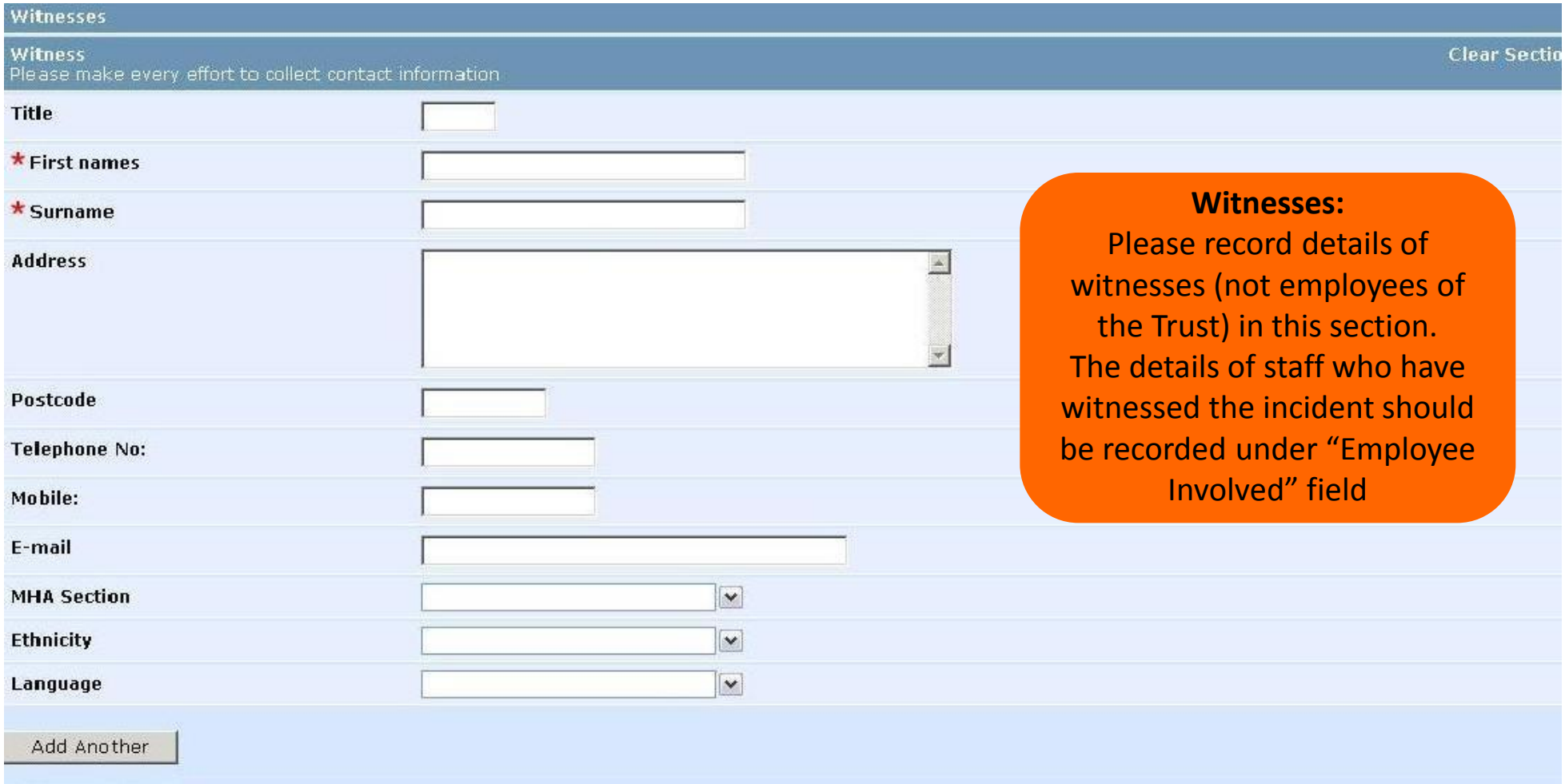
Add Another

Please complete all **relevant** fields in this section.

Always try to insert **H&C No**
(Exception: Twin Newborn Babies)
ROI patients will have a temporary H&C No.
If it is an incident affecting staff insert staff number in the field below instead

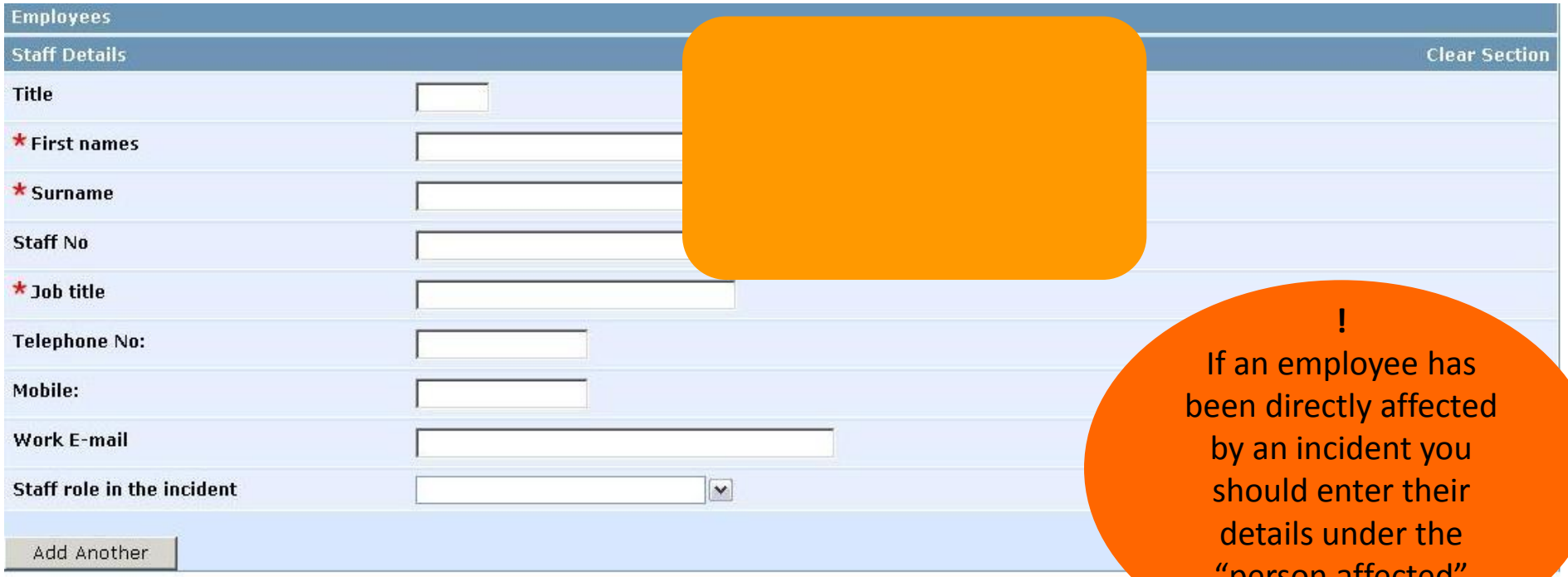
INJURY: Ticking this box will open up a section for you to select the injury type and body part. You can add multiple injuries

Witnesses



Witnesses:
Please record details of witnesses (not employees of the Trust) in this section.
The details of staff who have witnessed the incident should be recorded under “Employee Involved” field

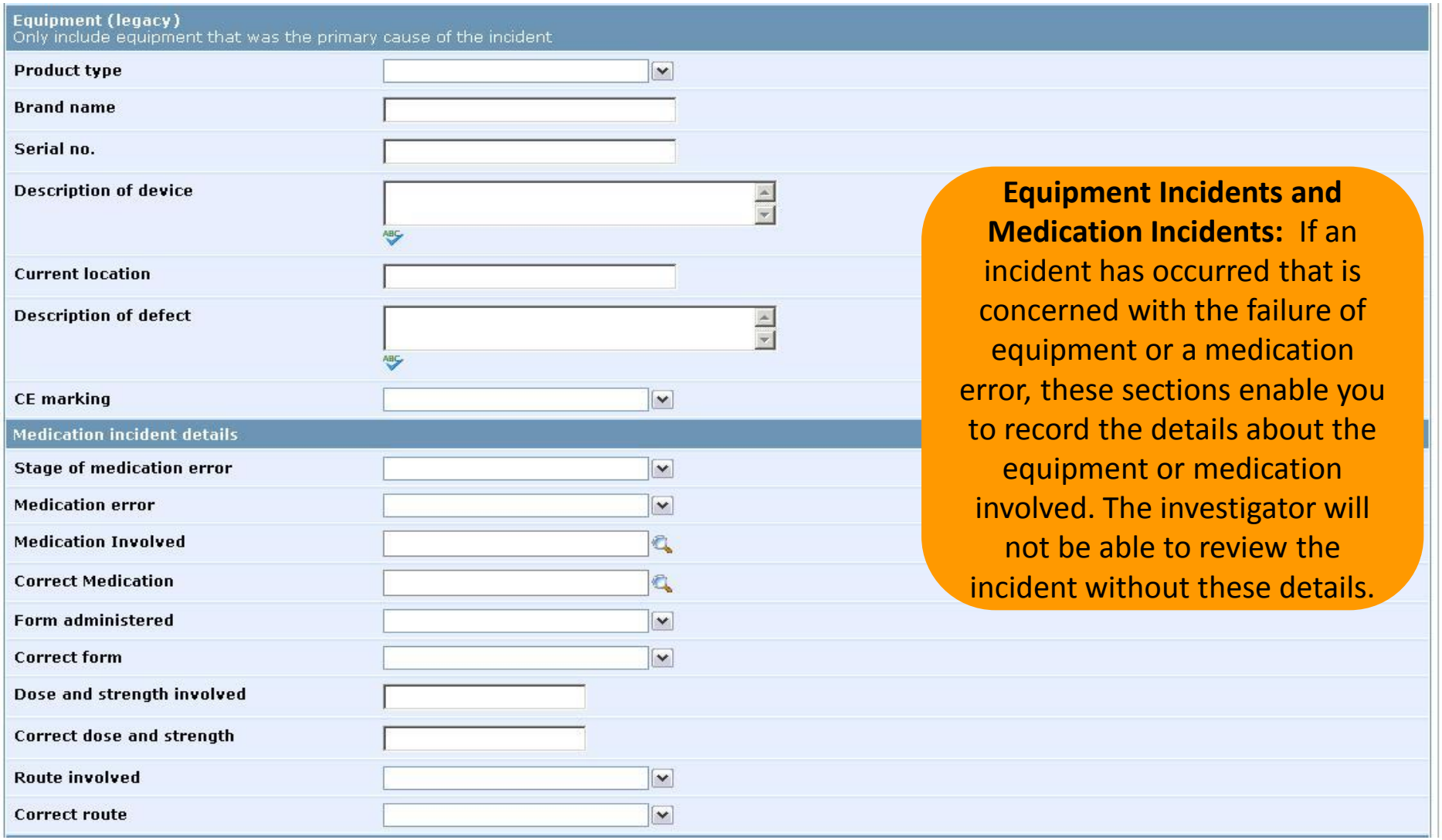
Employees Involved In the Incident



Attach Document

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Equipment and Medication



Equipment Incidents and Medication Incidents: If an incident has occurred that is concerned with the failure of equipment or a medication error, these sections enable you to record the details about the equipment or medication involved. The investigator will not be able to review the incident without these details.

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Feedback & Submit

All feedback is welcomed and will be used to inform implementation of Datix across all sites.

Thank you

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

ACUTE DIRECTORATE

Process for the Reporting of Serious Adverse Incidents (SAI) & Reporting Early Alerts – December 2017 update

When a Serious Adverse Incident (SAI) occurs:

1. **The Staff member, on becoming aware of the incident, must telephone their Line Manager who will notify their Head of Service, Assistant Director and Acute Governance Coordinator.**
   The Staff member must also immediately complete a Trust Adverse Incident Reporting Form (IR1) online via Datix Web.

*NB some incidents (e.g. high media profile incidents / homicide / inpatient suspected suicide etc. will require immediate meeting/conference call between AD/ Director/AMD/HoS/Governance Coordinator and subsequent contact with the Chief Executive's Office and Public Relations Department.

An adverse incident is defined as: "*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 a HSC organisation / Special Agency or commissioned service: The following regional criteria will determine whether or not an incident constitutes an SAI. This list is not exhaustive: (if in doubt report!)

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;

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

CONTACTs:

Acute Governance Coordinator: Trudy Reid
Tel: Personal Information redacted by the USI or Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

Medicine & Unscheduled Care:-
Anne McVey (Asst Dir): Personal Information redacted by the USI

Heads of Service
(HoS) Mary Burke: Personal Information redacted by the USI
(HoS) Kay Carroll: Personal Information redacted by the USI
(HoS) Katriona McGoldrick: Personal Information redacted by the USI
(HoS) Louise Devlin: Personal Information redacted by the USI

Surgery & Elective Care and Anaesthetics Theatres Intensive Care Services
Ronan Carroll (Asst Dir): Personal Information redacted by the USI

Heads of Service
(HoS) Martina Corrigan: Personal Information redacted by the USI
(HoS) Wendy Clayton: Personal Information redacted by the USI
(HoS) Brigeen Kelly: Personal Information redacted by the USI
HoS) Helena Murray (Personal Information redacted by the USI

Integrated Maternity & Womens Health and Cancer & Clinical Services:

Heather Trouton (Asst Dir): Personal Information redacted by the USI
Heads of Service.
(HoS) Patricia McStay: Personal Information redacted by the USI
(HoS) Geoff Kennedy: Personal Information redacted by the USI
(HoS) Fiona Reddick: Personal Information redacted by the USI
(HoS) Jeanette Robinson: 028

Function Services:
Anita Carroll (Asst Dir): Personal Information redacted by the USI

Pharmacy:
Dr Tracey Boyce (Asst. Dir) Personal Information redacted by the USI

2. EARLY ALERT PROCESS:

The decision about activating the DHSSPSNI/HSC BOARD "Early Alert"(EA) process will be **taken solely by the Director / Assistant Director** (*following discussion with the Governance Coordinator and Head of Service) in order to ensure that DHSSPSNI and/or the HSC Board are notified as appropriate. (The purpose of the Early Alert System is to ensure that the Trust notifies DHSSPSNI and HSC Board in a **timely way** of any issues that may require the attention of the Minister or the Chief Officers.

Current Regional Early Alert criteria are:

1. **RISK & WIDER HSC:** Urgent regional action is required by the DHSSPS e.g. where risk identified that could impact on the wider HSC service or systems.

2. **TRUST NEED TO CONTACT PATIENTS/CLIENTS re HARM/POTENTIAL HARM:** The Trust is going to contact a number of patients or clients about harm or possible harm that has occurred as result of care they received.

3. **TRUST TO ISSUE PRESS RELEASE RE HARM/POTENTIAL HARM:** The Trust is going to issue a press release about harm or potential harm to patients or clients (may relate to one patient or client)

4. **MEDIA ENQUIRY ABOUT EVENT:** The media have enquired about the event

5. **PSNI INVOLVED IN INVESTIGATION OR DEATH/SERIOUS HARM:** The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service (where there are concerns that a HSC service or practice issue whether by omission or commission may have contributed to or caused the death of a patient or client)
   (this **does not include any deaths routinely referred to the Coroner** unless there has been an event which has given rise to a Coroner's investigation; or evidence comes to light during Coroner's investigation or inquest which suggests possible harm was caused to patient as result of treatment or care they received or the coroner's inquest is likely to attract media interest.)

6. **IMMEDIATE SUPENSION OF STAFF** There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

7. **DEATH/SIGNIFICANT HARM – CHILDRENS SERVICES**
   a. Always notify the following
      - Death of or significant harm to a child, and abuse or neglect are known or suspected toe a factor;
      - Death of or significant harm to a Looked after Child or a child on the Child Protection Register;
      - Allegation that a child accommodated in a children's home has committed a serious offence;
      - Any serious complaint about a children's home or person working there.

3. ROLES & RESPONSIBILITIES

All Staff
Report the incident immediately & verbally to line management & also via Datix, after taking all immediate, appropriate, reasonable and proportionate actions to minimise the likelihood of the incident recurring. The situation must be made safe.

Assistant Director / Heads of Service via their Team Leaders / Ward & Facility Managers will ensure that:

- Ensure isolation & centralization of healthcare notes / all relevant documentation (if applicable). Original notes are to be sent to the Acute Governance Department, CAH.
- 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 or where CCTV can assist with immediate review of events e.g. AWOLs etc.
- Security staff and/or the PSNI should be informed immediately, where appropriate. PSNI advice should be followed until directed otherwise by them e.g. where they advise to cordon off a specific area/room etc. Staff should document the content of conversations/interaction with PSNI.
- Consideration should be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures).
- An immediate debrief is conducted and any staff support requirements are identified, offered and /or provided in a timely manner.(see Appendix 1)
- In liaison with the Governance Coordinator ensure that the SAI review is completed and a report is provided to the Director / Assistant Director for submitting to all relevant agencies where applicable e.g. RQIA/HSC Board/Coroner.
- Ensure that any SAI review action plan/recommendations are implemented & monitored and that any learning is disseminated appropriately. The HOS will provide regular updates to the relevant governance fora on the implementation of recommendations.

The Acute CSC Governance Office in liaison with the reporting staff member(s) / Head(s) of Service / Assistant Director / Director / AMD will:-

1. Notify Chief Executive's office and Communications Department *where appropriate.

2. Assist the Assistant Director / Director in reporting an Early Alert, if required.

3. Report the SAI to all relevant bodies within the required timescales via the Corporate Governance Office.

4. Coordinate **all stages** of the SAI review process including service user/family engagement and report compilation/submission process.

5. Maintain central coordination function between Acute and other departments/agencies e.g. Litigation Dept. (who process requests from coroner for statements/casenotes); Health & Safety Dept.; nominated PSNI liaison person etc.; HSCB/RQIA/DHSS. All communications with external agencies should be issued via the Governance Office.

6. Liaise with the Trust's Lead Social Worker for Adult Safeguarding, Professional Governance and external agencies where appropriate.

APPENDIX 1
ACUTE DIRECTORATE

Brief Guidance on supporting Acute staff during the respectful management and review of an adverse incident / serious adverse incident –

The Trust promotes an open, just, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed without fear of reprisal. This enables lessons to be identified; allows for 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 respectfully support staff during the adverse incident management and investigation/review process.

Staff Support
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 same.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident allowing sufficient time to do so. 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.
- Reaffirming confidence in staff and not apportioning blame or accountability either directly or inferred.
- Informing staff of the Directorate's processes in relation to incident investigation / review; keeping staff informed of likely next steps in that process; the rationale for same, and, informing staff of who they can contact for advice including the Acute Governance Office who coordinate all serious adverse incident reviews. In some circumstances staff may be required to prepare a statement as part of the incident investigation/review data gathering process. Where this is the case support for development of such statements may be provided by the Acute Governance Office, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Being visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an investigation/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, Inspire or Hospital Chaplains.
- For incidents involving Violence and Aggression, refer to the MOVA Guide to Post Incident Management Support, Reporting and Analysis.
- Providing feedback to staff at the different stages of an investigation/review and in particular in relation to the outcome(s) of incident investigations / reviews and any lessons learned.

USEFUL CONTACT NUMBERS
In addition to contacts within your operational team:

Name - Role	Contact Details
Trudy Reid (Acute Clinical & Social Care Governance Coordinator)	Personal Information redacted by the USI or Tel: Personal Information redacted by the USI
Temporary Manager: Judith Cunningham (Litigation Department)	Personal Information redacted by the USI or Personal Information redacted by the USI
Carmel Harney (Assistant Director AHP Governance, Workforce Development & Training)	Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Margaret Marshall Assistant Director for Nursing Governance)	Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Lynn Fee (Assistant Director of Nursing Workforce Development & Training)	Personal Information redacted by the USI or Tel: Personal Information redacted by the USI
Francesca Leyden,(Assistant Director of Social Work Governance, Workforce Development & Training)	Personal Information redacted by the USI Tel: Personal Information redacted by the USI
SHSCT Security Manager Paul Chapman, CAH.	Personal Information redacted by the USI
SHSCT Communications Department	Head of Communications Ruth Rogers Personal Information redacted by the USI Jane McKimm Personal Information redacted by the USI
Ray King Head of Health & Safety SHSCT	Personal Information redacted by the USI
Victim Support Northern Ireland	028 9024 4039 or 0845 3030 900
Citizens Advice Bureau	028 9023 1120
Community Safety Unit	028 9082 8555
Lifeline	0808 808 8000
Samaritans	116 123
The Compensation Agency	028 9024 9944
Law Society of Northern Ireland	028 9023 1614
Trade Union Side Office, Newry	028 3083 5166
Catriona Campbell - Occupational Health –	Personal Information redacted by the USI
Management of Violence & Aggression (MOVA) Specialist Advisors for MHD - Eamonn Hughes / Margaret Tierney	Personal Information redacted by the USI
Anne Coyle – Bereavement Co-ordinator	Personal Information redacted by the USI or Personal Information redacted by the USI

APPENDIX 2
ACUTE DIRECTORATE

Brief Guidance on the Role and Responsibilities of an SAI Review Independent Chairperson -

The Acute Directorate will request the assistance the Medical Director to regionally request an independent chair for SAI review. 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 main responsibilities of the review Chairperson are:

1.0 Prior to the Review:

1.1 liaising with the Acute Governance Coordinator to agree the SAI Review Team Membership ensuring that the process involves all relevant members of the MDT, staff who were involved in the incident, any member of staff with specialist knowledge considered appropriate and, where appropriate, involve services users/family members and other external agencies/stakeholders in the review process.

1.2 reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident.

2.0 During the Review

2.1 at the outset of the review explain the rationale for same including the requirement by Trusts to have in place systems/processes to review practice.

2.2 ensuring that all attendees at the review are introduced to each other and are aware of their role.

2.3 facilitating a process that is conducive to learning and analysis without interference from personal disagreements, criticisms, perceptions or dissatisfaction.

2.4 ensuring that the review is open, fair and participative and focuses on systems and processes rather than on a punitive approach aimed at individual performance.

2.5 ensure that participants in the review are supported / offered time-out as required / appropriate. The chair should also remind participants about further sources of support as needed, such as Inspire, Line managers etc. and reference/direct staff to the "*Acute Brief Guidance on supporting Acute staff during the respectful management and review of an adverse incident / serious adverse incident*" (see Appendix 1).

2.6 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. Refer to the review meeting agenda template below (Appendix 3). and incident investigation guidance. (Appendix 4).

2.7 concluding the review meeting when all matters have been attended to and summarise the conclusions and recommendations (if any).

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 all relevant stakeholders 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 the report being sent to the AMD / Assistant Director / Director.

3.2 If there are queries / comments raised by the AMD / Assistant Director/ Director following their perusal of the draft report, the Chair should consider these and reconvene the review team if necessary to address same.

3.3 reporting practices, systems or other issues which the review team feel require immediate attention to the relevant Assistant Director, Head of Service and Associate Medical Director where appropriate. Chairs should also be mindful of their responsibility to report any serious concerns identified in relation to a doctor to the Trust Medical Director / Responsible Officer.

3.4 where required and when appropriate, meet with patients/relatives/carers to discuss the findings of the review team after approval by the Trust SMT and within the parameters of the Data Protection Act, supported by the Governance Coordinator and relevant senior operational staff.

The most important qualities of a good Chairperson are impartiality, firmness, tact, diligence, courtesy, patience and common sense.

APPENDIX 3

ACUTE DIRECTORATE

Suggested Format of Adverse & Serious Adverse Incident Review Meetings –

Note incident investigations may vary depending upon the type of incident and the degree of severity. Therefore this template may be adapted in order to suit both the specialist nature of the incident and the specific requirements of the Trust.

1. Introduction

Brief outline of the purpose of the review meeting.

2. Note of Methodology for Investigation

e.g. Review of patient / service user records (if relevant), Review of staff / witness statements (if available).

3. Analysis / Summary of Incident/Case

A summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events:

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

OR

If Root Cause Analysis is Used:

i) Care Delivery Problems (CDP) *E.g. problem related to the direct provision of care, usually actions or omissions by staff e.g. failure to monitor, observe or act; incorrect decision, NOT seeking help when necessary.*

ii) Service Delivery Problems (SDP).*e.g. acts and omissions not associated with direct care provision. e.g. failure to undertake risk assessment, equipment failure, lack of guidance.*

Ii) Contributory Factors for each CDP of SDP identified: e.g.: factors may include: Individual/Staff, Team and Social, Communication, Task, Education & Training, Equipment and Resource, Working Conditions, Organisational and Management, Patient / Client.

4. Conclusions

List of issues that need to be addressed (if required) Discussion of good practice identified. Where appropriate include details of any ongoing engagement / contact with family members or carers.

5. Recommendations

List of improvement strategies or recommendations for addressing the issues above (if required)

- Local recommendations
- Regional recommendations
- National recommendations

6. Learning

Identify to whom learning should be communicated.

Reference: Review of Procedure for the reporting and follow-up of SAI's HSC 2016

APPENDIX 4
ACUTE DIRECTORATE

Acute Brief Incident Investigation Guidance.

A key principle of the CSC governance framework is that incidents are investigated and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident investigation process 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? Investigations need to be undertaken in a proportionate, non-threatening manner to identify the root causes of the event.

Although there will be some incidents which require investigation using methodologies as contained within e.g. individual agency reviews, adult safeguarding investigations, health & safety investigations, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) root cause analysis tools. Nonetheless all incident investigations 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 investigation techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Office on Tel [redacted] or emailing Trudy.reid[redacted] visiting the NPSA RCA toolkit Resource.

Divisional Screening - DATE
In attendance:

Department		Type	Patient details	Background	Screening update	Attachments
SAI Reports Completed						
Any Other Business						

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

SCREENING TEMPLATE
HCN:

Directorate:	
Reporting Division:	
Date of Incident:	
Date of Screening	
Incident (IR1) ID:	
Grade of Incident:	
Screening Team:	
Summary of Incident	
Summary of Discussions	
Level and Type of Review	
Review Team	

APPENDIX 1
Revised November 2016 (Version 1.1)

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE**:
3. HOSPITAL / FACILTY / COMMUNITY LOCATION:	**4. DATE OF INCIDENT**:
5. DEPARTMENT / WARD / LOCATION EXACT:	
6. CONTACT PERSON:	**7. PROGRAMME OF CARE**: Acute

8. DESCRIPTION OF INCIDENT:

DOB: **GENDER**: **AGE**:
(complete where relevant)

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	x	

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE:	DETAIL:	ADVERSE EVENT:

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE: -

11. CURRENT CONDITION OF SERVICE USER:

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*			
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*			

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	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM	
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 <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: *(please select)*		NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?		DATE INFORMED: DD/MM/YY
	NO	*specify reason:* To be informed when review team meet

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*		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)		

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM		
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	
* 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:		
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: Irrelevant information redacted by the USI
and (*where relevant*) Irrelevant information redacted by the USI

Information Sessions

The management of Incidents, Risks and Complaints

Aim of Sessions: To ensure staff are aware of their roles and responsibilities in relation to the management of incidents, risks and complaints.

DATE	TIME	VENUE
Tuesday 25 September 2012	2.30pm - 3.30pm	Tutorial Room 1 Craigavon Area Hospital
Wednesday 3 October 2012	11.00am -12.00 noon	Lecture Theatre South Tyrone Hospital
Wednesday 10 October 2012	2.30pm – 3.30pm	Committee Room 1 Daisy Hill Hospital
Tuesday 16 October 2012	2.30pm – 3.30pm	Board Room, Ground Floor Craigavon Area Hospital
Tuesday 6 November 2012	11.00am - 12.00 noon	Board Room, Ground Floor Craigavon Area Hospital
Tuesday 13 November 2012	11.00am – 12.00 noon	Committee Room 1 Daisy Hill Hospital
Wednesday 14 November 2012	11.00am – 12 noon	Lecture Theatre South Tyrone Hospital
Monday 3 December 2012	3.00pm – 4.00pm	Board Room, Ground Floor Craigavon Area Hospital
Wednesday 12 December 2012	11.00am – 12.00 noon	Board Room Daisy Hill Hospital

Information Sessions open to all levels of staff.

Please contact Roisin Farrell on [redacted] or email [redacted]
Pamela Truesdale [redacted] or email [redacted] to book your place.

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Information Sessions

Governance within the Acute Setting

Aim of Sessions: To ensure staff are aware of their roles and responsibilities in relation to the management of incidents, risks and complaints.

DATE	TIME	VENUE
Thursday 7 February 2013	3.30 pm	Boardroom, Daisy Hill Hospital
Monday 11 February 2013	10.30 am	Lecture Theatre, South Tyrone Hospital
Monday 25 February 2013	9.30 am	Boardroom, Craigavon Area Hospital
Friday 1 March 2013	2.15 pm	Boardroom, Daisy Hill Hospital
Monday 4 March 2013	10.30 am	Lecture Theatre, South Tyrone Hospital
Thursday 14 March 2013	9.00 am	Lecture Theatre, Craigavon Area Hospital
Tuesday 19 March 2013	9.30 am	Committee Room 1, Daisy Hill Hospital
Thursday 11 April 2013	2.30 pm	Lecture Theatre, South Tyrone Hospital
Wednesday 17 April 2013	10.30 am	Boardroom, Craigavon Area Hospital
Wednesday 24 April 2013	10.00 am	Boardroom, Daisy Hill Hospital
Thursday 30 April 2013	3.15 pm	Lecture Theatre, South Tyrone Hospital

Information Sessions open to all levels of staff who work within Acute Services.

Please contact Pamela Truesdale on Personal Information redacted by the USI or by email at Personal Information redacted by the USI to book your place.

Information Sessions

Governance within the Acute Setting

Aim of Sessions: To ensure staff are aware of their roles and responsibilities in relation to the management of incidents, risks and complaints.

DATE	TIME	VENUE
Monday 10 June 2013	15.15	Boardroom, CAH
Monday 17 June 2013	09.45	Boardroom, DHH
Tuesday 2 July 2013	10.15	Boardroom, CAH
Wednesday 17 July 2013	09.45	Boardroom, DHH
Friday 9 August 2013	15.15	Boardroom, DHH
Tuesday 20 August 2013	15.15	Boardroom, CAH
Wednesday 11 September 2013	10.15	Boardroom, CAH
Friday 13 September 2013	09.45	Boardroom, DHH
Monday 7 October 2013	09.45	Boardroom, DHH
Friday 25 October 2013	15.15	Boardroom, CAH
Thursday 7 November 2013	09.45	Boardroom, DHH
Monday 11 November 2013	10.15	Boardroom, CAH
Wednesday 4 December 2013	10.15	Boardroom, CAH
Tuesday 10 December 2013	15.15	Boardroom, DHH

Information Sessions open to all levels of staff who work within Acute Services.

Please contact Pamela Truesdale on Personal Information redacted by the USI or by email at Personal Information redacted by the USI to book your place.

Incidents, Risks and Complaints

What do they mean for you and your team??

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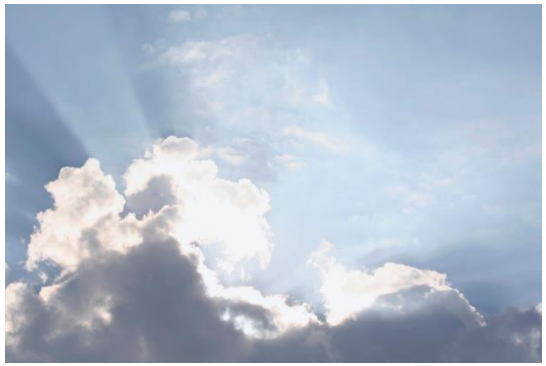
Quality Care - for you, with you

Learning outcomes

At the end of the session you will know:

- What clinical and social care governance entails.
- What your responsibility is in relation to risk, how to identify a risk within your area and have an aware of the system in place to manage them.
- What constitutes an incident and how to report one.
- Why it is important to have a complaints process, how you can de-escalate them and when things have gone wrong, say sorry.

Elements of Session



[redacted]

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Clinical and Social Care Governance

The framework through which organisations are accountable for..

- continuously improving the quality of their services
- safeguarding high standards of care by creating an environment in which excellence in healthcare will flourish

Quality at the heart

- Quality is a fundamental goal in healthcare provision, protecting the patients, clinicians, and the reputation of the organisation.

- Quality services can reduce the levels of human distress, professional stress and the drain on valuable resources arising from clinical negligence or systematic error

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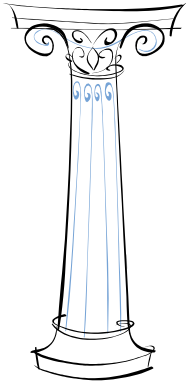
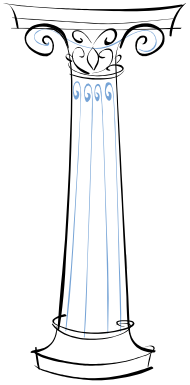
3 Pillars of Governance

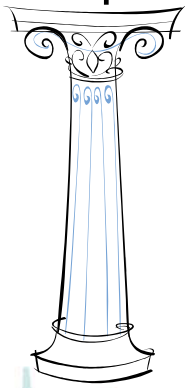
Patient Safety



Clinical Effectiveness



[redacted] Patient Experience



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Patient Safety

- Incident Management
- Risk Management
- Alerting System
- Waste Management
- Medicines Management
- Safe Environment
- Safeguarding

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Clinical Effectiveness

- Cost Effectiveness
- Clinical Guidelines
- NICE Guidelines
- Evidence-based Practice
- Care Pathways
- Clinical Audits
- Policy Development
- Information Governance
- Staff Management
- Education and Training
- Equality and Diversity

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Patient Experience

Complaints Management
Consent
Nutrition and Hydration
Patient centred care
Patient Information
Patient Involvement
Patient Needs/Choice

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Risk Assessment & Risk Register Processes

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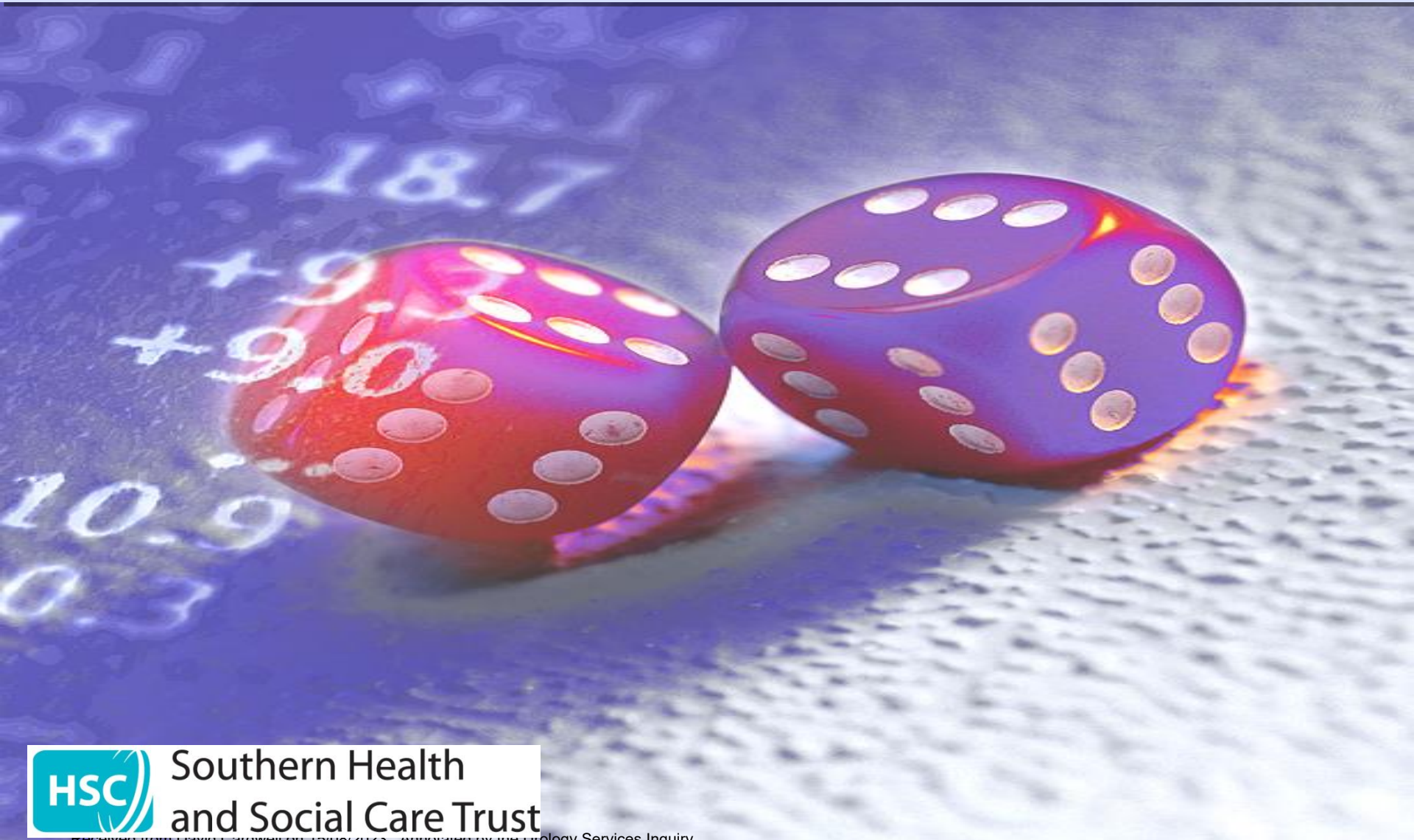
Risk Management requires good systems……



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…and risk awareness!!

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What is Risk?

The likelihood of a substance, activity or process to cause harm

[redacted]

Risk Management – *Basic Concepts*

- Risk management is everyone's business
- It is a continuous and developing process that needs to be embedded within individual teams as well as the organisation's culture.
- The focus of good risk management processes is to effectively *identify* and *treat* risk

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The management of risk / safety is just about common sense……

but common sense is not so common!

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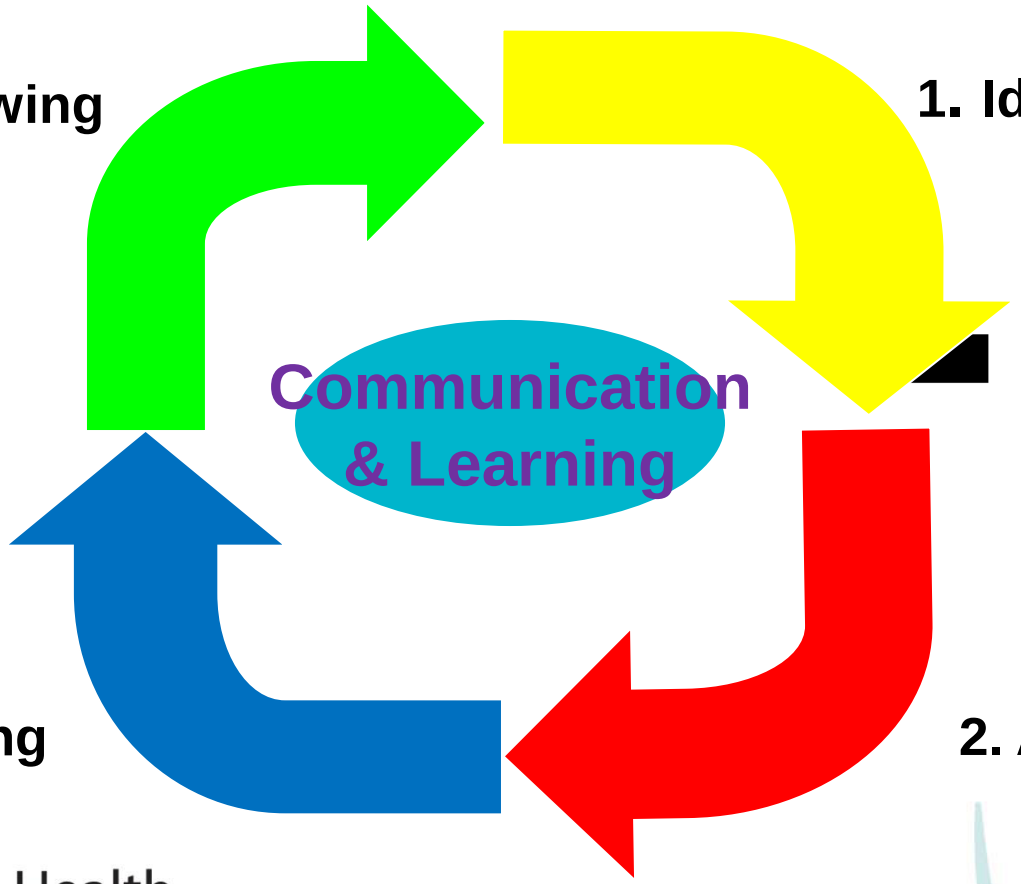
Voltaire

The Risk Management Process

Risk Environment / Risk Context



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Risk Management Model, 2002

Identifying Risk?

- How do you identify risk?
- Where do you discuss/review risk?
- Who do you discuss risks with?
- Who reviews your risk register?

[redacted]

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Assessing Risk

- Perceptions vary between individuals and groups, one persons high risk is another's low risk.

- Consider the following 6 activities and rate them in order of perceived risk

1 = highest 6 = lowest

A. Riding a motorcycle
B Buying a second hand car
C. Bungee jumping
D. Taking part in a clinical medication trial
E. Starting your own business using your own home as security

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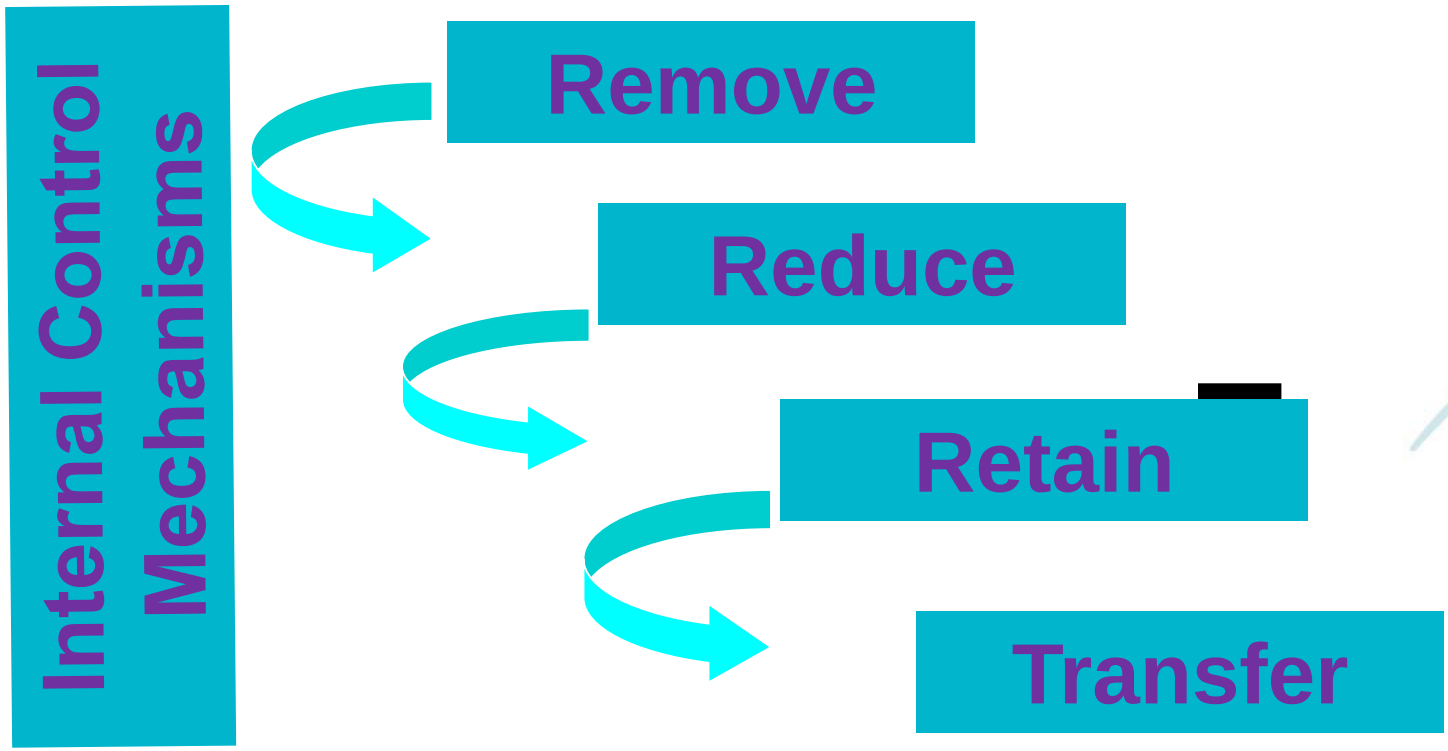
Addressing Risk



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Reviewing Risk

-

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Processes for the Management of Risk

[redacted]

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Risk Register – *What is it?*

- A tool that enables your team to understand risks within your area

- A ‘dynamic’ and ‘living’ document which enables risk to be quantified and ranked.

- Can be either proactive or reactive.

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APPENDIX 1 – TRUST RISK ASSESSMENT

SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM		Risk ID No
Directorate:	Facility/Department/Team:	Date:
Where is this being carried out? (e.g. Trust premises/home of client/staff/ private nursing home etc)	Objective(s) i.e. Corporate, Legislative requirements etc.:	

Risk Title: (Threat to achievement of objective)

Outline the potential for harm: *(Consider injury to client, staff, litigation, etc)*

Description of Risk:
(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)

Summary of current control measures: (Consider equipment, training, environment, policy/procedure, training, documentation, information - this list is not exhaustive).

Are these controls: (a) Effective or (b) Require Further Action *(if [b], complete Action Plan)*

Please list control measures considered but discounted and why (where appropriate):

Assessment of Risk	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)

ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):

Action/Treatment	Action Lead	Start Date	Target Date	Progress/Review Date
Date of first review (to be determined by risk rating)				

Predicted Risk Assessment once all control measures are implemented	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)

ANTICIPATED RESOURCE IMPLICATIONS (details and cost)				£
None				
Funding identified?	Yes	No	N/A	Source of funding

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

LIKELIHOOD	CONSEQUENCE (POTENTIAL IMPACT)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
(5) Almost Certain (will undoubtedly recur, a persistent issue) 1:10	**5**	**10**	**15**	**20**	**25**
(4) Likely (will probably recur, not a persistent issue) 1:100	**4**	**8**	**12**	**16**	**20**
(3) Possible (may recur occasionally) 1:1,000	**3**	**6**	**9**	**12**	**15**
(2) Unlikely (do not expect it to happen again) 1:10,000	**2**	**4**	**6**	**8**	**10**
(1) Rare (can't believe it will ever happen again) 1:100,000	**1**	**2**	**3**	**4**	**5**

What informs our Risk Registers?

Internal

- Complaints
- Incidents/SAIs
- Audit/Inspections
- Organisational objectives
- Risk assessments

External

- RQIA
- External reports
- Benchmarking
- Targets
- Outcomes of SAIs

Benefits of a Risk Register

- Helps to identify risk priorities
- Formally records risks and how you manage them
- Allows all of those concerned with risk management to see the overall risk profile and how their areas of responsibility fit [redacted] it
- Facilitates the review and monitoring of risks.

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Who handles the risk?

Risk level	Action level
	Directorate and/or corporate level
	Divisional or directorate level
	Department/team /facility level
	Department/team /facility level

Risk or incident

Risk

- Should be proactive rather than
- Prevention
- Anticipation

Incident

- Reactive
- [redacted]
- Has happened – can no longer be prevented

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Incidents and associated reporting procedures

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What is an incident?

Any event that has given or may give rise to actual or possible personal injury, to patient/client dissatisfaction or to property loss or damage

[redacted]

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What is a near miss?

Any event that did not lead to personal harm but could have, an occurrence which but for luck or good management would in all probability have become a fully blown incident.

[redacted]

Note – should be reported using the IR1 form.

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Who/what suffers from incidents and/or near misses?

- Quality of service
- People
- Resources
- Reputations

[redacted]

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What is your role and responsibility?

- Report incidents and near misses
- Report concerns/risks
- Complete IR1 form electronically
- Maintain confidentiality [redacted]
- Aware of professional standards and legal responsibilities
- Deliver safe care
- Be familiar with Trust policies/procedures

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Top 5 incidents for Directorate

(1 April 2012 to 31 March 2013
Total 4637 Incidents in Acute Services Directorate

Fall from a height, bed or chair	406
Verbal abuse or disruption	293
Fall on level ground	251
Omitted/delayed medicine or dose	216
Physical abuse, assault or violence	211

IR1 form

1. If Datix does not already appear on your desktop as a White with Orange ICON
2. Open the Trust's Intranet Site.
3. Click on Useful Links
4. Scroll down to Sothern Trust Datix.
5. Click Datix Incident Reporting Form
6. Right click on the blue part of the form and create a shortcut to your desktop

Guidance on how to complete the form can be accessed by clicking on the user guide.

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[redacted]

We all have a responsibility..

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Risk/hazard/near miss/incident

An unsheathed needle lying on the floor is a ….

The….. Is that someone receives a needlestick injury

Needle picked up and placed in sharps box without injury is a …….

Someone picks up the needle and injures themselves is an…….

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Understanding Complaints, their de-escalation and saying sorry

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Beliefs about Complaints!

What do you think?

[redacted]

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What is a Complaint?

Definition:

"Any expression of dissatisfaction which requires a response"

(HSC Complaints Procedure 2009)

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Expectations

- To voice their concerns and to be listened to
- An explanation and an apology (if appropriate)
- An assurance that their experience will not happen again [redacted]
- A report of action taken as a result of their complaint.

Why people complain

(1 April 2012 to 31 March 2013)
Total 551 Formal Complaints in Acute Services Directorate

Treatment and care quality	133
Staff attitude/behaviour	85
Communication/information to patients	
Appointments, delay/cancellation (outpatients)	
Professional assessment of need	

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Overarching Objectives of the HSC Complaints Procedure

Listening

Learning

Improving

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What does the HSC Procedure cover?

- Complaints about care or treatment in the Trust, Health Board and Family Practitioner Services settings.

What does it NOT Cover?

- Private care / treatment or services

- Issues covered by other processes
  e.g.
  - -Staff grievances, disciplinaries or Investigation by professional and regulatory bodies or an independent inquiry
  - -Freedom of Information and Data Protection Act requests
  - -Child Protection and Children Order Complaints
  - -Protection of Vulnerable Adults
  - -Criminal investigations or litigation

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Why do Complaints Matter?

- To the Organisation:

- Identify risks
- Learn lessons
- Improve services
- Reputation
- Make case for more resources

- To the Service User:

- Public accountability
- Restore confidence
- Address negative feelings
- Closure [redacted]
- Improvement
- Valued / worthwhile

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Role of Ombudsman

- Deals with complaints from people who believe they have suffered injustice as a result of **maladministration** by government departments and public offices in Northern Ireland
- Completely Independent Body & External to HSC [redacted]

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Patient Support Service

- Based in Front Foyer
- Craigavon Area Hospital
- Edel Corr and Paula McAloran
- Telephone Number **3861 2395/4285**

Act as patient advocate to deal with inpatient issues at ward/department level.

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De-escalation

Turning a challenge into an opportunity

Many of us have to deal with unhappy patients/relatives as part of our roles and it's never easy. But, if we know what to say and, more importantly, how to say it, we may be able to save the situation.

In fact, we can even end up with a better relationship with our patient/relatives than we had before.

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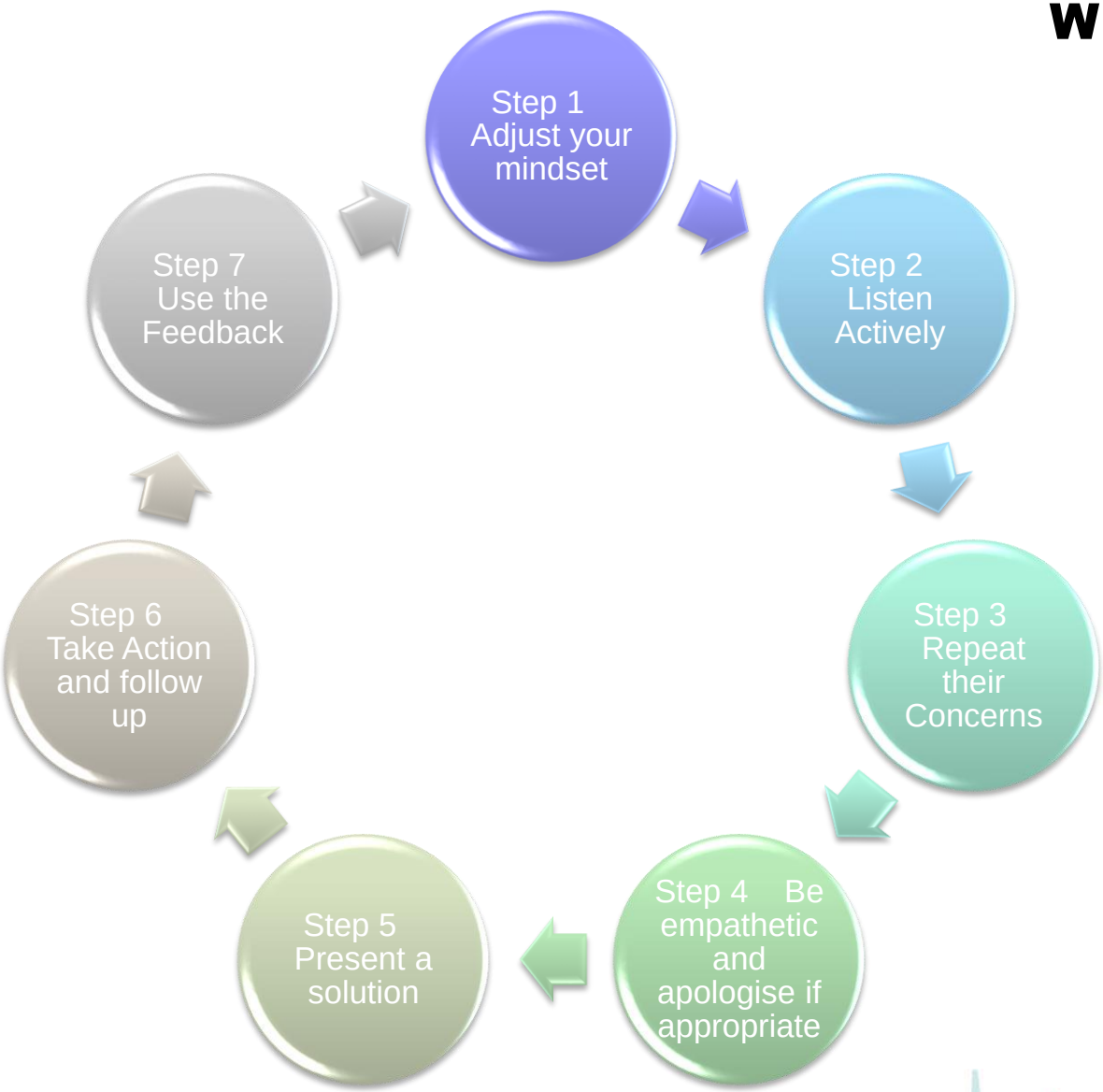

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Do's and Don'ts

Be honest	Avoid Issues
Empathise	Patronise
Identify issues	Use Jargon
Continue with care provision	Be distracted [redacted]
Treat issues seriously	Inappropriate humour
Accept that you may not be able to resolve	Make unreasonable promises

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Saying Sorry

- Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, apology.

- You must not allow a patients complaint to affect a[redacted]ersely the care or treatment you provide or arrange.

GMC Good Practice Guidance (2006)

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What is an apology? – make it meaningful

- An apology means accepting that something has been wrong and taking responsibility for it.
- It can be defined as a 'regretful acknowledgement of an offence or failure.'
- The most appropriate form and method of communicating an apology will depend on the circumstances of a particular case.
- Cleary explain why the failure happened and include that it was not intentional.
- Demonstrate that you are sincerely sorry.
- Assure the complainant that you will not repeat the failure.
- Provide the complainant with a statement of the action taken.
- The timing of an apology is critical to getting it right. It is also important that the correct person is apologised to.

NI Ombudsman (Rights, Responsibilities and Redress)
A framework for effective complaint handling 2009

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Staff Support & Feedback

- Staff should be supported throughout the process
- Given feedback on outcome of investigation
- ‘Need to Know Guide for Staff’

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Finally!

[redacted]

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Can you?

- Define what is clinical and social care governance.
- Outline your responsibility is in relation to risk, know how to identify a risk and have an understanding of the system in place to manage them.
- Understand what constitutes an incident and how to report one.
- Say why it is important to have a complaints process, what your role is in de-escalation and when things have gone wrong, say sorry.

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Questions & Contacts

For more information or to contact a member of the Directorate of Acute Services, Governance Team, please telephone Personal Information redacted by the USI or Personal Information redacted by the USI

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Trudy Reid, Acute Services Clinical & Social Care Governance Co-Ordinator
David Cardwell, Acute Services Senior Governance Officer

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Learning outcomes

At the end of the session you will know:

- What clinical and social care governance entails.
- What constitutes an incident and how to report one
- What your responsibility is in relation to risk, how t[redacted]entify a risk within your area and have an awareness of the system in place to manage them.
- Why it is important to have a complaints process, how you can de-escalate them at ward level and when things have gone wrong, say sorry.

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Clinical and Social Care Governance

The framework through which organisations are accountable for..

- continuously improving the quality of their services
- safeguarding high standards of care by creating an environment in which excellence in healthcare will flourish

Quality at the heart

- Quality is a fundamental goal in healthcare provision, protecting the patients, clinicians, and the reputation of the organisation.

- Quality services can reduce the levels of human distress, professional stress and the drain on valuable resources arising from clinical negligence or systematic error

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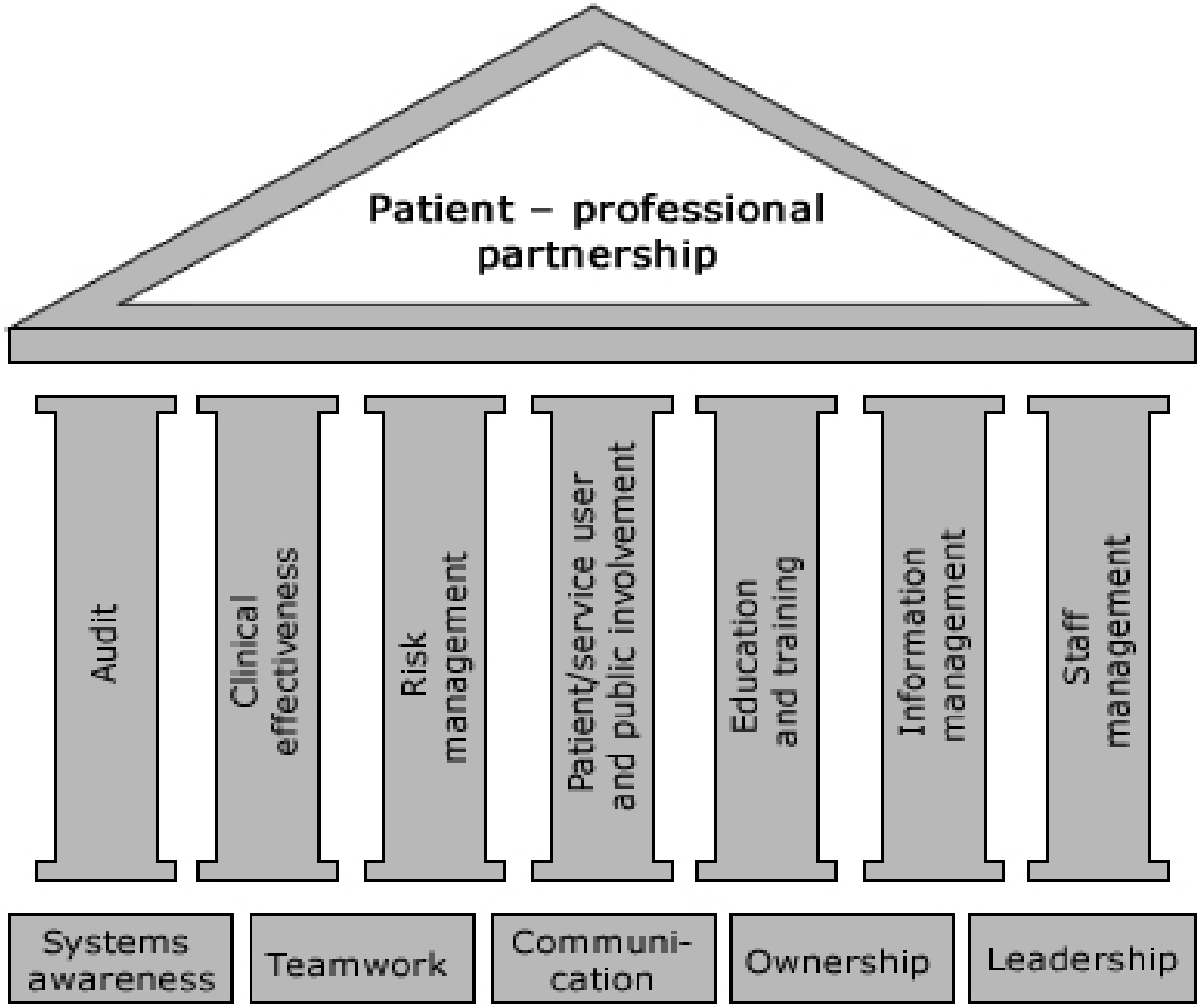

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Risk Management

is about minimising risks to patients by:

- identifying what can and does go wrong during care
- understanding the factors that influence this
- learning lessons from any adverse events
- ensuring action is taken to prevent recurrence
- putting systems in place to reduce risks

Clinical audit

- is a way that doctors, nurses and other healthcare professionals can measure the quality of the care they offer. It allows them to compare their performance against a standard to see how they are doing and identify opportunities for improvement. Changes can then be made, followed by further audits to see if these changes have been successful. Nursing NQI's etc
- As well as individual audits carried out by individual members of staff, SHSCT participates in national audits including those of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and other national and international audit.
- Benchmarking –CHKS is a leading provider of healthcare intelligence and quality improvement services

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Education, training and continuing professional development

- It is vital that staff caring for patients have the knowledge and skills they need to do a good job. It is for that reason that you are given opportunities to update your skills to keep up with the latest developments as well as learn new skills through courses, study days, practice based and self directed learning
- CPD is essential
- Revalidation

Evidence-based care and effectiveness

- Care for patients should be based on good quality evidence from research.
- The National Institute for Health and Clinical Excellence (NICE) is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
- At SHSCT Clinical Effectiveness Manager monitors & works with clinical teams to give assurances regarding the Trust's compliance with NICE guidance.

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Staffing and staff management

- Staffing and staff management is vital to our ability to provide high-quality care. We need to have highly skilled staff, working in an efficient team and in a well supported environment.

Patient and Carer experience and involvement

- If the Trust is to offer the highest quality care it is important that we work in partnership with patients and carers. This includes gaining a better understanding of the priorities and concerns of those who use our services by involving them in our work, including our policy and planning.

- One way we gain the views of patients and carer's is through our patient and public partnership and patient and public involvement work streams. 10,000 Voices.

- We also monitor the views of patients through the complaints and compliments received by the Patient Services Department and contacts with the Patient Support Team

Incidents and associated reporting procedures

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What is an incident?

Any event that has given or may give rise to actual or possible personal injury, to patient/client dissatisfaction or to property loss or damage

[redacted]

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What is a near miss?

Any event that did not lead to personal harm but could have, an occurrence which but for luck or good management would in all probability have become a fully blown incident.

[redacted]

Note – should be reported using the IR1 form.

Who/what suffers from incidents and/or near misses?

- People
- Quality of service
- [redacted]
- Resources
- Reputations

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What is your role and responsibility?

- Deliver safe care
- Aware of professional standards and legal responsibilities
- Be familiar with Trust policies/procedures
- Maintain confidentiality [redacted]
- Report incidents and near misses
- Report concerns/risks
- Complete IR1 form electronically

Top 5 incidents for Directorate

(1 April 2015 to 31 March 2016)
Total 5662 Incidents in Acute Services Directorate

Fall on height, bed or chair	461
Fall on level ground	367
Absconder	262
Omitted and delayed medications	240
Delay in treatment	219

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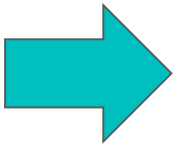
IR1 form

To access the Southern Trust's Electronic Incident Reporting form:

1. Open the Trust's Intranet Site.
2. Click on Useful Links  Other Useful Links
3. Scroll down to Datix. Click Datix Incident Reporti[redacted]Form

Guidance on how to complete the form can be accessed by clicking on the user guide.

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LIKELIHOOD	CONSEQUENCE (POTENTIAL IMPACT)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
(5) Almost Certain (will undoubtedly recur, a persistent issue) 1:10	**5**	**10**	**15**	**20**	**25**
(4) Likely (will probably recur, not a persistent issue) 1:100	**4**	**8**	**12**	**16**	**20**
(3) Possible (may recur occasionally) 1:1,000	**3**	**6**	**9**	**12**	**15**
(2) Unlikely (do not expect it to happen again) 1:10,000	**2**	**4**	**6**	**8**	**10**
(1) Rare (can't believe it will ever happen again) 1:100,000	**1**	**2**	**3**	**4**	**5**

[redacted]

We all have a responsibility..

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Risk Management

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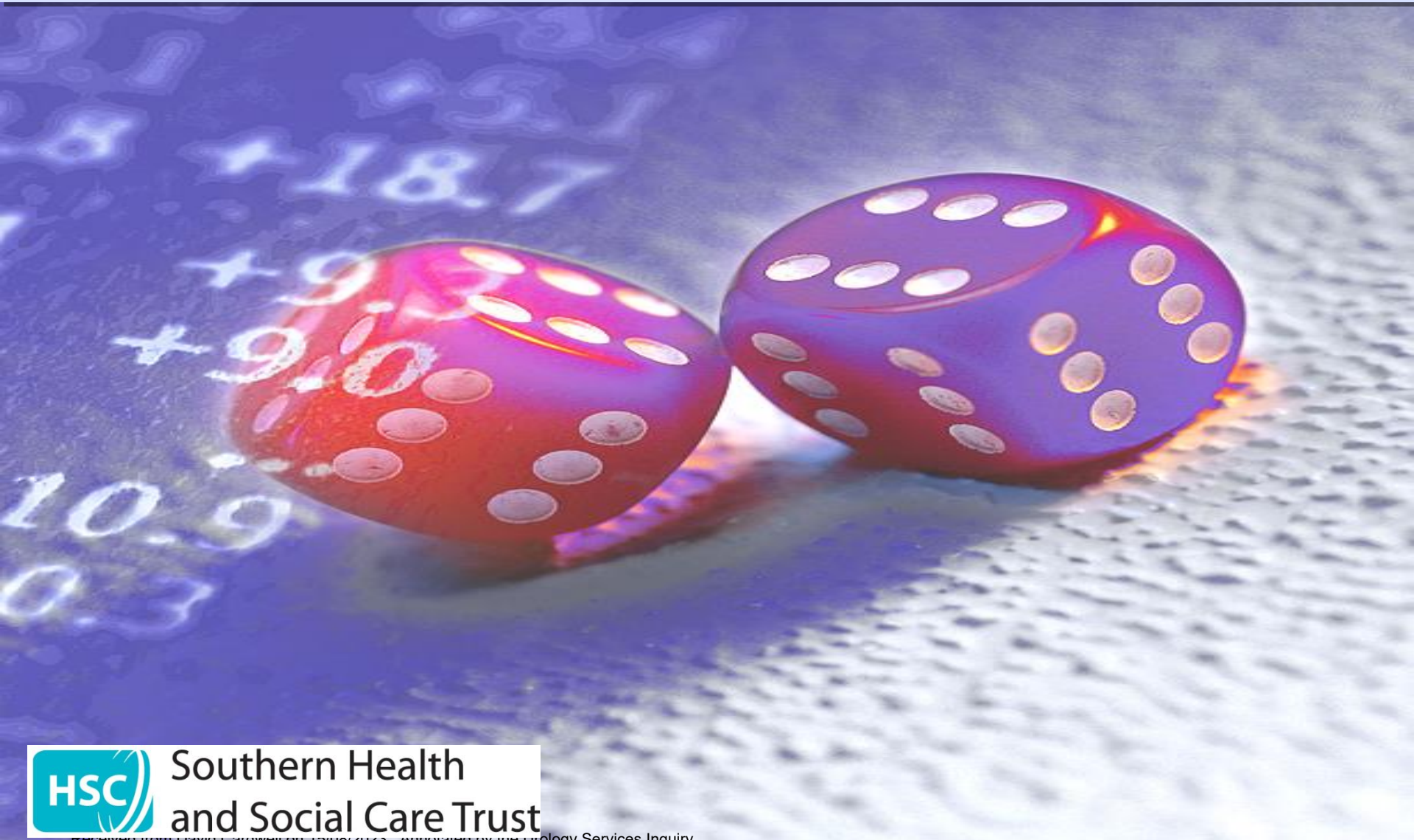
Risk Management requires good systems……



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…and risk awareness!!

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

What is Risk?

The likelihood of a substance, activity or process to cause harm

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Risk Management – *Basic Concepts*

- Risk management is everyone's business
- It is a continuous and developing process that needs to be embedded within individual teams as well as the organisation's culture.
- The focus of good risk management processes is to effectively *identify* and *treat* risk

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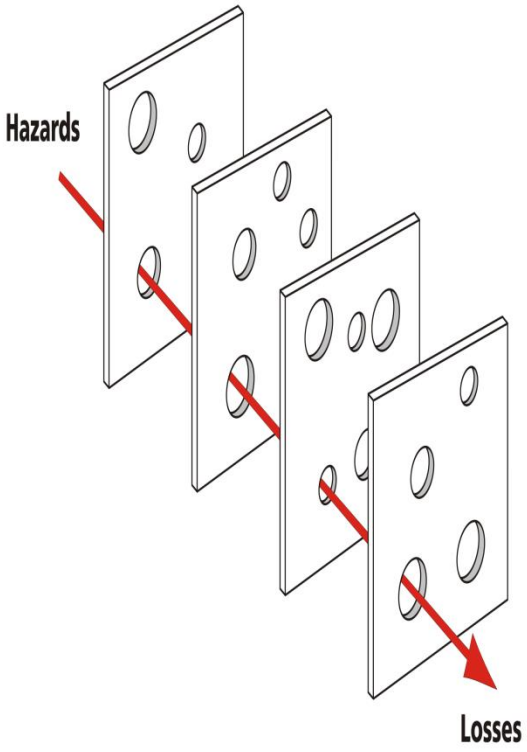
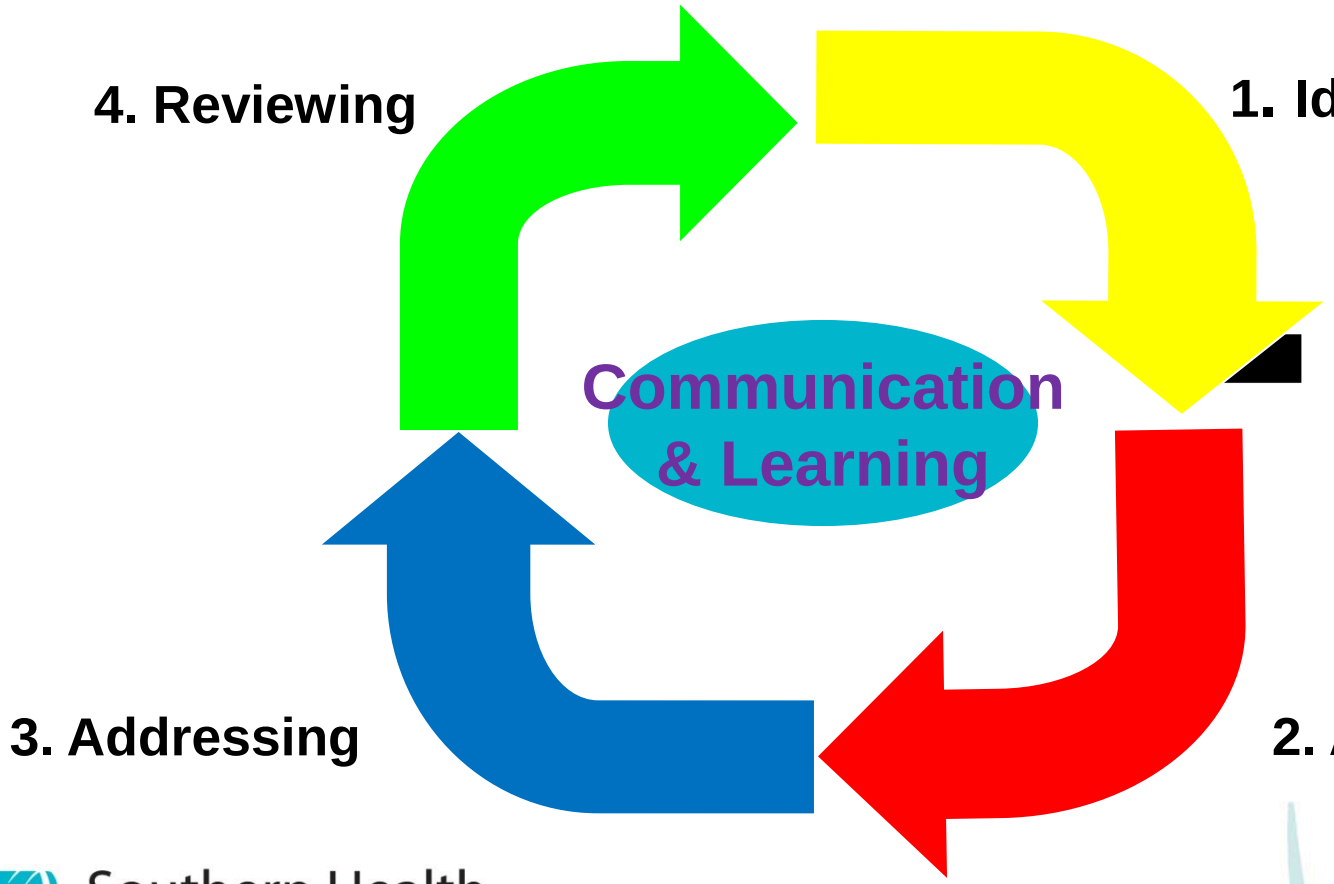
The **Swiss Cheese model** of accident causation is a **model** used in **risk** analysis and **risk management**, including aviation, engineering, healthcare. It likens human systems to multiple slices of swiss cheese, stacked side by side, in which the risk of a threat becoming a reality is mitigated by the differing layers and types of defences which are "layered" behind each other. Therefore, in theory, lapses and weaknesses in one defence do not allow a risk to materialize, since other defences also exist



The Risk Management Process

Risk Environment / Risk Context



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Risk Management Model, 2002

Perceptions!

- Perceptions vary between individuals and groups, one persons high risk is another's low risk.

- Consider the following activities and rate them in order of perceived risk

1 = highest 6 = lowest

A. Riding a motorcycle
B Buying a second hand car
C. Bungee jumping
D. Taking part in a clinical medication trial
E. Starting your own business using your own home as security

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Risk Register – *What is it?*

- A tool that enables your team to understand risks within your area
- A ‘dynamic’ and ‘living’ document which enables risk to be quantified and ranked.
- Can be either proactive or reactive.

What informs our Risk Registers?

Internal

- Complaints
- Incidents/SAIs
- Audit/Inspections
- Organisational objectives
- Risk assessments

External

- RQIA
- External reports
- Benchmarking [redacted]
- Targets
- Outcomes of SAIs

Benefits of a Risk Register

- Helps to identify risk priorities
- Formally records risks and how you manage them
- Allows all of those concerned with risk management to see the overall risk profile and how their areas of responsibility fit [redacted] it
- Facilitates the review and monitoring of risks.

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Who handles the risk?

Risk level	Action level
	Directorate and/or corporate level
	Divisional or directorate level
	Department/team /facility level
	Department/team /facility level

Risk or incident

Risk

- Should be proactive rather than
- Prevention
- Anticipation

Incident

- Reactive
- [redacted]
- Has happened – can no longer be prevented

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Risk/hazard/near miss/incident

An unsheathed needle lying on the floor is a ….

The….. Is that someone receives a needlestick injury

Needle picked up and placed in sharps box without injury is a …….

Someone picks up the needle and injures themselves is an…….

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Understanding Complaints, their de-escalation and saying sorry

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Quality Care - for you, with you

Overarching Objectives of the HSC Complaints Procedure

Listening

Learning

Improving

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What does the HSC Procedure cover?

- Complaints about care or treatment in the Trust, Health Board and Family Practitioner Services settings.

What does it NOT Cover?

- Private care / treatment or services

- Issues covered by other processes
  e.g.
  - -Staff grievances, disciplinaries or Investigation by professional and regulatory bodies or an independent inquiry
  - -Freedom of Information and Data Protection Act requests
  - -Child Protection and Children Order Complaints
  - -Protection of Vulnerable Adults
  - -Criminal investigations or litigation

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Why do Complaints Matter?

To the Organisation:

- Identify risks
- Learn lessons
- Improve services
- Reputation
- Make case for more resources
- Contribute to risk register

To the Service User:

- Public accountability
- Restore confidence
- Address negative feelings
- Closure [redacted]
- Improvement
- Valued / worthwhile

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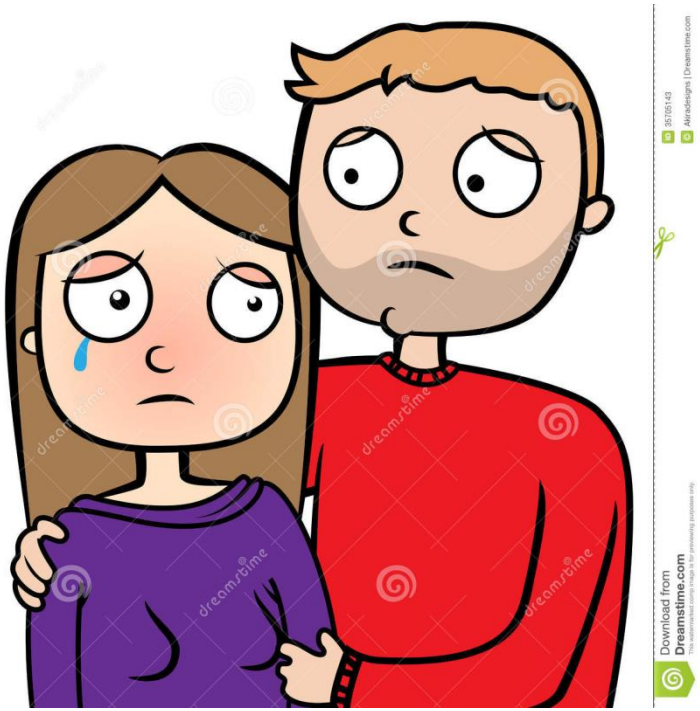
What is a Complaint?



Definition:

“Any expression of dissatisfaction which requires a response”

(HSC Complaints Procedure 2009)

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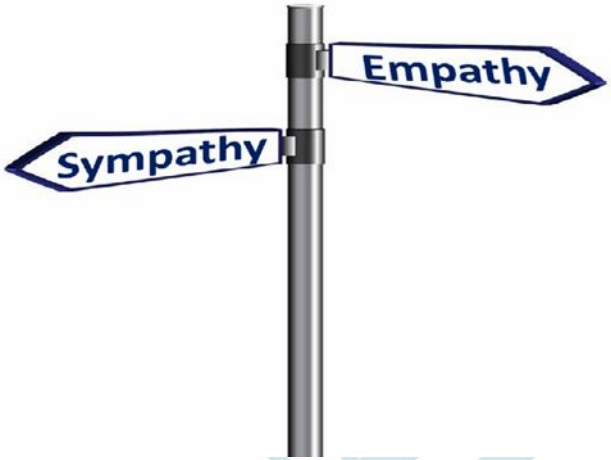
Expectations

- To voice their concerns and to be listened to
- An explanation and an apology (if appropriate)
- An assurance that their experience will not happen again [redacted]
- A report of action taken as a result of their complaint.



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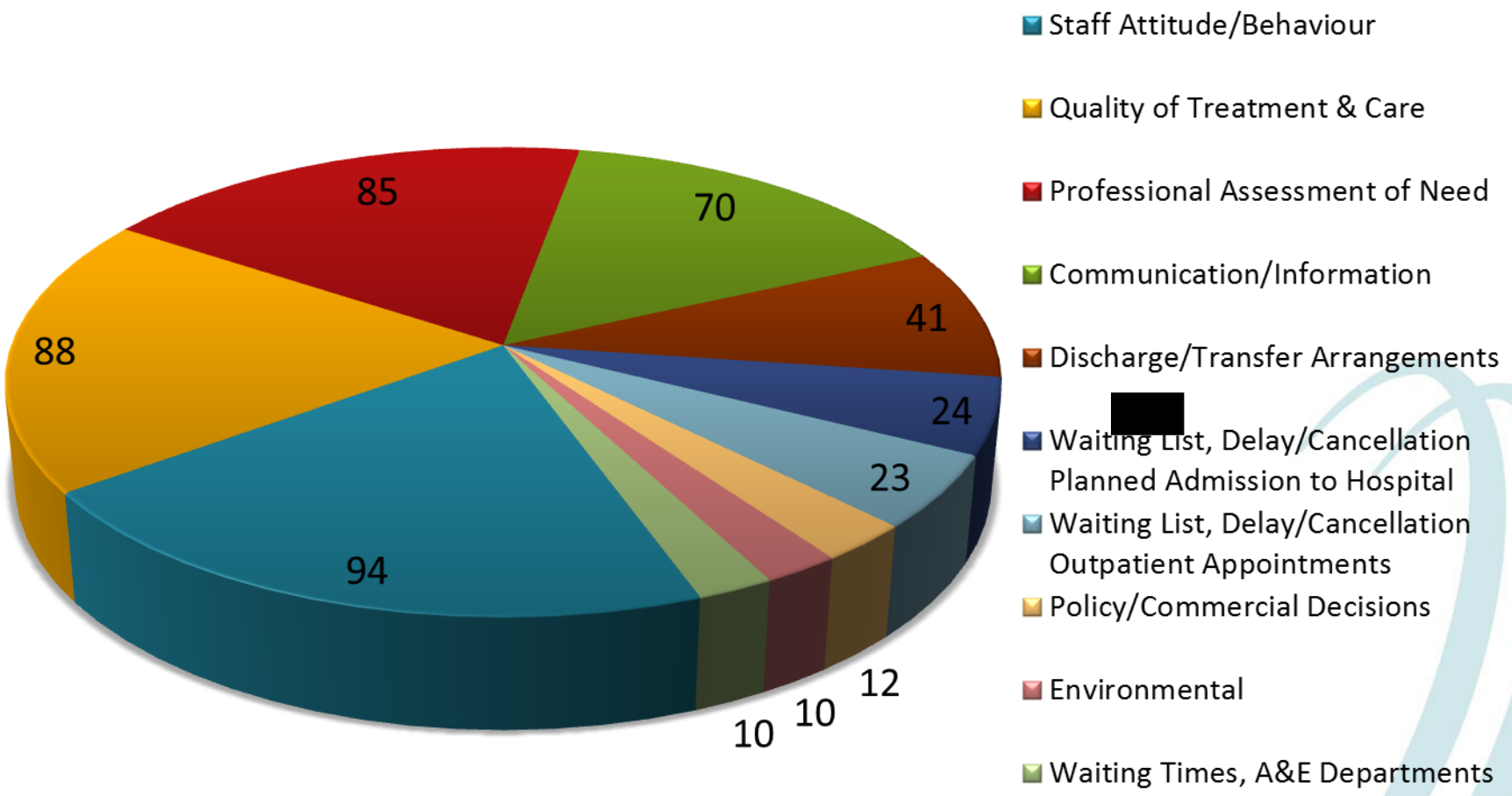
Why people complain

2015/2016 Financial Year – **541** Formal Complaints



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Prevention is better than cure

How to minimise the potential for a complaint

- Good Communication and appropriate attitude to include an explanation and an apology when appropriate.
- It is good practice to always introduce yourself to the patient [redacted]
- Be aware of how you come across to others.
- Remember that many patients are not familiar with your processes so keeping them informed is crucial.

De-escalation

Turning a challenge into an opportunity

Many of us have to deal with unhappy patients/relatives as part of our roles and it's never easy. But, if we know what to say and, more importantly, how to say it, we may be able to save the situation.

In fact, we can even end up with a better relationship with our patient/relatives than we had before.

Do's and Don'ts

Be honest	Avoid Issues
Empathise	Patronise
Identify issues	Use medical or nursing jargon
Continue with care provision	Be distracted [redacted]
Treat issues seriously	Inappropriate humour
Accept that you may not be able to resolve	Make unreasonable promises

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Local arrangements & processes

- We Value Your Views Leaflet
- Investigating Complaints & User Views – advice toolkit for staff

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What happens next?

- If the complainant remains unhappy they are asked to provide the reasons for which they remain dissatisfied and to provide a list of issues they feel have not been addressed.

- Re-Opened complaints may be addressed by:

  - Telephone if appropriate;
  - With a further letter;
  - By a meeting.

- When the complaints process is exhausted the Complainant is advised to approach the Northern Ireland Public Services Ombudsman if they remain unhappy.

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Role of the Ombudsman

- Deals with complaints from people who believe they have suffered injustice as a result of **maladministration** by government departments and public offices in Northern Ireland
- Completely Independent Body & External to HSC [redacted]
- Currently 11 cases being investigated.

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If an apology is required –
What is an meaningful apology?

- An apology means accepting that something has been wrong and taking responsibility for it. It can be defined as a 'regretful acknowledgement of an offence or failure.'

- Cleary explain why the failure happened and include that it was not intentional.

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Staff Support & Feedback

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