It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  '.hscni.net',
  'n-i.nhs.uk'
  'ni.gov.uk' or
  '.ni.gov.net'

  No sensitive or patient/service user data must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  Note: Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  Step 1 Contact the recipient and ask for their email address.
  Step 2 Send a test email to the address provided to ensure that you have inserted the correct email address.
  Step 3 Ask the recipient on receiving the test email to reply confirming receipt.
  Step 4 Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel 028 95 362912

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level

- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents@hscni.net

HSC Trusts to copy RQIA at seriousincidents@rqia.org.uk in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated

correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents@hscni.net.

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising

of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

12.6 Review/Learning Summary Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

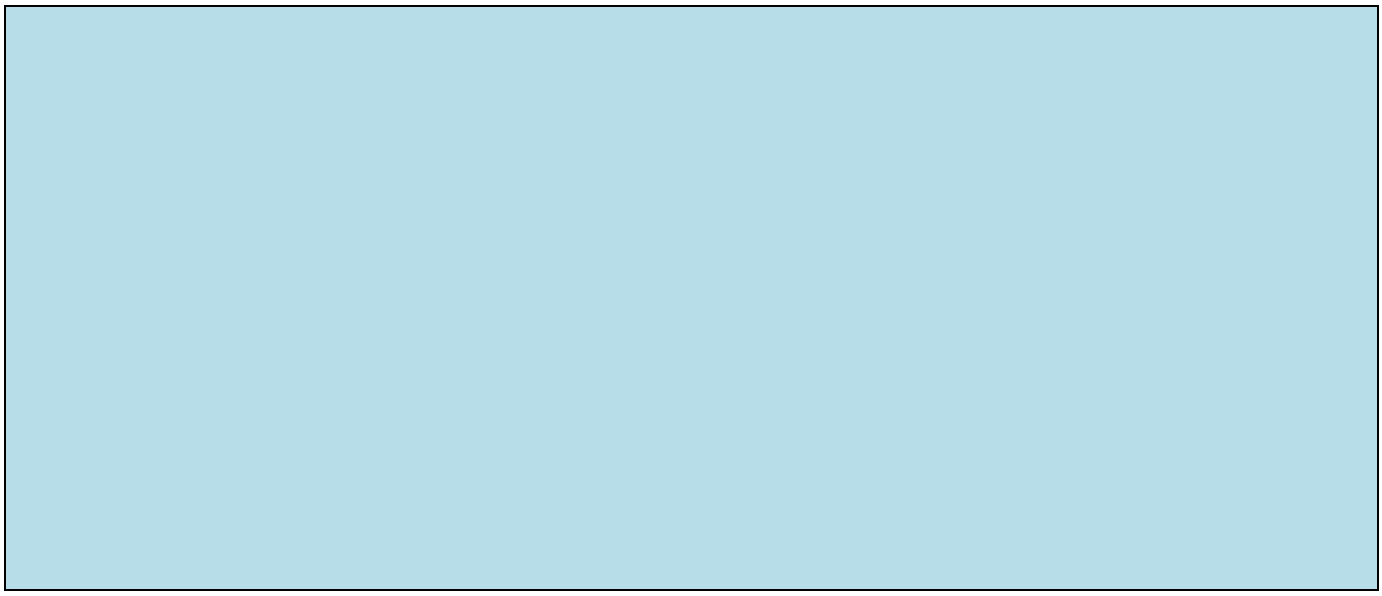
13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION TWO APPENDICES



APPENDIX 1

Revised November 2016 (Version 1.1)

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes
SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT? Yes/No *(please select)*	If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
***Where relevant** please provide details on the current condition of the service user the incident relates to.*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)*	YES	NO	N/A

14. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*	
DoH EARLY ALERT			
HM CORONER			
INFORMATION COMMISSIONER OFFICE (ICO)			
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)			
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)			
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)			
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)			
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)			
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)			
19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.

The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 3
Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ **DESIGNATION:** _____

Email: **Telephone:** **Date: DD / MM / YYYY**

Completed proforma should be sent to: seriousincidents@hscni.net

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY
14. WHAT HAS BEEN LEARNED:
15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?
16. RECOMMENDATIONS (please state by whom and timescale)
17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:
18. FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	24. DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory*	
8. SUMMARY OF EVENT: ***As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)***	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER: *Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10*	10. TEAM MEMBERS PRESENT: *NAMES AND DESIGNATIONS*
11. SERVICE USER DETAILS: ***Complete where applicable*** *DOB / GENDER / AGE*	
12. WHAT HAPPENED? *(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).*	
13. WHY DID IT HAPPEN? *(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)*	

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*	24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
			NO	

SECTION 2 INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**				**NO**			
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**				**NO**			
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 7
Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

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

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

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

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

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

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

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report				
	b) Plan to share final review report at a later date and further engagement planned				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the review
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

- **Level 1 - SEA Reviews**

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

- **Level 2 and 3 RCA Reviews**

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

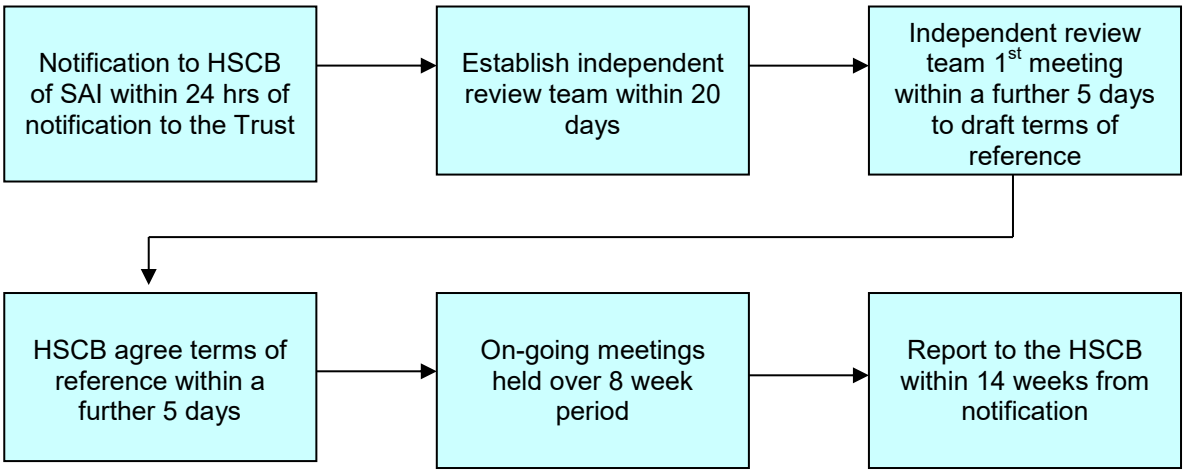
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 15

ADMINISTRATIVE PROTOCOL

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: ***seriousincidents@hscni.net***
and RQIA: **seriousincidents@rqia.org.uk**

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

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

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

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

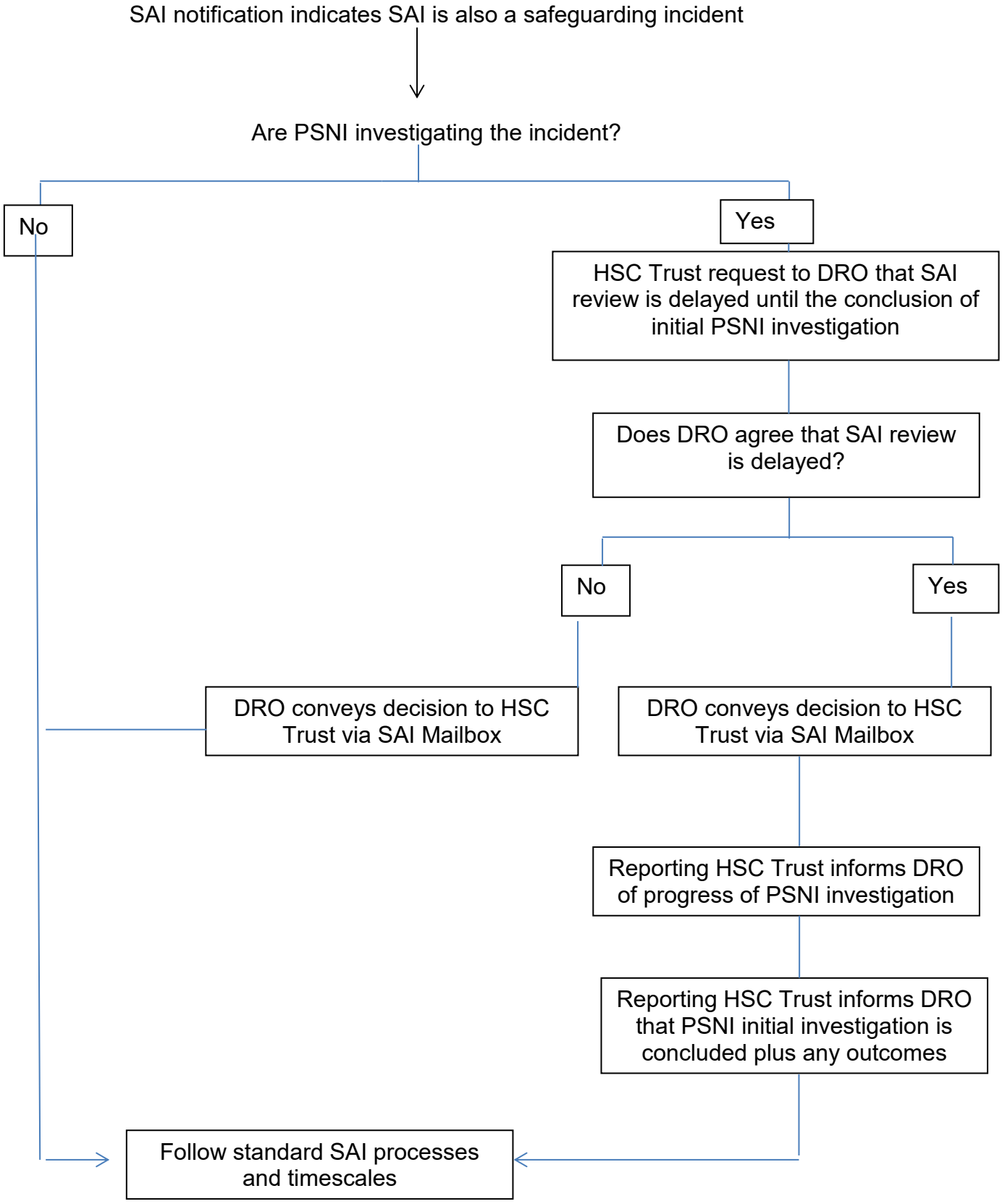
In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM

ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff

should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social

care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with

the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you" **Your understanding of their Story: (Summarising)** "I understand from what you said that" xxx "and you are very upset and angry about this"

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) "Am I right in saying that you……..." **Your Story** "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? "Do you mind if I tell you what we have been able to establish at this stage?" "We have been able/unable to determine at this stage that……." "We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds" "You may at a later stage experience xx if this happens you should ……."
Inquire	"Do you have any questions about what we just discussed?" "How do you feel about this?" "Is there anything we talked about that is not clear to you?"
Solutions	"What do you think should happen now?" "Do you mind if I tell you what I think we should do?" "I have reviewed your case and this is what I think we need to do next" "What do you think about that?" "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?" "I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?"
Progress	"Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen" "We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future" "I will be with you every step of the way as we get through this and this is what I think we need to do now" "We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team" "Would you like us to contact you to set up another meeting to discuss our progress with the review?" "I will be seeing you regularly and will see you next in….days/weeks. "You will see me at each appointment" "Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……" "If you think of any questions write them down and bring them with you to your next appointment." "Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services"

Appendix 4

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING	***Note taking***
There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____

Southern Health and Social Care Trust

Quality Care - for you, with you

'YOUR RIGHT TO RAISE A CONCERN'

(WHISTLEBLOWING)

SOUTHERN HSC TRUST
POLICY ON RAISING CONCERNS

Lead Policy Author & Job Title:	Regional HSC Policy
Directorate responsible for document:	HR & Organisational Development
Issue Date:	01 April 2018
Review Date:	01 April 2021

Policy Checklist

Policy name:	'Your Right to Raise a Concern' (Whistleblowing)
Lead Policy Author & Job Title:	Head of Employee Relations
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Lynda Gordon, Head of Equality, Sarah Moore, HR Manager and Lesley Dowey, HR Advisor on 03/01/2018
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	
Date approved by SMT:	
Policy circulated to:	Directors, Assistant Directors, Heads of Service for onward distribution to line managers/staff, Global email, Staff Newsletter
Policy uploaded to:	SharePoint and Trust Intranet

Version Control

Version:	**Version 1_0**		
Supersedes:	N/A		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
N/A	N/A	N/A	N/A

Contents

1. Introduction

All of us at one time or another may have concerns about what is happening at work. The Southern Health & Social Care Trust (the Trust) wants you to feel able to raise your concerns about any issue troubling you with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or the Trust itself, it can be difficult to know what to do.

The Trust recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

2. Aims and Objectives

The Trust is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the Trust;
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards;
- provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The Trust's roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. Scope

The Trust recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary Procedure, Grievance Procedure, Maintaining High Professional Standards Framework, Conflict, Bullying & Harassment Policy, Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the Trust, including permanent, temporary and bank staff, staff in training working within the Trust, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;

- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

If you feel that something is of concern, and that it is something which you think the Trust should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the Trust's Grievance procedure, Harassment at Work procedure or Working Well Together procedure which can be obtained from your manager. This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. Suspected Fraud

If your concern is about possible fraud or bribery the Trust has a number of avenues available to report your concern. These are included in more detail in the Trust's Anti-Fraud Policy & Fraud Response Plan and Anti-Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Director of Finance, Procurement & Estates
  Ms Helen O'Neill

- Fraud Liaison Officer (FLO)
  Mrs Fiona Jones

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.reporthealthfraud.hscni.net These avenues are managed by Counter Fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The Trust's Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the Trust or under its control. The Trust expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

5. Our Commitment to You

5.1 Your safety

The Trust Board and Senior Management Team, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The Trust will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The Trust expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

Provided you are acting in good faith, it does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the

law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the Trust reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the Trust hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to a member of staff in Human Resources.

The Trust is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3. Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Protect (see contact details under Independent Advice).

6. Raising a concern

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

Option 1: In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager (or lead clinician or tutor). But where you do not think it is appropriate to do this, you can use any of the other options set out below.

Option 2: If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, please raise the matter with another senior person you can trust. This might be another manager / professional lead or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

The Deputy Director of HR Services, Mrs Siobhan Hynds is the designated HR representative for Raising Concerns

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

Option 3: If you still remain concerned after this, you can contact:

- Mrs Vivienne Toal - Director of Human Resources & Organisational Development who is the lead director for Raising Concerns
- Dr Maria O'Kane - Executive Medical Director
- Mrs Heather Trouton – Interim Executive Director of Nursing, Midwifery & AHPs
- Mr Paul Morgan – Executive Director of Social Work
- Mrs Helen O'Neill – Executive Director of Finance, Procurement & Estates

- Mr John Wilkinson – Lead Non-Executive Director for Raising Concerns on Trust Board – contactable through the Office of the Chair, Trust HQ.

All these people are required to receive training in dealing with concerns and will give you information about where you can go for more support.

Option 4: If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see paragraph 7 below).

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity, Protect (formerly Public Concern at Work (PCaW)) on 020 3117 2520.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing. A dedicated email address is also available: raising.concerns@southerntrust.hscni.net.

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

If in writing or email, you should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

6.4 Supporting you

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Deputy Director of HR Services or a nominated deputy throughout any investigation process. The Deputy Director of HR Services will not undertake an investigation role in the whistleblowing case but will provide support throughout the process, ensuring that feedback is provided at appropriate stages of the investigation. The Trust also provides independent support services to all employees through its Employee Assistance Programme - Inspire; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Deputy Director of HR Services will arrange for you to receive advice and support throughout the process. If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Deputy Director of HR Services.

7. Raising a concern externally

The Trust hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the Trust would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the Trust recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health;
- A prescribed person, such as:

- General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
- The Regulation and Quality Improvement Authority;
- The Health and Safety Executive;
- Serious Fraud Office,
- Her Majesty's Revenue and Customs,
- Comptroller and Auditor General;
- Information Commissioner
- Northern Ireland Commissioner for Children and Young People
- Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Protect (formerly PCaW) or your Trade Union representative will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. The Media

You may consider going to the media in respect of concerns if you have done all you can by raising them with the Trust or an external body and you feel they have not been properly addressed. Your professional regulatory body, if applicable, will be able to provide guidance / advice in this situation. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The Trust reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the Communications Department on behalf of the Trust. Any member of staff approached by the media should direct the media to our Communications Department in the first instance.

9. Conclusion

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the Trust listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

10. Equality, Human Rights & DDA

The Southern Health & Social Care Trust confirm this policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity.

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an

equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

11. Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

12. Sources of advice in relation to this document

The Director of Human Resources & Organisational Development should be contacted with regard to any queries on the content of this policy.

APPENDIX A

Roles and Responsibilities

The Trust Board and Senior Management Team of the Southern Health & Social Care Trust

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.
- To share learning, as appropriate, via the Trust's lessons learned arrangements

Lead Non-Executive Director (NED)

- To provide assurance to Trust Board that there are robust arrangements in place in relation to raising and handling concerns
- To have responsibility for oversight of the culture of raising concerns within the Trust.

Director of Human Resources & Organisational Development

- To take responsibility for ensuring the implementation of the whistleblowing arrangements
- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through appropriate management levels / professional lines
- To ensure that all awareness and training requirements arising from this policy are delivered
- To establish a network of advocates, to support the implementation of this policy

All Directors & Managers

- To ensure staff are familiar with and have access to the Raising Concerns Policy and Procedure
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive and confidential manner
- To respond quickly to concerns and take all concerns seriously and in confidence, wherever possible
- To seek immediate advice from HR on the handling of any concern raised, and other professionals within the Southern Health & Social Care Trust where appropriate
- To ensure that staff are supported following the raising of a concern so as not to suffer detriment
- To foster an environment in which their teams are engaged in the delivery of high quality and safe services and feel secure to raise concerns as a matter of good practice
- To create an open and safe atmosphere (in team meetings, appraisals etc.) where staff feel their views, regarding the effective and safe delivery of care and services to our service users, will be welcomed and be seen as an opportunity to learn and to consider how services can be improved
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved.

Deputy Director of HR Services

- To ensure Medical Director, Director of Nursing & AHPs, or Director of Social Work is informed, if the concern raised deems this to be appropriate in order to ensure the safety of patients and clients.
- To oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations.
- To work with Directors and Managers to address the culture and tackle the obstacles to raising concerns.

All Members of Staff

- To recognise that it is your duty to draw to the Trust's attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain the duty of confidentiality to patients and the Trust and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of Trade Unions and other Organisations

- All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health & Care Professions Council and the Northern Ireland Social Care Council.

APPENDIX B

SOUTHERN HSC TRUST PROCEDURE FOR RESPONDING TO CONCERNS

HOW WE WILL DEAL WITH THE CONCERN

Stage 1

1) Any manager / Director to whom a concern is raised must arrange to meet with the employee to discuss the detail of the concern **without delay**.

2) The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff).

3) The manager / Director should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter. The manager should document a summary of the discussion.

4) The manager should explain that they will need to seek advice from their Assistant Director / Director, providing there are no specific objections raised by the employee regarding protection of their confidentiality in this regard. If there are concerns expressed as to who should be made aware, then the manager / Director should seek advice immediately from the Director of HR or Deputy Director of HR Services.

5) ALL whistleblowing concerns must be notified by the Assistant Director / Director to the HR Director's office for logging and decision on best course of action to address the concern.

6) If the concern is raised with the Director of HR, s/he will refer the concern to the Deputy Director of HR Services to arrange to meet with the employee to discuss the detail of the concern.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is decided that further action cannot be justified, the reasons for this decision should be documented and retained by the HR Director's Office.

Stage 2

Once the issue(s) of concern has been established, the approach to independently investigating the concern will be discussed and agreed by an Oversight Group, chaired by the Director of HR and an Executive Director, depending on the nature of the concern. The Director of HR will advise the relevant operational Director that a concern has been raised and the nature of it. The Director of HR will withhold the identity of the individual raising the concern, if requested.

A record should be made of the decisions and/or agreed actions which should be signed and dated. Agreed Terms of Reference for any investigation should be established.

The Director of HR will ensure that the Deputy Director of HR Services is aware of the concern (if not previously aware) to ensure any necessary support can be provided to the employee raising the concern.

Stage 3

Within a prompt and reasonable timescale of the concern being received, the Deputy Director of HR Services must meet with the employee to:

- Acknowledge that the concern has been received
- Discuss if confidentiality is to be / can be maintained throughout investigation, and ensure this is documented using the ***Record of Discussion Regarding Confidentiality***
- Discuss how the matter will be dealt with and by whom
- Outline the support available
- Provide an estimate as to how long it will take to provide a final response.

A summary of the discussions will be followed up in writing.

Stage 4

A proportionate investigation – using someone suitably independent (usually from a different part of the organisation), will be undertaken and conclusion reached within a reasonable timescale. The investigation will be objective and evidence-based, and a report of the findings will be produced.

Stage 5

The Oversight Group will consider the report and determine any action required, based on the findings, including any lessons to be learned to prevent problems recurring.

Stage 6

The HR Director will ensure that feedback to the individual raising the concern is provided.

If You Remain Dissatisfied

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in the Trust's Policy. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly.

RECORD OF DISCUSSION REGARDING CONFIDENTIALITY

Name of individual raising concern

SUMMARY OF DISCUSSION REGARDING CONFIDENTIALITY

Please record a summary of the discussion with the individual raising a concern regarding maintaining their confidentiality under the Trust's Raising Concerns (Whistleblowing) Policy

CONSENT TO REVEAL IDENTITY

Does the individual wish to their identity to remain confidential during any whistleblowing investigation? **YES / NO** **Who has the individual given consent for their name to be revealed to as part of the whistleblowing investigation?** **Is the individual aware that should further action be required following a whistleblowing investigation in the form of disciplinary action for example, that their identity may have to be revealed following discussion with them and that they may have to provide a witness statement?**

YES / NO

INFORMATION STORAGE

Summary of discussion regarding how information will be held and investigation undertaken to ensure identity is protected.

Signed by individual raising concern(s): **Date:**

Signed by Trust representative : **Date:**

Southern Health and Social Care Trust

Quality Care - for you, with you

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

'YOUR RIGHT TO RAISE A CONCERN'

(WHISTLEBLOWING)

HSC FRAMEWORK

CONTENTS

INTRODUCTION

1. Health and social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve.

2. Encouraging staff to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of services and patient safety. Many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. When concerns are raised and dealt with appropriately at an early stage, corrective action can be put in place to ensure safe, high quality and compassionate care.

3. The importance of raising concerns at work in the public interest (or "whistleblowing") is recognised by employers, workers, trade unions and the general public. Working in partnership with Trade Unions, staff associations and employee representatives is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place[1].

DEFINING WHISTLEBLOWING

4. Whistleblowing is defined as "when a worker reports suspected wrongdoing at work"[2]. The wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences such as those highlighted in the Mid Staffordshire Report (2013)[3].

[1] Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health & Social Care (NHS, 2014)
[2] *Government Whistleblowing Policies* National Audit Office (2014)
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

5. Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:
   - patient safety;
   - health and safety at work;
   - environmental damage; or
   - a criminal offence (e.g. fraud).

6. Whistleblowing can also be broadly defined as simply 'raising a concern'[5]. People outside the organisation, including stakeholders, suppliers and service users, can also raise concerns through the Policy for Management of Complaints. However, whistleblowing is different from making a complaint or raising a grievance. Whistleblowers can often act out of a feeling of fairness or ethics rather than a personal complaint. As Public Concern at Work (PcAW) states, it is important to note that:

   "....*the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequently, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it*".[4]

WHY DOES WHISTLEBLOWING MATTER?

7. Staff who are prepared to speak up about malpractice, risk, abuse or wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation by identifying and addressing problems that disadvantage or endanger other people[5].

8. It is important for individuals to feel safe and listened to when raising concerns. An open approach to whistleblowing promotes the values of openness,

[4] Where's whistleblowing now? 10 years of legal protection for whistleblowers, PCaW, March 2010
[5] Whistleblowing in the Public Sector: A good practice guide for workers and employers, published jointly in November 2014 by Audit Scotland, the National Audit Office, the Northern Ireland Audit Office and the Wales Audit Office, with the support of Public Concern at Work

transparency and candour and encourages employees to treat patients and service users with dignity, respect and compassion.

9. From the employer's point of view, there are good business reasons for listening to staff who raise concerns, as it gives an opportunity to stop poor practice at an early stage before it becomes normalised and serious incidents take place.

10. From the staff members' perspective, the freedom to raise concerns without fear means that they have the confidence to go ahead and "do the right thing". It is part of encouraging staff to reflect on practice as a way of learning[1].

SCOPE

11. This Framework and Policy have been developed in response to the recommendations arising from the Regulation and Quality Improvement Authority's (RQIA) Review of the Operation of Health and Social Care Whistleblowing Arrangements[6]. The Policy, to be adopted by all HSC organisations in Northern Ireland, accompanies this FrameworkHSC organisations may tailor the Policy to take account of their individual organisation's policies and procedures.

12. This Framework and Policy applies to **all staff** (employees, workers[7]) involved in the work of an HSC organisation. It does not apply to patients and clients or members of the public who wish to complain or raise concerns about treatment and care provided by the HSC organisation or about issues relating to the provision of health and social care. These will be dealt with under the **Trust's Complaints Procedure**.

13. This Framework and Policy is for staff to raise issues where the interests of others or the organisation are at risk. If a member of staff is aggrieved about their

[6] Review of the Operation of Health and Social Care Whistleblowing Arrangements (RQIA, 2016)
[7] Definitions set out in Articles 3 (3) and 67K of the Employment Rights (Northern Ireland) Order 1996

personal position they must use the organisation's **HSC Grievance Procedure, Harassment at Work Procedure** and/or the **Working Well Together Policy**.

14. All cases of suspected, attempted or actual fraud raised under this policy should be handled promptly in line with the organisation's **Fraud Response Plan.**

PURPOSE AND AIMS

15. The aim of this Framework and Policy is to ensure that under the terms of the Public Interest Disclosure (Northern Ireland) Order 1998 a member of staff is able to raise legitimate concerns when they believe that a person's health may be endangered or have concerns about systematic failure, malpractice, misconduct or illegal practice without fear of retribution and/or detriment.

16. If a member of staff has honest and reasonable suspicions about issues of malpractice/wrongdoing and raises these concerns through the channels outlined in the policy, they will be protected from any disciplinary action and victimisation, (e.g. dismissal or any action short of dismissal such as being demoted or overlooked for promotion) simply because they have raised a concern under this policy.

17. This Framework and Policy aims to improve accountability and good governance within the organisation by assuring the workforce that it is safe to raise their concerns.

18. The benefits of encouraging staff to report concerns include[1]:
    - identifying wrongdoing as early as possible;
    - exposing weak or flawed processes and procedures which make the organisation vulnerable to loss, criticism or legal action;
    - ensuring critical information gets to the right people who can deal with the concerns;
    - avoiding financial loss and inefficiency;
    - maintaining a positive corporate reputation;

- reducing the risks to the environment or the health and safety of employees or the wider community;
- improving accountability; and
- deterring staff from engaging in improper conduct.

KEY PRINCIPLES AND VALUES

Distinction between grievance & whistleblowing concerns

19. Whistleblowing concerns generally relate to a risk, malpractice or wrongdoing that affects others, and may be something which adversely affects patients, the public, other staff or the organisation itself. A grievance differs from a whistleblowing concern as it is a personal complaint regarding an individual's own employment situation. A whistleblowing concern is where an individual raises information as a witness whereas a grievance is where the individual is a complainant. Grievances are addressed using the Grievance Procedure.

Raising a concern openly, confidentially, or anonymously

20. In many cases, the best way to raise a concern is to do so openly. Openness makes it easier for the organisation to assess the issue, work out how to investigate the matter, understand any motive and get more information. A worker raises a concern confidentially if they give their name on the condition that it is not revealed without their consent. If an organisation is asked not to disclose an individual's identity, it will not do so without the individual's consent unless required by law (for example, by the police). A worker raises a concern anonymously if they do not give their name at all. If this happens, it is best for the organisation to assess the anonymous information as best it can, to establish whether there is substance to the concern and whether it can be addressed. Clearly if no-one knows who provided the information, it is not possible to reassure or protect them.

Malicious claims & ulterior motives

21. There may be occasions when a concern is raised either with an ulterior motive or maliciously. In such a case, and as set out in the policy, the organisation cannot give the assurances and safeguards included in the policy to someone who is found to have maliciously raised a concern that they also know to be untrue. Such situations should be handled carefully. The starting point for any organisation is to look at the concern and examine whether there is any substance to it. Every concern should be treated as genuine, unless it is subsequently found not to be. However, if it is found that the individual has maliciously raised a concern that they know is untrue, disciplinary proceedings may be commenced against that individual.

LEGAL FRAMEWORK

22. The Public Interest Disclosure (Northern Ireland) Order 1998[8] (the Order), allows a worker to breach his duty as regards confidentiality towards his employer for the purpose of 'whistle-blowing'. It was introduced in the interest of the public, to protect workers from detrimental treatment or victimisation from their employer if they raise a genuine concern, whether it is a risk to patients, financial malpractice, or other wrongdoing. These are called "qualifying disclosures". A "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following circumstances:

- where criminal activity or breach of civil law has occurred, is occurring, or is likely to occur;
- where a person has failed, is failing or is likely to fail to comply with any legal obligation he is subject to;
- where a miscarriage of justice has occurred, is occurring or is likely to occur
- where the health and safety of any individual has been, is, or is likely to be endangered;
- where the environment has been, is being or is likely to be damaged;

[8] The Public Interest Disclosure (Northern Ireland) Order 1998

- where information indicating evidence of one of the above circumstances is being or is likely to be deliberately concealed.

23. A qualifying disclosure is made by the worker:

- to his employer, or where the worker reasonably believes that the relevant failure relates solely or mainly to the conduct of a person other than his employer or any other matter for which a person other than his employer has legal responsibility, to that other person;
- to a legal adviser for the purpose of obtaining legal advice;
- to the Department of Health or the Minister for Health;
- to a person prescribed by an Order[9] made by the Department for the Economy for the purposes of Article 67F of the Employment Rights (Northern Ireland) Order 1996.[10] The worker should reasonably believe that the relevant failure falls within any description of matters in respect of which that person is so prescribed and that the information disclosed, and any allegation contained in it are substantially true.

24. If the worker makes a disclosure to a person other than his employer or to a person not noted above, it will be a qualifying disclosure in accordance with the Order provided the following conditions are met:

- the worker reasonably believes the information disclosed and any allegation contained within it are substantially true;
- the disclosure is not made for personal gain;
- the worker must act reasonably, taking into account the circumstances;

In addition one, or more, of the following conditions must be met:

- the worker reasonably believes he will suffer a detriment if he makes the disclosure to his employer; or

[9] Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014
[10] The Employment Rights (Northern Ireland) Order 1996 as amended by the Employment Act (Northern Ireland) 2016

- in the case where there is no prescribed person as noted above, the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer; or
- the worker has previously made the disclosure to his employer or a prescribed person.

25. In determining whether it is reasonable for the worker to make the disclosure, regard shall be had, in particular, to:
    - the identity of the person to whom the disclosure is made;
    - the seriousness of the relevant failure;
    - whether the conduct is continuing or likely to occur in the future;
    - whether the disclosure is made in breach of a duty of confidentiality owed by the employer to any other person;
    - whether any previously made concern was acted upon;
    - whether the worker followed any procedure laid down by the employer.

26. It should be noted that a disclosure of information is not a qualifying disclosure if the person making the disclosure commits an offence by making it.

27. The Order covers all workers including temporary agency staff, student nurses and student midwives, persons on training courses and independent contractors who are working for and supervised by the Trust. It does not cover volunteers. It also makes it clear that any clause in a contract that purports to gag an individual from raising a concern that would have been protected under the Order is void.

HANDLING CONCERNS

28. To enable a whistleblowing policy to work in practice and to avoid unnecessary damage, it is important to ensure that policies authorise all staff, not just health and medical professionals, to raise a concern, and identifies who they can contact.

29. Legal protection is very important if staff are to be encouraged to raise a concern about wrongdoing or malpractice. However, it is vital that employers develop an open culture that recognises the potential for staff to make a valuable contribution to the running of public services, and to the protection of the public interest.

30. Where an individual is subjected to a detriment by their employer for raising a concern or is dismissed in breach of the Order, they can bring a claim for compensation under the Order to an Industrial Tribunal.

31. Managers can lead by example, by being clear to staff as to what sort of behaviour is unacceptable, and by role modelling the appropriate behaviours themselves. They should encourage staff to ask them what is appropriate if they are unsure before - not after - the event. If wrongdoing or a potential risk to patient safety is found, it should be taken seriously and dealt with immediately.

IMPLEMENTING LOCAL POLICY

32. It is important that all HSC organisations are committed to the principles set out in their whistleblowing arrangements and can ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their organisation. To achieve this, it is necessary to ensure buy-in and leadership from management, and Trade Union engagement.

33. Within each organisation, an appropriate senior manager should be appointed to take responsibility for ensuring implementation of the whistleblowing arrangements. This could be the clinical governance lead, the nursing or medical director, or responsible officer. The Trust should also consider appointing an appropriate number of advisors/advocates to signpost and provide support to those wishing to raise a concern. In addition, each organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.

34. As an employer, HSC organisations must take all concerns raised seriously. However, it may not be necessary to carry out a formal investigation in each case. Employers should consider a range of possibilities depending on the nature of each case[4]:
    - explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns
    - minor concerns might be dealt with straightaway by line management
    - a review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment
    - there may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices
    - there may be a clear need for a formal investigation.

35. Having considered the options it is important that employers clearly document the rationale for the way forward. The HSC organisation's local policy should make it clear whose responsibility it is to decide on the approach to be adopted.

36. If necessary, the HSC organisation can also seek advice and guidance from the relevant prescribed person.

37. Once local arrangements are in place, it is important to ensure all staff are aware of them, and this can be achieved in a number of ways: through hard copy correspondence with staff, communication by email and/or via organisation's intranet sites, through team briefings and inductions, or the message appearing on payslips. It is also important to ensure that the policies are accessible.

BRIEFING & TRAINING

38. Many concerns will be raised openly with line managers as part of normal day-to-day practice. Good whistleblowing arrangements should do nothing to undermine this. It is important that this is made clear to both staff and managers.

39. All managers and designated contacts should be briefed on:

- the value and importance of an open and accountable workplace;
- how to handle concerns fairly and professionally;
- how to protect staff who raise a genuine concern and where staff can get help or refer a concern;
- how to manage expectations of confidentiality;
- the importance of an alternative to line management if the usual channels of communication are unavailable; and
- how to brief their staff on arrangements.

40. Senior managers and designated contacts who are given a specific role in the whistleblowing arrangements should receive training in the operation of their policy for raising concerns.

AUDIT, REVIEW & REFRESH

41. A well run organisation will periodically review its whistleblowing arrangements to ensure they work effectively and that staff have confidence in them. The following points can sensibly be considered to assure that the arrangements meet best practice. Monitoring the arrangements in line with this checklist will also help the organisation demonstrate to regulators that their arrangements are working:

- arrange regular feedback sessions to evaluate progress and collect data on the nature and number of concerns raised;
- check the procedures used are adequate to track the actions taken in relation to concerns raised and to ensure appropriate follow-up action has been taken to investigate and, if necessary, resolve problems indicated by whistleblowing. Is there evidence of constructive and timely feedback?
- have there been any difficulties with confidentiality?
- have any events come to the organisation's attention that might indicate that a staff member has not been fairly treated as a result of raising a concern?
- look at significant adverse incidents/incident management systems or regulatory intervention - could the issues have been picked up or resolved earlier? If so, why weren't they?

- compare and correlate data with information from other risk management systems;
- find out what is happening on the ground - organisations should consider including a question about awareness and trust of arrangements in any future local staff surveys;
- organisations should seek the views of trade unions/professional organisations, as employees might have commented on the whistleblowing arrangements or sought their assistance on raising or pursuing a whistleblowing concern;
- organisations could also consider other sources of information, including information from exit interviews, the Order or other legal claims;
- key findings from a review or surveys should be communicated to staff. This will demonstrate that the organisation listens and is willing to learn and act on how its own arrangements are working in practice;
- refresh whistleblowing arrangements regularly. Regular communication to staff about revised arrangements is also recommended;
- although volunteers are not covered by the Order, the application of this Framework and Policy should be considered in the handling of their concerns; and
- think about reporting good news - success stories encourage and reassure everybody.

REPORTING AND MONITORING

42. Concerns raised by staff are an important source of information for the HSC organisations. It is important that they capture key aspects so that the value of their whistleblowing arrangements can be determined and lessons learned where appropriate.

43. In addition to individual case files HSC organisations should maintain a central register of all concerns raised, in a readily accessible format. Any system for recording concerns should be proportionate, secure and accessible by the minimum necessary number of staff.

44. An analysis of whistleblowing caseload should be reported regularly to senior management and the HSC organisation's Audit Committee. In addition, an annual return on caseload, actions and outcomes should be made available to the Department of Health. These will help inform those charged with governance that arrangements in place for staff to raise concerns are operating satisfactorily or will highlight improvements that may be required. The HSC organisations should consider reporting on the effectiveness of their whistleblowing arrangements in their annual report[4].

Stinson, Emma M

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 10 May 2018 10:33
To: Devlin, Shane
Cc: Wright, Elaine
Subject: RE: Meet

Morning

I understand one of the issues I needed to discuss with you came up yesterday.

Could we set a time to meet ASAP? I am happy to come in from my week of leave next week (providing it fits around Personal information redacted by USI if that suits.

Mark

From: Devlin, Shane
Sent: 04 May 2018 08:34
To: Haynes, Mark
Cc: Wright, Elaine
Subject: RE: Meet

HI Mark

I would be very happy to meet. I will ask my PA, Elaine, to make contact with you to arrange

Regards

Shane

From: Haynes, Mark
Sent: 04 May 2018 07:06
To: Devlin, Shane
Subject: Meet

Morning Mr Devlin

I am a consultant Urologist and AMD for Surgery and Elective Care. At our previous brief interactions you had mentioned that you would be keen to meet and discuss issues within our areas of responsibility and you also mentioned you would be keen to shadow us.

I wonder if we could set up a meeting at some point to discuss Surgery and Elective Care? I am Urologist of the week until next Thursday morning so dependent upon unscheduled activity may be able to meet today / Tues / weds on Craigavon site. Thursday and Friday would not be manageable for me as I am in Belfast / at MDM. I am on leave the following week. Week commencing 21st May the only availability I have would be Tuesday 22nd May between 9 and 12 and between 2 and 3:30.

Mark Haynes
Personal Information redacted by the USI

Stinson, Emma M

From: Haynes, Mark [redacted]
Sent: 08 June 2018 13:28
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M; Devlin, Shane
Subject: RE: Urology Waiting Lists

Dear Esther

Following on from below, a meeting took place. However, that meeting was to resolve the issues of the impact of the loss of extended day operating on the urology team such that the impact of this was spread across the surgical teams. The meeting did not result in Urology having its full number of weekly theatres (11 with backfill), nor was it intended to address any increase in urology operating to address the waiting list backlog.

In preparation for the meeting, waiting time information across different specialities were collated as below (as at 25/5/18);

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waiting	Total on waiting list
Urology	596	208	237	225	378	173	541	212	1752 patients
ENT	29	1x38 19	142	64	64	23	923	80	1158 patients
General Surgery	113	147	75	139	437	131	901	121	1526 patients
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38	50 patients
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128	2290 patients
Gynae	28	11	168	50	26	1 x 26 6	106	44	328 patients

As such, consideration needs to be given as to how the clinical risk associated with such significant waiting time disparities across specialities should be managed. As highlighted in my previous e-mail, amongst the urology cases are patients where there is well documented increased risk associated with longer waiting times. Unfortunately given the current constraints of available theatre time and inpatient beds along with nursing staffing pressures, I cannot see a solution that doesn't impact on the waiting times of patients from other specialities. However, I do not believe we can justify accepting the current situation.

Could we look to meet at some point next week to discuss this, perhaps we could use our 1:1 meeting next Tuesday with Ronan, Martina and Barry joining us?

From a urology team perspective, I think it would also be helpful to meet the full consultant team. We are all available on Thursday 14th June at 12:30 and would be happy to meet then if that suits?

Thanks

Mark

From: Gishkori, Esther
Sent: 22 May 2018 18:05
To: Haynes, Mark
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M
Subject: RE: Urology Waiting Lists

Dear Mark,
Thank you for sharing this.
Prima Fascia, it looks like the death of this Personal Information redacted by USI could have been avoided.
Ronan,
For this reason, please begin the SAI process in the first instance. Once screened, we can grade appropriately.
Also though, Mark reports here that the longer urology patients have to wait, the higher the incidence of an adverse incidence occurring.
I know that regionally urology is an issue but during our conversation with Mark today, he told us we had the longest waiters. I need to understand fully why this is but also if we have it within our gift to improve the situation within the Trust without making any other service unsafe or unstable.
I would also be grateful if you would, in the first instance, set up a meeting with Mark, you, me, Martina and Barry so that initial steps to reduce this waiting list can be discussed and actioned.
Shane,
For your information only at this point. I will keep you informed as we go but am happy to discuss at any point.
Dr Khan,
You are welcome to join us any time although the first few steps in this are probably operational. I will of course copy you into all correspondence.

Many thanks
Best,
Esther.

From: Haynes, Mark
Sent: 22 May 2018 13:31

To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Subject: Urology Waiting Lists
Importance: High

Dear Esther

I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

Tragically, a Personal Information redacted by USI male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early Personal information redacted by USI as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.

Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4 additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

I am happy to meet to discuss timescales to implement the changes required.

Yours Sincerely

Mark Haynes

Stinson, Emma M

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 20 July 2018 13:28
To: Devlin, Shane
Subject: RE: ?are you available

PS my office number is Personal Information or mobile Personal Information redacted by the USI

From: Haynes, Mark
Sent: 20 July 2018 13:27
To: Devlin, Shane
Subject: ?are you available

Hi Shane

Apologies for on-spec e-mail. Are you about for a quick phone conversation>?

Mark

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 05 September 2018 07:51
To: Conway, Barry; Toal, Peter; Carroll, Anita; Holloway, Janice; ONeill, Kate; McMahon, Jenny; McCourt, Leanne; Campbell, Dolores; Young, Jason; McCreesh, Kate; Leonard, Mairead; Mulholland, Nuala; Hanvey, Leanne; Johnston, Pamela; Caddell, Caroline; McClenaghan, Nichola
Cc: McVey, Anne; Trouton, Heather; Carroll, Ronan; Khan, Ahmed; Gibson, Simon; McKimm, Jane; Rogers, Ruth; Brownlee, Roberta; Devlin, Shane; Stinson, Emma M; Conlon, Noeleen; Boyce, Tracey
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Thanks

I feel very embarrassed to be named as my input in to Mr Harte's care has been negligible compared to that of others. In particular the Thorndale outpatients team (who I have copied in) and my secretary who have arranged and carried out his treatment, provided him with support, and carried out much of his follow-up (and fitted it all around his commitments with Tyrone GAA), and the theatre and ward teams when I have done his surveillance procedures. It is their work that has resulted in the praise, not mine.

However, the current status of urology waiting lists, and challenges with equipment, compounded by staffing pressures which mean that a number of inpatient theatre lists that are part of the normal compliment of elective theatres not being able to run, gives me serious concern that the service which was provided to Mr Harte (and many patients like him) when he first presented, would not be deliverable today.

Within the outpatients department, at first presentation with symptoms of bladder cancer, we offer a 'single visit' service whereby patients have all necessary diagnostics at the time of their initial attendance, thereby enabling the shortest time we can deliver from referral to first treatment. However, Our time to first appointment is now considerable (On Monday 3rd September I saw patients referred on as red flag in mid July). When patients do attend, we have insufficient flexible cystoscopes (this is due to the demands of the service now compared with 3 years ago, and a significant issue recurring with a number of scopes being out of circulation due to repair needs) to perform diagnostic cystoscopies and as a result some patients hare not getting their diagnostics performed at the time of attendance, being placed on a further waiting list for this procedure.

Once patients have had their initial surgical treatment for bladder cancer, many patients, like Mr Harte will go on to have intravesical chemotherapy or immunotherapy. This service is delivered by Janice Holloway and Kate McCreesh. However, it is at capacity and struggling to meet demand. Additionally, as has been ongoing since the services inception, the intravesical treatment service, as I understand, requires funding and staffing with the staffing being provided from the ward and OPD. This service runs as an entirely nurse delivered service.

Following treatment all patients with bladder cancer go onto surveillance programmes as the risk of recurrence is high (as high as the 80% quoted by Mr Harte in his interview in certain situations). The pressures on our waiting lists are such that these 'planned' surveillance procedures are delayed by significant periods of time – a patient for whom I performed such a procedure on Monday 3rd September had been due his procedure in June 2018. While rightly the impact of delays in these cancer surveillance procedures should give cause for concern, as I have detailed in previous correspondence, there are many patients awaiting planned surgery for benign conditions who are placed at higher risks of gram negative sepsis, as a result of prolonged waiting times, whose risk in our opinion (the urologists) is far higher. In June 2018 there were 596 patients on the Urgent IP WL for urological surgical procedures, with a waiting time of 4 years (208 weeks). In all other elective surgical specialities (including Gynaecology) there were a total of 396 patients and the shortest waiting time in these specialities was 11 weeks. This discrepancy between patients requiring urological surgery, and those requiring other speciality surgery cannot be acceptable..

Winter is coming and the almost inevitable cancellations of cases due to bed pressures will result in further deterioration in our waiting times.

In order to satisfy the demands of our population and continue to provide the service that Mr Harte has rightly praised, the urology department requires a number of immediate actions;

1) If available, engagement of further locum consultants (we have 2 working at present) to provide outpatient services to bring waiting times for urology outpatients down to an acceptable level, for all patients (Red flag, urgent and routine). Outpatient staffing will need to be adequate (ie increased) to enable this delivery of additional clinics.
2) Investment in flexible cystoscopes to bring the total number available (if all in circulation) in the Thorndale unit to 16. This will enable diagnostics to be performed on all patients at the time of their first OP attendance.
3) Long term funding / staffing of the intravesical treatment service to a level whereby it is deliverable 5 days a week.
4) Additional theatre capacity provided to bring urology waiting times down to an acceptable level – with 2 locum consultants and item (1) we would be able to staff these from within the 5 consultants or the 3 locums. This can be provided by either; (a) renting of a portable, staffed theatre (along with staffing of additional ward beds) for use by urology week days on Craigavon site, (b) outsourcing of work to the IS (however this failed previously in NI as there are not sufficient providers and the co-morbidites of urology patients typically means that the IS do not wish to take this work on), (c) redistribution of theatre lists within southern trust such that the number of available lists to urology is increased while other specialities theatre lists are reduced, until such a point as waiting times are equitable in all specialities.
5) Investment in equipment to provide LA, OP transperineal biopsies of the prostate (this will become a standard of care in the next 12-24 months, is not deliverable as an OP with our current equipment and would necessitate a GA for procedures currently carried out daily by Kate O'Neill / Leanne McCourt in the OPD, this would further add to our IP WL issues).
6) Long term we need investment / securing of additional consultant posts in southern trust, along with necessary theatre and outpatient infrastructure to bring the total number of funded consultant posts to 8 (I can share capacity:demand work which I carried out in 2014 which demonstrated a need at that point for a 7th post if people are interested).

I would be delighted to meet if anyone wishes to discuss these issues further.

Mark

From: Conway, Barry
Sent: 04 September 2018 16:35
To: Toal, Peter; Carroll, Anita
Cc: McVey, Anne; Trouton, Heather; Carroll, Ronan; Khan, Ahmed; Gibson, Simon; McKimm, Jane; Rogers, Ruth; Haynes, Mark; Brownlee, Roberta; Devlin, Shane; Stinson, Emma M; Conlon, Noeleen; Boyce, Tracey
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Peter – this is good feedback.

Mark – thanks to you and all the Urology Team for your ongoing work.

Barry.

From: Toal, Peter
Sent: 04 September 2018 16:31
To: Carroll, Anita
Cc: Conway, Barry; McVey, Anne; Trouton, Heather; Carroll, Ronan; Khan, Ahmed; Gibson, Simon; McKimm, Jane; Rogers, Ruth; Haynes, Mark; Brownlee, Roberta; Devlin, Shane; Stinson, Emma M; Conlon, Noeleen; Boyce, Tracey
Subject: Tyrone GAA Manager praises CAH staff for care and treatment

FYI,

See below message and Belfast Live article we have retweeted today re praise from Mickey Harte (Tyrone GAA Manager) about his care and treatment in CAH (Mark Haynes is named by Mr Harte).
Many Thanks
Peter Toal
Communications Manager
Southern Health and Social Care Trust

Southern Trust 14m14 minutes ago

Kind words from Mickey Harte about his care and treatment @SouthernHSCT - our staff are delighted that he felt very well looked after and has recovered so well! @healthdpt @HSCBoardhttps://twitter.com/BelfastLive/status/1036983585948008448 …

Belfast Live

https://www.belfastlive.co.uk/sport/gaa/gaelic-football/mickey-harte-says-grief-steeled-15107923?utm_source=twitter.com&utm_medium=social&utm_campaign=sharebar

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 19 October 2018 07:02
To: Gibson, Simon; Carroll, Anita; Magwood, Aldrina; Gishkori, Esther; Carroll, Ronan
Cc: Devlin, Shane; Khan, Ahmed; Stinson, Emma M
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment
Attachments: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3) (17.6 KB)

Further to this meeting have any minutes / action plans been drawn up?

During the meeting on how over the past year the spread of lost theatre lists had perversely been least in the speciality with the shortest waiting time. I stated that I felt a formal Coorporate direction / strategy was needed regarding how planned theatre reductions are tackled within the trust. The view of others was that this is an operational issue within the acute directorate.

Attached is some email communication regarding plans for this winters 30% reduction. One option put forward has been to 'rebalance' the loss over the last year according to waiting list pressures and responses are within the email chain.

I firmly believe any solution that attempts to redress the inequities in waiting times requires a firm, formal, corporate stance, communicated clearly to all teams. Without this a negotiated solution will fail to address the issue.

Mark

From: Witczak, Maria
Sent: 08 October 2018 14:32
To: Haynes, Mark; Montgomery, Ruth; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Anita; Magwood, Aldrina
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Dear all,

I would like to inform that "Tyrone GAA Manager praises CAH staff for care and treatment" meeting has been moved to 09.00am – Meeting room 1.

Kind regards

Maria Lisiak - Witczak
Personal Secretary to Ronan Carroll
Assistant Director of Surgery and Electicve Care and ATIC's
Ext. [redacted]

From: Haynes, Mark
Sent: 05 October 2018 10:36
To: Witczak, Maria; Montgomery, Ruth; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Anita; Magwood, Aldrina
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Morning al1.

Apologies – the venue of my 11am meeting was not clear on my diary for Maria – it is with HSCB / PHA / Prostate cancer UK in Belfast and starts at 11am.

I therefore need to leave CAH by 9:30am at the latest as I will be getting the train to Belfast.

Would everyone be able to meet earlier say 9-9:30am? And reschedule the 9am meeting I have that day?

Mark

From: Witczak, Maria
Sent: 02 October 2018 12:42
To: Montgomery, Ruth; Haynes, Mark; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Anita; Magwood, Aldrina
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment
Importance: High

Dear All,

There is a mistake on the time of the meeting.

Please accept my apologies :

The actual time is ***10.00 – 10.30***
Meeting Room 1

Kind Regards

Maria Lisiak - Witczak
Personal Secretary to Ronan Carroll
Assistant Director of Surgery and Electicve Care and ATIC's
Ext. Personal Informati
Personal Information redacted by the USI

From: Witczak, Maria
Sent: 21 September 2018 13:52
To: Montgomery, Ruth; Haynes, Mark; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Ronan; Carroll, Anita; Magwood, Aldrina
Subject: Tyrone GAA Manager praises CAH staff for care and treatment
Importance: High

Dear all,

It has been agreed that meeting in re *"Tyrone GAA Manager praises CAH staff for care and treatment"* will be held :

09th October 2018 @ 10.30 – 11.00

Venue : Meeting room 1

Thank you for co-operation.

Any queries please do not hesitate to contact me via email or by phone.

Kind regards

Maria Lisiak - Witczak
Personal Secretary to Ronan Carroll
Assistant Director of Surgery and Electicve Care and ATIC's
Ext. Personal Informati
Personal Information redacted by the USI

Stinson, Emma M

From: Conway, Barry <[redacted]>
Sent: 18 October 2018 21:57
To: Haynes, Mark; Carroll, Ronan
Cc: Carroll, Anita; Scullion, Damian; Gishkori, Esther; Khan, Ahmed; Hogan, Martina; Kennedy, Geoff; Sim, David
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Dear all,

I can see the view on all sides in this debate. I have discussed a reduction with Gynae and they understand they will have to take a hit. Options proposed included 30% and 35%, however I don't expect they will be content to take a reduction 57% of their operating time for the reasons noted below. experience would also show that the pressures will last beyond 31 March 2019.

I agree with Ronan that we need to defer to corporate SMT for them to make a call on this.

Martina / Geoff / David – copying to you for information.

Barry.

From: Haynes, Mark
Sent: 18 October 2018 21:45
To: Carroll, Ronan
Cc: Conway, Barry; Carroll, Anita; Scullion, Damian; Gishkori, Esther; Khan, Ahmed
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

But last winter Gynae didn't get the 30% reduction (they were 25.9%), from March onwards and through the summer they didn't get an 18% reduction (6%).

The speciality with the shortest waiting times has been protected over a year, while specialities with considerably longer waits have lost a greater percentage of their lists. The arguments surrounding training apply to every speciality and cannot be used for one.

Surely a winter 're-balancing' the last 12 months is appropriate and justified?

Mark

From: Carroll, Ronan
Sent: 18 October 2018 21:38
To: Conway, Barry; Carroll, Anita
Cc: Haynes, Mark; Scullion, Damian
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Barry,
I would say couple of things

1. All Trusts have been asked to reduce by 30% so gynae could well be affected the same way in other Trusts.
2. This is for winter so I don't think 4mtsh would deskill any surgeon eg if off sick x 4nths we wouldn't be doing anything to upskill them.
   NIMTDA & trainees again this si from HSCB/DHPSS

Clinicians will not agree on the options this is clear to me so rather than us batting back & forth Anita I would ask that SMT discuss the paper, confirm their priorities and endorse an option.

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information

From: Conway, Barry
Sent: 18 October 2018 20:00
To: Carroll, Ronan; Carroll, Anita
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Ronan,

Thanks for the revised paper. Will definitely need round table discussions. I don't think a 57% reduction for Gynae would be acceptable. some issues raised with me to date include:

- Gynae surgeons already have limited operating time
- A reduction of this scale would impact on numbers required to maintain their skills
- Unable to provide theatre time for trainees and would not be acceptable to NIMDTA
- Could destablise the O+G service – some surgeons could decide to go elsewhere

Gynae would be prepared to take a proportion of the hit but 57% would not be acceptable in my view.

Barry.

From: Carroll, Ronan
Sent: 17 October 2018 20:45
To: Conway, Barry; Carroll, Anita
Subject: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Anita/Barry,
Please find attached draft proposal. Happy to chat through
No doubt round table discussions will need to take place – in cah tomorrow pm – off Friday

Stinson, Emma M

From: Wright, Richard <[redacted]>
Sent: 12 December 2017 12:00
To: Wright, Richard; Haynes, Mark
Subject: 1-1 meeting with Dr Wright -[redacted])

Subject: 1-1 meeting with Dr Wright -[redacted])
Location: Dr Wright's office THQ
Categories: Meeting
Importance: Normal
Start: 2017-12-12 12:00:00Z
End: 2017-12-12 13:00:00Z

Body:

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 16 November 2017 08:02
To: Carroll, Ronan; Gishkori, Esther
Subject: 3S / winter plans

Morning Ronan / Esther

Just a consideration re winter plans and 3S. We currently have 31 urology inpatients, 26 currently on 3S, 5 elsewhere. The urology team is small with no SHO grades. As / if / when the ward becomes just 18 beds our patients will be spread further around the hospital with many of them housed on wards where there is no FY1 cover (recovery, 1WE, Gynae). I fear we will be swapping outlier management issues that are currently noted with medical outliers for a similar problem for urology. If 3S had no ENT patients and no GS patients, urology would still have 13 outliers, the reality will be more outliers than this as there will be ENT tracheostomy patients that will be in beds on 3S.

There will be inevitable delays in patient reviews, discharge planning and response to emergency calls (SPR and consultant cannot be everywhere at once) affecting urology patients.

We discussed on Friday with Francis if any junior Dr posts could improve things for the winter pressures. I suggest that there is an urgent need to find junior cover for 1WE / 1W Gynae 8-6 daily (covering all speciality patients) and consideration of a similar plan for Recovery if these are the locations where these patients will be housed.

Can we look to recruit (presumably from agency in first instance) ASAP?

Mark

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 28 October 2018 06:29
To: Gishkori, Esther
Subject: FW: 3S transfer to 3N??

Morning

Further to Anne's email, this was a further email from me on the subject with further thoughts regarding the suggestion.

Mark

From: Haynes, Mark
Sent: 27 October 2018 08:07
To: Bradley, Una; Carroll, Ronan
Cc: McVey, Anne; Murphy, Philip
Subject: RE: 3S transfer to 3N??

Thanks Una

Expanding on my previous reply…

The origin of this suggestion frustrates me immensely. I warned last year that re-designating half of the combined urology / ENT ward as medical could be the start of a permanent reduction in capacity for these services. This suggestion can be viewed as a clear strategic move to a permanent reduction in these services, at a time when an increase in capacity is urgently required. To base assumptions on inpatient data, for services that have been unable to provide their full services due to reduced theatre and inpatient bed availability for 12 months is fundamentally flawed. Over the summer ENT have been only operating at 2/3 capacity due to theatre reductions. Urology have lost 16% of their theatre lists.

All members of the SMT should be well aware of serious concerns raised about the urology service. Our waiting lists are over 4 years for clinically urgent surgery. Patients are recurrently requiring unscheduled ED attendances / inpatient treatment with largely urinary sepsis secondary to indwelling catheters / stents while they await surgery (you and your colleagues I imagine also see this with elderly patients admitted with catheter related urosepsis). We have had an elective surgical death from urosepsis in a patient who waited longer than recommendations suggest with an indwelling stent (with risk of sepsis increasing the longer a patient waits).

Management of urological patients requiring irrigation, with nephrostomies in, or after major surgery as outlying patients is unsafe. All urologists have experienced iatrogenic bladder perforations in patients irrigated on outlying wards. Most of us have experienced a patient death as a result. Management of inpatient ENT elective surgery (after upper airway surgery or where the upper airway is at risk if surgical complication occurs) is equally unsafe.

Urology is the only service providing male specific medical and surgical interventions. Urology routine outpatient referrals are dating back to early 2016 and still wait with no routine referrals currently being booked to clinics. Our red flag outpatient wait is >6weeks. There is already a marked inequity in access for these male specific services vs female specific services (Breast and Gynaecology services). If the situation were reversed it would be a nationwide scandal. An added issue faced by urologists across the NHS as the Mesh controversy has rolled forwards is that although urologists have largely not been involved or provided the primary mesh surgery, they are involved in the assessment of and subsequent surgical management of patients with mesh complications so our female specific workload is increasing too!

The need for medical beds is urgent and I would always support, we are well behind the curve in all aspects – infrastructure, nursing staffing and medical staffing. It is inevitable, given where we are, that in order to provide the required increase in capacity to deliver this unscheduled care another service will need to have its capacity reduced… but some of these unscheduled care beds are regularly filled by patients on waiting lists for surgery in the service that is being reduced. Another winter of urology not operating on any clinically urgent patients and increasing waiting times for our cancer surgery will further increase the number of unscheduled admissions in these beds and create further unscheduled care pressure. To increase the medical beds by reducing the service with the longest waiting times in the trust defies logic.

For the urology service, if this were to happen it may well prove to be a tipping point for our two senior colleagues who are already talking about retirement (one being >65). For the ENT service, one senior consultant has already taken a sabbatical. I know that the perceived intent to reduce the service by recent trust decisions (the impact of the new paeds wards, and the reduction of the service due to unscheduled care pressures) was a factor in his decision to take a sabbatical and if this were to progress I would not be surprised to the move become permanent. I have heard rumour further ENT consultants considering their options.

As outlined, if this were to be ultimately the trusts decision moving into winter, it is not a decision I could support.

Mark

From: Bradley, Una
Sent: 26 October 2018 18:04
To: Carroll, Ronan; Haynes, Mark
Cc: McVey, Anne; Murphy, Philip
Subject: RE: 3S transfer to 3N??

Mark,

Apparently this was suggested by the Chief Executive today based on medical inpatient data, increasing medical admissions and winter pressure planning.

Potentially more medical beds are planned to open from the beginning of December.

Una

From: Carroll, Ronan
Sent: 26 October 2018 17:14
To: Haynes, Mark
Cc: McVey, Anne; Murphy, Philip; Bradley, Una
Subject: 3S transfer to 3N??

Mark
Anne/Phillip have asked would it be possible that MUSC takes all of 3S for MUSC and we transfer to 3N on 18beds - yes/no?
Ronan

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

Stinson, Emma M

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 18 October 2018 21:45
To: Carroll, Ronan
Cc: Conway, Barry; Carroll, Anita; Scullion, Damian; Gishkori, Esther; Khan, Ahmed
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

But last winter Gynae didn't get the 30% reduction (they were 25.9%), from March onwards and through the summer they didn't get an 18% reduction (6%).

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From: Carroll, Ronan
Sent: 18 October 2018 21:38
To: Conway, Barry; Carroll, Anita
Cc: Haynes, Mark; Scullion, Damian
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

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Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Informatio

From: Conway, Barry
Sent: 18 October 2018 20:00
To: Carroll, Ronan; Carroll, Anita
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Ronan,

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- Gynae surgeons already have limited operating time
- A reduction of this scale would impact on numbers required to maintain their skills
- Unable to provide theatre time for trainees and would not be acceptable to NIMDTA

- Could destablise the O+G service – some surgeons could decide to go elsewhere

Gynae would be prepared to take a proportion of the hit but 57% would not be acceptable in my view.

Barry.

From: Carroll, Ronan
Sent: 17 October 2018 20:45
To: Conway, Barry; Carroll, Anita
Subject: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Anita/Barry,
Please find attached draft proposal. Happy to chat through
No doubt round table discussions will need to take place – in cah tomorrow pm – off Friday

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 28 October 2018 07:42
To: Carroll, Ronan; Gishkori, Esther; Stinson, Emma M; Conway, Barry
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Below are the considerations from my perspective. I truly feel this requires a steer from SMT in writing. Collective amnesia is endemic when issues arise from necessary difficult decisions and there is no decision which is without a risk.

Over the past 12 months there have been reduced theatre sessions, the spread of the loss of theatres within CAH has not been uniform across specialities. The tables below illustrate the reductions in each speciality in winter and then summer;

December 2017 – March 2018	G Surgery	ENT	Urology	Gynae	Breast
CAH	30.5% (3 sessions)	35.30% (4.5 sessions)	33.90% (3.7 sessions)	25.9% (1.8 sessions)	17.9% (0.7 sessions)
Total sessions lost	39	58	48	23	9

April – August 2018 CAH	G Surgery	ENT	Urology	Gynae	Breast
Mean % theatre reduction	15.5%	36.2%	15.3%	6.4%	7.8%
Total sessions lost	34	92	35	9	6

It is evident from these tables that the reduction in theatres has not been spread equally amongst specialities with ENT taking the largest reductions. Breast and Gynae have lost the fewest sessions (the summer figures are for the CAH site only).

Waiting times for the specialities also vary considerably at all urgencies (below), as do total numbers of patients on waiting lists – I cannot lay my hands on this table at present but I am sure Wendy can run off a comparative table of numbers of patients on each specialities WL for surgery, I know when I last saw it that there were more on the urology waiting list than all other specialities **combined**;

	Waitings times as at 30/9/18		
	Red flag	**Urgent (weeks)**	**Routine (weeks)**
General Surgery	<4wks	141	157
Breast	<5wks	60	62

Gynae	<4wks	23	50
Urology	<7wks	221	243
ENT	<4wks	14	78

In terms of patient risk, patients on the longest waiting list are coming to harm. They are attending ED, they are having emergency admissions, they are requiring more difficult complex procedures due to the duration of time on the waiting list. I can, if required, give you patient ID's to illustrate this.

With regards training and staffing, there has been a reduction of 1/3 in ENT surgery over a prolonged period. This has reduced exposure to procedures for ENT trainees and continues to do so. One ENT consultant has taken a sabbatical from the trust. Loss of operating was a factor in this decision. An experienced Staff grade has also left the ENT department. The non-cancer surgeons in the ENT team spent last winter essentially not operating and are potentially facing another winter of the same. Last winter they were at least able to continue some children's surgery but with the reduction in paediatric bed numbers in the trust after the move to the new units, it is extremely likely that these will be reduced as winter bed pressures are likely to result in cancellations. In urology the 2 senior consultants have spoken about retirement plans with increasing frequency as the team find themselves increasingly unable to offer treatment to patients within acceptable timescales. Alongside the theatre reduction discussions, the combined ENT / Urology ward has been the 'target' for surgical bed reductions. Last winter half the ward was re-designated as medical, this destabilised the nursing establishment (further from what was already a difficult nursing staffing position), It also led to increasing numbers of outliers, particularly for urology patients. There are now, as you are aware from other discussions, conversations about moving this combined ward to a smaller (in terms of bed numbers) ward area. Viewed from within, and without, the appearance of the combinations of the waiting times, reductions in theatre availability and bed numbers for these specialities gives the impression that there is a intention 'run down' in these services. If things continue as per current suggestions then there is a very real risk of further loss of senior medical staff from the trust in these specialities.

My view is that the very minimum that should be achieved in the reductions for theatre for this winter is an approach which rebalances the loss of theatres which has not been spread equally between specialities over the past year. This would mean the largest reduction for this winter happening in Gynae and Breast surgery with the least reductions in ENT. While I recognise that Breast surgery workload is largely RF, there is a reality that Urology RF waits are longer than in other specialities. There is a gender inequality here that must be addressed. Once a rebalancing has been achieved, the next question is going forwards is it morally right for us to stand over and accept waiting time inequities as they are at present? I am clear in my view that it is not. I know that if the waiting time inequities were reversed there would be no way in which it would be accepted. If nothing is done to attempt to redress the inequity between Urology (the only men's health surgical speciality) and Breast/Gynaecology, the message being given is that this inequity is acceptable to the trust. I also urge that any bed changes within SEC occur outside of ENT/Urology.

I would encourage that a clear strategic direction is given from the trust SMT in writing (and that this is communicated in writing to the trust board) and then this can be taken forwards within acute.

Mark

From: Carroll, Ronan
Sent: 26 October 2018 17:10
To: Gishkori, Esther
Cc: Conway, Barry; Stinson, Emma M; Haynes, Mark
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Esther
I have JP appeal training on Tuesday am in Belfast –
I can 1:1 Monday if your diary permits from DHH or after SMT on Tuesday in CAH
We are at an impasse with the options
Ronan

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

From: Gishkori, Esther
Sent: 26 October 2018 17:05
To: Carroll, Ronan
Cc: Conway, Barry; Stinson, Emma M
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Ronan,
Proper 1:1 on Tuesday.
Clearly you and Barry have had a conversation with the wider teams and I would be eager to hear which option floats to the top as a result.
Both the Cx and I would be keen (this year anyway) to try to comply with the consensus.
Best
Esther.

From: Carroll, Ronan
Sent: 26 October 2018 13:01
To: Gishkori, Esther
Cc: Conway, Barry; Stinson, Emma M
Subject: FW: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Esther
Did you get an opportunity to speak with Shane re which option we are to go with. Conscious of the booking cycle
Ronan

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

From: Carroll, Ronan
Sent: 18 October 2018 21:38
To: Conway, Barry; Carroll, Anita
Cc: Haynes, Mark (Personal Information redacted by the USI); Scullion, Damian
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Barry,
I would say couple of things

1. All Trusts have been asked to reduce by 30% so gynae could well be affected the same way in other Trusts.
2. This is for winter so I don't think 4mtsh would deskill any surgeon eg if off sick x 4nths we wouldn't be doing anything to upskill them.
   NIMTDA & trainees again this si from HSCB/DHPSS

Clinicians will not agree on the options this is clear to me so rather than us batting back & forth Anita I would ask that SMT discuss the paper, confirm their priorities and endorse an option.
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery

Mob Personal Information redacted by the USI
Ext Personal Informatio

From: Conway, Barry
Sent: 18 October 2018 20:00
To: Carroll, Ronan; Carroll, Anita
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Ronan,

Thanks for the revised paper. Will definitely need round table discussions. I don't think a 57% reduction for Gynae would be acceptable. some issues raised with me to date include:

- Gynae surgeons already have limited operating time
- A reduction of this scale would impact on numbers required to maintain their skills
- Unable to provide theatre time for trainees and would not be acceptable to NIMDTA
- Could destablise the O+G service – some surgeons could decide to go elsewhere

Gynae would be prepared to take a proportion of the hit but 57% would not be acceptable in my view.

Barry.

From: Carroll, Ronan
Sent: 17 October 2018 20:45
To: Conway, Barry; Carroll, Anita
Subject: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Anita/Barry,
Please find attached draft proposal. Happy to chat through
No doubt round table discussions will need to take place – in cah tomorrow pm – off Friday

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 21 September 2018 09:10
To: Carroll, Ronan; Magwood, Aldrina; Carroll, Anita; Gishkori, Esther
Cc: Stinson, Emma M; Conway, Barry; Khan, Ahmed; Gibson, Simon
Subject: Re: Winter plan

As Ronan states;

1) the 30% reduction has continued beyond 'winter'.
2) 30% reduction in capacity was insufficient to meet RF and urgent demand last year and remains insufficient this summer. It will be insufficient this winter too. This is illustrated by the fact that the wait for urgent inpatient urological surgery 3 months ago was 208 weeks. It is now 222 weeks ie we do not have capacity to provide urgent surgery.
3) even with the 30% reduction on day / day before cancellations occurred last winter and have also occurred this summer suggesting that there will be more cancellations if we continue at the same level into this winter without a significant increase in available inpatient beds.
4) the reduction has not been spread evenly across specialities through the summer. Indeed perversely the speciality with the shortest waiting times has lost the smallest percentage of sessions.
5) to continue to apply a reduction as it has been across the specialities will exacerbate the already stark inequalities across services. Waiting times for clinically urgent surgery are unacceptable in some specialities, particularly when compared with other specialities.
6) waiting times for red flag surgery also differ across the specialities. Can red flag pathway times also be shared as these I suspect will mirror the urgent waits?
7) other temporary winter plans from last winter also remain in place eg designation of half of 3S as medical beds. This is despite assurances given at the time that it was temporary and would revert to being a surgical ward in April. This means the reported medical outliers numbers are lower than should be recognised and creates issues with nursing morale. It also creates a difficult working relationship between us as a management team and the ward staff as we gave them reassurances, in a meeting of unions and staff that this re-designation was temporary.

I have raised these same issues on a number of occasions and yet we continue to sit in the same place. No more talking is required. A senior trust decision is needed to either accept the current inequity of provision of service and ideed perpetuate it or reassign available resource (theatre space and beds) according to waiting times and clinical need.

A final thought;
A man referred with incontinence to urology will wait for outpatients and when placed on the list for urgent surgery will wait 222 weeks. A women with the same condition will wait 12 weeks. Can this really continue?

Mark

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Thursday, 20 September 2018 20:39
To: Magwood, Aldrina; Carroll, Anita; Gishkori, Esther
Cc: Stinson, Emma M; Haynes, Mark; Conway, Barry

Subject: RE: FW: Winter plan

Esther/Aldrina/Anita
Attached spreadsheet shows theatre sessions undertaken by each surgical specialty from April 18.
With the deficit in theatre nurses we have effectively continued with a 30% reduction (not able to provide evening sessions, which affected Urology and ENT)
Rows 51-56 are the keys rows
We have also provided the waiting times for each specialty. I would ask that we discuss this data as part of winter planning asap
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Informatio

From: Magwood, Aldrina
Sent: 20 September 2018 11:12
To: Carroll, Anita
Cc: Carroll, Ronan
Subject: RE: FW: Winter plan

Thanks Anita – yes a more granular plan at speciality level makes sense

---

From: Carroll, Anita
Sent: 20 September 2018 07:00
To: Magwood, Aldrina
Cc: Carroll, Ronan
Subject: Re: FW: Winter plan

Aldrina I was at acute director meeting and I advised we had diownturned 30 % last year this differed for others and the application of same differed
We had same % across all specialties but others took account of position by speciality

Ronan and I will discuss
Anita

On 20 Sep 2018 00:04, "Magwood, Aldrina" <Personal Information redacted by the USI> wrote:
Anita/ Ronan – have you been involved in these discussions? This area is still outstanding in our USC plan (in discussion indications were 30% may not be effective this year re: RF/urgent demand) in terms of what we are planning to put in place this year re elective. Can you please advise current position/ thinking.

Thanks
A

From: Coulter, Roisin [mailto:Personal Information redacted by the USI]
Sent: 19 September 2018 09:58
To: Thompson, Jennifer
Cc: Molloy Teresa; Magwood, Aldrina; Breige Donaghy; ONeill Maura; McGoran, Seamus; McAleer, Emma; Moore, Helen
Subject: Re: Winter plan

Folks all directors of acute met on Monday and discussed agreeing same dates I believe. We mentioned this to Miriam yesterday re a consistent approach, agreed early. I think that all content, just Bernie fro belfast to check with other acute directors in Belfast. (not to include areas that do not impact pressures eg musgrave etc)

Hope helpful

Roisin.

Sent from my iPhone

On 19 Sep 2018, at 09:10, Thompson, Jennifer <Personal Information redacted by the USI> wrote:

> Teresa
> Our initial plan indicates the following
>
> 1.1 Cessation of routine Inpatient Elective Activity from 22nd Dec to 30th Jan 2019 (inclusive).
>
> **Impact:** To minimise the number of patients surgery cancellations at short notice because of unscheduled pressures.
>
> These dates will be subject to ongoing review
> We have our meeting with HSCB next week to discuss further
> Regards
> Jennifer

From: Molloy Teresa <Personal Information redacted by the USI>
Sent: 17 September 2018 12:46
To: Aldrina Magwood <Personal Information redacted by the USI>; Roisin Coulter <Personal Information redacted by the USI>; Breige Donaghy <Personal Information redacted by the USI>; Thompson, Jennifer <Personal Information redacted by the USI>
Cc: ONeill Maura <Personal Information redacted by the USI>
Subject: Winter plan

Guys
If you recall we had a regional we vision last year to downturn IP routine elwctive patients in our acute hospitals.
Can I ask what assu.ptions you have made in your winter plan?
Are any of you replanning consultant job plans as a result?
Teresa

Sent with BlackBerry Work (www.blackberry.com)

Theatre utilisation - Funded -vs- Used (Main theatres CAH) April - August 2018

April 2018	General Surgery		Urology		ENT		Breast		Ortho		Gynae		DCC/TOE		Bhol	audit
	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used		
w/c 02.04.18	4	4	7	5	9	3	2	2	10	8	4	4	0	0	2	
w/c 09.04.18	11	8	11	9	12	8	4	4	18	18	7	6	0	0		
w/c 16.04.18	9	6	10	6	12	9	4	4	16	16	6	6	0	1		1
w/c 23.04.18	11	11	11	8	13	9	4	3	18	18	7	7	0	0		
w/c 30.04.18	12	10	11	9	12	6	4	4	18	18	7	7	0	0		
Total:	47	39	50	37	58	35	18	17	80	78	31	30	0	1		

Total funded	284	
Total used	236	(-48)
Sessions unused	53	
Session b/filled	5	(-48)

DCC b/f x 1 session
Core spec b/f x 4 sessions

May 2018	General Surgery		Urology		ENT		Breast		Ortho		Gynae		DCC/TOE		Bhol	audit
	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used		
w/c 07.05.18	8	9	10	7	11	7	2	2	14	14	5	4	0	0	1	
w/c 14.05.18	9	9	9	7	10	8	4	4	16	16	7	6	0	1		1
w/c 21.05.18	11	11	11	9	13	7	4	4	18	18	7	7	0	0		
w/c 28.05.18	9	9	10	8	11	8	2	2	14	14	5	4	0	0	1	
Total:	37	38	40	31	45	30	12	12	62	62	24	21	0	1		

Total funded	220	
Total used	195	(-25)
Sessions unused	30	
Session b/filled	5	(-25)

DCC b/f x 1 session
Core spec b/f x 4 sessions

June 2018	General Surgery		Urology		ENT		Breast		Ortho		Gynae		DCC/TOE		Bhol	audit
	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used		
w/c 04.06.18	11	10	11	10	12	9	4	4	18	18	7	5	0	0		
w/c 11.06.18	11	10	11	10	12	10	4	4	18	14	7	7	0	0		
w/c 18.06.18	10	11	9	8	12	9	4	2	16	16	7	6	0	0		1
w/c 25.06.18	11	10	11	10	12	7	4	4	18	17	7	6	0	0		
Total:	43	41	42	38	48	35	16	14	70	65	28	24	0	0		

Total funded	247	
Total used	217	(-30)
Sessions unused	44	
Session b/filled	14	(-30)

July 2018	General Surgery		Urology		ENT		Breast		Ortho		Gynae		DCC/TOE		Bhol	audit
	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used		
w/c 02.07.18	11	9	11	10	12	6	4	4	18	10	7	7	0	0		
w/c 09.07.18	9	0	11	11	10	5	2	4	14	12	5	5	0	0	1	
w/c 16.07.18	10	6	9	8	9	6	4	2	16	15	7	6	0	0		1
w/c 23.07.18	11	8	11	7	13	9	4	2	18	12	7	7	0	0		
w/c 30.07.18	11	9	11	9	12	9	4	4	18	10	7	7	0	0		
Total:	52	32	53	45	56	35	18	16	84	59	33	32	0	0		

Total funded	296	
Total used	219	(-77)
Sessions unused	89	
Session b/filled	12	(-77)

August 2018	General Surgery		Urology		ENT		Breast		Ortho		Gynae		DCC/TOE		Bhol	audit
	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used	Funded	Used		
w/c 06.08.18	11	11	11	9	12	9	4	3	18	10	7	7	0	0		
w/c 13.08.18	10	8	11	12	11	4	3	3	16	10	6	6	0	2		1
w/c 20.08.18	11	8	11	11	13	8	4	4	18	15	7	7	0	1		
w/c 27.08.18	8	8	10	10	11	6	2	2	14	11	5	5	0	0	1	
Total:	40	35	43	42	47	27	13	12	66	46	25	25	0	3		

Total funded	234	
Total used	190	(-44)
Sessions unused	56	
Session b/filled	12	(-44)

DCC.TOE b/f x 3 sessions
Core spec b/f x 9 sessions

Totals Funded and Used	219	185	228	193	254	162	77	71	362	310	141	132
Variance: Used - Funded	-34		-35		-92		-6		-52		-9	
%	-15.53%		-15.35%		-36.22%		-7.79%		-14.36%		-6.38%	

Urgent (wks)	141, 127		222		28		59, 44		129		12	
Routine (wks)	157		243		80		61		135		56	

Stinson, Emma M

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 30 October 2019 11:23
To: Carroll, Ronan; McClements, Melanie
Cc: OKane, Maria
Subject: FW: Correspondence to HSCB : Surgical Waiting List Risks
Attachments: NICaN Urology CRG Surgical Waiting Lists October 2019 (2).pdf

Importance: High

Morning

Just FYI in case it comes up. Attached is a letter sent by me on behalf of the urology NICAN CRG regarding risks and current waiting times for urological cancer surgery in NI.

Mark

From: Sarah Donaldson [mailto:Personal Information redacted by the USI]
Sent: 25 October 2019 09:22
To: Haynes, Mark; Mr Hugh O'Kane; Mr Sam Gray; Colin Mulholland; Mr Alex Mac Leod; John Keane (niecr); John McKinght (niecr); Chris.thomas Personal Information redacted by the USI; Glackin, Anthony; Brian Duggan
Cc: Lisa Houlihan (BHSCT); pat.mcclelland Personal Information redacted by the USI; Bridget Tourish; Mary Jo Thompson; Ciara Toal; Reddick, Fiona
Subject: Correspondence to HSCB : Surgical Waiting List Risks
Importance: High

"This email is covered by the disclaimer found at the end of the message."

****Sent OBO Mr Mark Haynes, Chair of NICaN Urology CRG****

Dear All,

Please find attached final correspondence sent to the HSCB this am.

Many thanks

Sarah

Sarah Donaldson
Macmillan Network Co-ordinator-NICaN
12-22 Linenhall Street
Belfast
BT2 8BS
Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Northern Ireland Cancer Network HSC 70 NHS 70

Northern Ireland Cancer
Network
First Floor
Health and Social Care Board
12-22 Linenhall Street
Belfast

Date: 25 October 2019

VIA EMAIL
Dr Miriam McCarthy
Director of Commissioning
Health and Social Care Board
12 – 22 Linenhall Street
Belfast
BT1 8BS

Dear Dr McCarthy,

RE: UROLOGY SURGICAL WAITING LISTS

I write to you in my capacity as the Chair of the NICaN Urology Clinical Reference Group. At our recent group meeting we had in depth discussions on the current challenges with regards demand vs capacity for urological surgery in Northern Ireland with particular reference to waiting times for urological cancer surgery.

The current position is placing the urological cancer surgeons in a position of not being able to consistently offer surgery within expected timescales for cancer treatments. This places the surgeons in a difficult position, where there is an increasing expectation placed on clinicians to risk assess patients awaiting cancer treatment to determine priority on the list and the risks associated with this expectation. In practice this means inevitably delaying some patient's cancer treatments in order to expedite another patient's treatment.

Urological Surgeons, across all Trusts have concerns regarding the position they are being placed in. While they recognise their clinical responsibility to prioritise according to clinical risk, the progressively increasing waiting times across urological services mean that those patients deemed to be low risk may wait considerably longer than is felt acceptable. There is concern that these 'low risk' patients may subsequently being found to have higher risk disease or disease progression when they have their definitive treatment. The alternative management strategy of managing all cancer treatments as equal risk and in chronological order we feel presents a higher risk of disease progression.

The urology teams across all Trusts are working to maximise the provision of cancer treatments within the available theatre time. However, there are limitations, as many urological patients are also at significant risk from benign disease and delivery of these treatments cannot be deferred without harm coming to this group of patients. Effectively, as you are aware, routine inpatient urological surgery is not being delivered at present. You will also be aware of the direct link between increasing waiting times and demand for community / primary

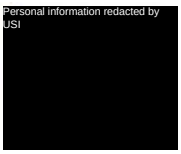
care / emergency department / unscheduled care which also consequently can impact on our ability to deliver inpatient treatments.

There was regional consensus that this should be flagged from the CRG to the HSCB so that there is recognition and acceptance that the urological surgeons are sub-stratifying cancer risks in order to manage increasing waiting times, that this does carry some risk to patients deemed to be low risk, and that this sub-stratification is essential and unavoidable at present.

We also request that the HSCB support the CRG in flagging this process to the Trusts and encourage Trusts to ensure that in the current situation where capacity is reduced in Trusts as a result of staffing and bed pressures, the Trusts ensure that the application of any inpatient theatre availability reductions (planned theatre reduction due to staffing pressures and unplanned due to lack of beds) is risk assessed across specialities to ensure the risk of harm to urology patients does not continue to increase disproportionally compared to other specialities as available inpatient theatre time is reduced.

I hope this information is of use and would welcome further discussion on this matter.

Yours sincerely



Mr Mark Haynes
Consultant Urologist
Chair NICaN Urology Clinical Reference Group

CC Ms Lisa McWilliams
Ms Cara Anderson
Mr David McCormick

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 05 September 2018 07:51
To: Conway, Barry; Toal, Peter; Carroll, Anita; Holloway, Janice; ONeill, Kate; McMahon, Jenny; McCourt, Leanne; Campbell, Dolores; Young, Jason; McCreesh, Kate; Leonard, Mairead; Mulholland, Nuala; Hanvey, Leanne; Johnston, Pamela; Caddell, Caroline; McClenaghan, Nichola
Cc: McVey, Anne; Trouton, Heather; Carroll, Ronan; Khan, Ahmed; Gibson, Simon; McKimm, Jane; Rogers, Ruth; Brownlee, Roberta; Devlin, Shane; Stinson, Emma M; Conlon, Noeleen; Boyce, Tracey
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Thanks

I feel very embarrassed to be named as my input in to Mr Harte's care has been negligible compared to that of others. In particular the Thorndale outpatients team (who I have copied in) and my secretary who have arranged and carried out his treatment, provided him with support, and carried out much of his follow-up (and fitted it all around his commitments with Tyrone GAA), and the theatre and ward teams when I have done his surveillance procedures. It is their work that has resulted in the praise, not mine.

However, the current status of urology waiting lists, and challenges with equipment, compounded by staffing pressures which mean that a number of inpatient theatre lists that are part of the normal compliment of elective theatres not being able to run, gives me serious concern that the service which was provided to Mr Harte (and many patients like him) when he first presented, would not be deliverable today.

Within the outpatients department, at first presentation with symptoms of bladder cancer, we offer a 'single visit' service whereby patients have all necessary diagnostics at the time of their initial attendance, thereby enabling the shortest time we can deliver from referral to first treatment. However, Our time to first appointment is now considerable (On Monday 3rd September I saw patients referred on as red flag in mid July). When patients do attend, we have insufficient flexible cystoscopes (this is due to the demands of the service now compared with 3 years ago, and a significant issue recurring with a number of scopes being out of circulation due to repair needs) to perform diagnostic cystoscopies and as a result some patients hare not getting their diagnostics performed at the time of attendance, being placed on a further waiting list for this procedure.

Once patients have had their initial surgical treatment for bladder cancer, many patients, like Mr Harte will go on to have intravesical chemotherapy or immunotherapy. This service is delivered by Janice Holloway and Kate McCreesh. However, it is at capacity and struggling to meet demand. Additionally, as has been ongoing since the services inception, the intravesical treatment service, as I understand, requires funding and staffing with the staffing being provided from the ward and OPD. This service runs as an entirely nurse delivered service.

Following treatment all patients with bladder cancer go onto surveillance programmes as the risk of recurrence is high (as high as the 80% quoted by Mr Harte in his interview in certain situations). The pressures on our waiting lists are such that these 'planned' surveillance procedures are delayed by significant periods of time – a patient for whom I performed such a procedure on Monday 3rd September had been due his procedure in June 2018. While rightly the impact of delays in these cancer surveillance procedures should give cause for concern, as I have detailed in previous correspondence, there are many patients awaiting planned surgery for benign conditions who are placed at higher risks of gram negative sepsis, as a result of prolonged waiting times, whose risk in our opinion (the urologists) is far higher. In June 2018 there were 596 patients on the Urgent IP WL for urological surgical procedures, with a waiting time of 4 years (208 weeks). In all other elective surgical specialities (including Gynaecology) there were a total of 396 patients and the shortest waiting time in these specialities was 11 weeks. This discrepancy between patients requiring urological surgery, and those requiring other speciality surgery cannot be acceptable..

Winter is coming and the almost inevitable cancellations of cases due to bed pressures will result in further deterioration in our waiting times.

In order to satisfy the demands of our population and continue to provide the service that Mr Harte has rightly praised, the urology department requires a number of immediate actions;

1) If available, engagement of further locum consultants (we have 2 working at present) to provide outpatient services to bring waiting times for urology outpatients down to an acceptable level, for all patients (Red flag, urgent and routine). Outpatient staffing will need to be adequate (ie increased) to enable this delivery of additional clinics.
2) Investment in flexible cystoscopes to bring the total number available (if all in circulation) in the Thorndale unit to 16. This will enable diagnostics to be performed on all patients at the time of their first OP attendance.
3) Long term funding / staffing of the intravesical treatment service to a level whereby it is deliverable 5 days a week.
4) Additional theatre capacity provided to bring urology waiting times down to an acceptable level – with 2 locum consultants and item (1) we would be able to staff these from within the 5 consultants or the 3 locums. This can be provided by either; (a) renting of a portable, staffed theatre (along with staffing of additional ward beds) for use by urology week days on Craigavon site, (b) outsourcing of work to the IS (however this failed previously in NI as there are not sufficient providers and the co-morbidites of urology patients typically means that the IS do not wish to take this work on), (c) redistribution of theatre lists within southern trust such that the number of available lists to urology is increased while other specialities theatre lists are reduced, until such a point as waiting times are equitable in all specialities.
5) Investment in equipment to provide LA, OP transperineal biopsies of the prostate (this will become a standard of care in the next 12-24 months, is not deliverable as an OP with our current equipment and would necessitate a GA for procedures currently carried out daily by Kate O'Neill / Leanne McCourt in the OPD, this would further add to our IP WL issues).
6) Long term we need investment / securing of additional consultant posts in southern trust, along with necessary theatre and outpatient infrastructure to bring the total number of funded consultant posts to 8 (I can share capacity:demand work which I carried out in 2014 which demonstrated a need at that point for a 7th post if people are interested).

I would be delighted to meet if anyone wishes to discuss these issues further.

Mark

From: Conway, Barry
Sent: 04 September 2018 16:35
To: Toal, Peter; Carroll, Anita
Cc: McVey, Anne; Trouton, Heather; Carroll, Ronan; Khan, Ahmed; Gibson, Simon; McKimm, Jane; Rogers, Ruth; Haynes, Mark; Brownlee, Roberta; Devlin, Shane; Stinson, Emma M; Conlon, Noeleen; Boyce, Tracey
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Peter – this is good feedback.

Mark – thanks to you and all the Urology Team for your ongoing work.

Barry.

From: Toal, Peter
Sent: 04 September 2018 16:31
To: Carroll, Anita
Cc: Conway, Barry; McVey, Anne; Trouton, Heather; Carroll, Ronan; Khan, Ahmed; Gibson, Simon; McKimm, Jane; Rogers, Ruth; Haynes, Mark; Brownlee, Roberta; Devlin, Shane; Stinson, Emma M; Conlon, Noeleen; Boyce, Tracey
Subject: Tyrone GAA Manager praises CAH staff for care and treatment

FYI,

See below message and Belfast Live article we have retweeted today re praise from Mickey Harte (Tyrone GAA Manager) about his care and treatment in CAH (Mark Haynes is named by Mr Harte).
Many Thanks
Peter Toal
Communications Manager
Southern Health and Social Care Trust

Southern Trust 14m14 minutes ago

Kind words from Mickey Harte about his care and treatment @SouthernHSCT - our staff are delighted that he felt very well looked after and has recovered so well! @healthdpt @HSCBoardhttps://twitter.com/BelfastLive/status/1036983585948008448 …

Belfast Live

https://www.belfastlive.co.uk/sport/gaa/gaelic-football/mickey-harte-says-grief-steeled-15107923?utm_source=twitter.com&utm_medium=social&utm_campaign=sharebar

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 19 October 2018 07:02
To: Gibson, Simon; Carroll, Anita; Magwood, Aldrina; Gishkori, Esther; Carroll, Ronan
Cc: Devlin, Shane; Khan, Ahmed; Stinson, Emma M
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment
Attachments: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3) (17.6 KB)

Further to this meeting have any minutes / action plans been drawn up?

During the meeting on how over the past year the spread of lost theatre lists had perversely been least in the speciality with the shortest waiting time. I stated that I felt a formal Coorporate direction / strategy was needed regarding how planned theatre reductions are tackled within the trust. The view of others was that this is an operational issue within the acute directorate.

Attached is some email communication regarding plans for this winters 30% reduction. One option put forward has been to 'rebalance' the loss over the last year according to waiting list pressures and responses are within the email chain.

I firmly believe any solution that attempts to redress the inequities in waiting times requires a firm, formal, corporate stance, communicated clearly to all teams. Without this a negotiated solution will fail to address the issue.

Mark

From: Witczak, Maria
Sent: 08 October 2018 14:32
To: Haynes, Mark; Montgomery, Ruth; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Anita; Magwood, Aldrina
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Dear all,

I would like to inform that "Tyrone GAA Manager praises CAH staff for care and treatment" meeting has been moved to 09.00am – Meeting room 1.

Kind regards

Maria Lisiak - Witczak
Personal Secretary to Ronan Carroll
Assistant Director of Surgery and Electicve Care and ATIC's
Ext. [redacted]

From: Haynes, Mark
Sent: 05 October 2018 10:36
To: Witczak, Maria; Montgomery, Ruth; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Anita; Magwood, Aldrina
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment

Morning al1.

Apologies – the venue of my 11am meeting was not clear on my diary for Maria – it is with HSCB / PHA / Prostate cancer UK in Belfast and starts at 11am.

I therefore need to leave CAH by 9:30am at the latest as I will be getting the train to Belfast.

Would everyone be able to meet earlier say 9-9:30am? And reschedule the 9am meeting I have that day?

Mark

From: Witczak, Maria
Sent: 02 October 2018 12:42
To: Montgomery, Ruth; Haynes, Mark; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Anita; Magwood, Aldrina
Subject: RE: Tyrone GAA Manager praises CAH staff for care and treatment
Importance: High

Dear All,

There is a mistake on the time of the meeting.

Please accept my apologies :

The actual time is ***10.00 – 10.30***
Meeting Room 1

Kind Regards

Maria Lisiak - Witczak
Personal Secretary to Ronan Carroll
Assistant Director of Surgery and Electicve Care and ATIC's
Ext. Personal Informati
Personal Information redacted by the USI

From: Witczak, Maria
Sent: 21 September 2018 13:52
To: Montgomery, Ruth; Haynes, Mark; Stinson, Emma M; Murphy, Jane S; Gregory, Louise; Conway, Barry
Cc: Gibson, Simon; Carroll, Ronan; Carroll, Anita; Magwood, Aldrina
Subject: Tyrone GAA Manager praises CAH staff for care and treatment
Importance: High

Dear all,

It has been agreed that meeting in re *"Tyrone GAA Manager praises CAH staff for care and treatment"* will be held :

09th October 2018 @ 10.30 – 11.00

Venue : Meeting room 1

Thank you for co-operation.

Any queries please do not hesitate to contact me via email or by phone.

Kind regards

Maria Lisiak - Witczak
Personal Secretary to Ronan Carroll
Assistant Director of Surgery and Electicve Care and ATIC's
Ext. Personal Informati
Personal Information redacted by the USI

Stinson, Emma M

From: Conway, Barry <[redacted]>
Sent: 18 October 2018 21:57
To: Haynes, Mark; Carroll, Ronan
Cc: Carroll, Anita; Scullion, Damian; Gishkori, Esther; Khan, Ahmed; Hogan, Martina; Kennedy, Geoff; Sim, David
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Dear all,

I can see the view on all sides in this debate. I have discussed a reduction with Gynae and they understand they will have to take a hit. Options proposed included 30% and 35%, however I don't expect they will be content to take a reduction 57% of their operating time for the reasons noted below. experience would also show that the pressures will last beyond 31 March 2019.

I agree with Ronan that we need to defer to corporate SMT for them to make a call on this.

Martina / Geoff / David – copying to you for information.

Barry.

From: Haynes, Mark
Sent: 18 October 2018 21:45
To: Carroll, Ronan
Cc: Conway, Barry; Carroll, Anita; Scullion, Damian; Gishkori, Esther; Khan, Ahmed
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

But last winter Gynae didn't get the 30% reduction (they were 25.9%), from March onwards and through the summer they didn't get an 18% reduction (6%).

The speciality with the shortest waiting times has been protected over a year, while specialities with considerably longer waits have lost a greater percentage of their lists. The arguments surrounding training apply to every speciality and cannot be used for one.

Surely a winter 're-balancing' the last 12 months is appropriate and justified?

Mark

From: Carroll, Ronan
Sent: 18 October 2018 21:38
To: Conway, Barry; Carroll, Anita
Cc: Haynes, Mark; Scullion, Damian
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Barry,
I would say couple of things

1. All Trusts have been asked to reduce by 30% so gynae could well be affected the same way in other Trusts.
2. This is for winter so I don't think 4mtsh would deskill any surgeon eg if off sick x 4nths we wouldn't be doing anything to upskill them.
   NIMTDA & trainees again this si from HSCB/DHPSS

Clinicians will not agree on the options this is clear to me so rather than us batting back & forth Anita I would ask that SMT discuss the paper, confirm their priorities and endorse an option.

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Informatio

From: Conway, Barry
Sent: 18 October 2018 20:00
To: Carroll, Ronan; Carroll, Anita
Subject: RE: 18.19 Proposal Winter plan reduction in theatres 2018 (3)

Ronan,

Thanks for the revised paper. Will definitely need round table discussions. I don't think a 57% reduction for Gynae would be acceptable. some issues raised with me to date include:

- Gynae surgeons already have limited operating time
- A reduction of this scale would impact on numbers required to maintain their skills
- Unable to provide theatre time for trainees and would not be acceptable to NIMDTA
- Could destablise the O+G service – some surgeons could decide to go elsewhere

Gynae would be prepared to take a proportion of the hit but 57% would not be acceptable in my view.

Barry.

From: Carroll, Ronan
Sent: 17 October 2018 20:45
To: Conway, Barry; Carroll, Anita
Subject: 18.19 Proposal Winter plan reduction in theatres 2018 (3)
Importance: High

Anita/Barry,
Please find attached draft proposal. Happy to chat through
No doubt round table discussions will need to take place – in cah tomorrow pm – off Friday

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 06 October 2017 16:56
To: David McCormick
Subject: BT 80

Hi David

Following on from the PIG Meeting, I recall Mr Mulholland saying he was in agreement with reverting to taking the BT80 referrals.

Is this to start immediately?

Thanks

Mark

Stinson, Emma M

From: Haynes, Mark <[redacted]>
Sent: 13 February 2018 14:23
To: Lisa McWilliams
Cc: Corrigan, Martina; David McCormick
Subject: RE: BT80

Sorry Lisa, I might be oversimplifying but why is a meeting required?

Team North-West are funded to provide care for patients from this area, Southern Trust are not. The interim arrangement was temporary while Team North-West were short of consultant staff due to sickness. As Team North-West are back at full complement (and have been for a considerable period) the interim arrangement should just stop.

I must reiterate, the continuation is negatively impacting on waiting times for all Southern Trust area patients and patients from the BT80 area.

Mark

From: Lisa McWilliams [mailto:[redacted]]
Sent: 13 February 2018 13:57
To: Haynes, Mark
Cc: Corrigan, Martina; David McCormick
Subject: RE: BT80

"This email is covered by the disclaimer found at the end of the message."

Mark and Martina
Thanks for the email on this issue. It was raised at the recent director led WHSCT service issues and performance meeting and it as agreed that a meeting would be convened involving both Trusts. I will follow this up with the Director of Commissioning's office to expedite a meeting.

Lisa

On 13 Feb 2018 11:40, "Haynes, Mark" <[redacted]> wrote:

The emergency patients are coming from Antrim, driving past BCH before getting to us…

From: Corrigan, Martina
Sent: 13 February 2018 11:21
To: Haynes, Mark; Lisa McWilliams; David McCormick
Subject: RE: BT80

Thanks Mark,

Lisa and David we really need this addressed as my understanding was that it was only to be outpatients, however we are increasingly getting emergency admissions from BT80 and when Mr Young challenged this last week and asked for the patient either to go to Belfast or Altnagelvin he was contacted by the consultants there to say they were not taking them as the agreement was that they needed to go to Craigavon. I understand all Trusts are experiencing bed pressures, but we really need this sorted please.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information redacted by th

EXTERNAL : Personal Information redacted by the USI

Mobile ersonal Information redacted by the USI

From: Haynes, Mark
Sent: 12 February 2018 16:23
To: Lisa McWilliams; David McCormick
Cc: Corrigan, Martina
Subject: BT80

Hi Lisa / David

Just enquiring regarding the BT80 patients. As you'll recall, at the last meeting this issue was raised and the Western Trust accepted that the conditions that existed when BT80 referrals were temporarily re-directed to Southern Trust no longer existed and that continuing the redirection was disadvantaging patients from the entire southern trust area and the BT80 patients. Following discussion it was agreed that the BT80 patients would revert back to being referred to the western trust for their urology management.

Unfortunately the BT80 patients continue to be directed to Southern Trust both for elective and emergency outpatient and inpatient care. This is continuing to mean that they add to our waiting list (impacting on the southern trust patients, and wait longer for treatment (given that western trust waiting times for urology are the shortest in the province).

What is the current status regarding the BT80 patients?

Mark

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: David McCormick <[redacted]>
Sent: 19 October 2018 08:21
To: Haynes, Mark; Lisa McWilliams
Cc: Corrigan, Martina
Subject: RE: BT80

"This email is covered by the disclaimer found at the end of the message."

Hi Mark

We have had several discussions with the Western Trust about their team taking on Fermanagh and also taking back BT80. The Trust have submitted costings for an extra consultant and associated support staff.

While there is no recurrent funding we are trying to clarify if the Trust would go at risk using Confidence and Supply funding as a source of funding. Will keep you updated.

If we can't get resolution this side of Christmas then it would be reasonable to ask the Western Trust to take back the BT80 catchment.

David

From: Haynes, Mark [mailto:[redacted]]
Sent: 19 October 2018 07:19
To: Lisa McWilliams
Cc: Corrigan, Martina; David McCormick
Subject: RE: BT80

Hi Lisa / David

Has this progressed any further?

Mark

From: Lisa McWilliams [mailto:[redacted]
Sent: 13 February 2018 13:57
To: Haynes, Mark
Cc: Corrigan, Martina; David McCormick
Subject: RE: BT80

"This email is covered by the disclaimer found at the end of the message."

Mark and Martina
Thanks for the email on this issue. It was raised at the recent director led WHSCT service issues and

performance meeting and it as agreed that a meeting would be convened involving both Trusts. I will follow this up with the Director of Commissioning's office to expedite a meeting.

Lisa

On 13 Feb 2018 11:40, "Haynes, Mark" <[redacted] > wrote:

The emergency pati

Confidential

Meeting on 17 December 2015
Associate Medical Director's Office – Admin Floor – Craigavon Area Hospital

Present:
Mr Mackle (chair)
Mr Young
Mr O'Brien
Mr Glackin
Mr Haynes
Martina Corrigan

Apologies: Mr O'Donoghue (on annual leave)

Mr Mackle outlined that the purpose of the meeting was to put a plan in place to support Personal Information redacted by the USI and assist him fulfil all aspects of job in a safe supported manner, and to determine his fitness and ability on all aspects of the job but in particular the ability to perform 'open' surgery.

Mr Mackle advised that he had outlined the Team's concerns to Dr Wright the Medical Director and he has asked that a documented plan is put in place in particular with respect to:

a) What training and courses needs to be identified and booked
b) What are the timescales
c) Support for when on call

TG = difficult for provide to cover by team in day to day.
Deficiency in open surgery e.g. injured bladders, injured uterus.

Pers onal Infor: doesn't recognise deficiencies – his perception different from Team (TG)

Surgery is not the only one element
Registrars – decision making on WR
"Lack of decision-making"

Long term. Here and now – how do we manage?

Process of defined training,
Second on call = MY tonight up on ward at 5pm to check patients.

Need to meet with Pers onal Infor and explain training + pro-active about patients.

More international.
Ward rounds to be accompanied by another consultant. (paid ½ PA)

6months. Consultants to do a supportive ward round:
Wed PM going to AOB in place.
Alternative Tuesday , AOB/TG.

Courses……..

1. MY to talk- decision making
2. EM to talk- decision making
3. Go to theatres
4. Talk to people
5. Courses

adept
Achieve | Develop | Explore
PROGRAMME FOR TRAINEES
NI Clinical Leadership Fellows' Programme

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

ADEPT PROJECT
Southern Trust
Stone Treatment Centre

Matthew Tyson
ST7 Urology/ADEPT Fellow

Project

1. To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust

2. Provide stone treatments recommended by NICE, BAUS and EAU

3. Provide patients with informed choice

To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust

- On-site ESWL

- Southern Trust 372926
- Stone service 472000
- + Referrals from South Eastern, Northern

Aims

- Decrease waiting list times for elective ESWL treatment to 2 weeks
- To provide emergency ESWL provision for upper and distal ureteric stones
- To decrease the cost of renal and ureteric stone treatment

Change of Practice 2017

- Referral pathway agreed (Urology/Radiology/A+E)
- Urology MDT since December 2017
- Decreased Nursing paperwork
- Improved treatment safety and effectiveness
- Improved pain relief
- E-discharge
- Improved patient follow-up pathway
- Data collection to demonstrate improvement
- Audit/ research and development

ESWL Day of Treatment

- Radiographer and Nurse led
- Currently 3 treatment a session
- 3 sessions a week
- 9 patients a week

Waiting List

- ESWL 233 PATIENTS JAN 2018
  - 108 Patients Jan 2017
  - **116% increase in 1 year!!**

- Ureteroscopy and laser to Stone 174 (December 2017)

URS

Craigavon Urology Theatre **for elective ureteroscopy**

- As an elective day case £1608
- As an elective case with average inpatient stay £2747

Craigavon Urology Theatre for **emergency ureteroscopy**

- Long stay inpatient £2862 per patient
- Short stay inpatient £2376 per patient

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

ESWL

Craigavon Stone Treatment Centre for **elective ESWL**

- **£363** per **elective outpatient** patient, as of February 2017.
- **This is based on a morning session with 3 patients, giving a total session cost of £1092**
- A time and motion study conducted at the Stone Treatment Center, December 2016, noted a possible 4 patients could be treated in the same time period, thus lowering the cost further per sessions and per patient.
- **Inpatient ESWL** £627 per patient as of February 2017

Compare

One session of elective ureteroscopy with no stay is equivalent to 4.4 sessions of ESWL.

One session of emergency ureteroscopy with a short stay is equivalent to 3.9 sessions of ESWL

Costs ESWL Waiting List

With the new pathway followed:

- If 233 patients needed on average 1.5 treatments then 318 treatments needed.

- Cost of £126868

Costs ESWL Waiting List

- Currently 9 patients per week treated
- If sessions increased to 9 per week, 3x9=21patients/per week
- Therefore 16.6 weeks need to clear waiting list
- Funded for 2.5 sessions per week currently, therefore **£81675** needed to over run and clear excessive waiting list.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

MDM

- If 233 patients on waiting list had been discussed at MDM, placed on a current treatment and imaging follow-up pathway then a **new and follow-up OPD might be saved**

OPD COST OF 233 PATIENTS =

- 233 X (250 (NEW) + 170 (Follow-up) = £97860

- Note: £81675, is required to potentially clear the list

Waiting List- All adult patients

- 108 Patients Jan 2017
- 233 Patients Jan 2018 (116% INCREASE)

Per month added to waiting list

- June 32 patients
- July 22 patients
- August 20 patients
- September 37 patients
- October 37 patients
- November 43 patients
- December 26 patients

Waiting time

- Currently booked patients for elective ESWL for January 2018, from patients booked May 2017.

- **8 month wait**

Emergency Stone Guidelines

‘For symptomatic ureteric stones, primary treatment of the stone should be the goal (LE 1b) and should be undertaken within 48h of the decision to intervene’

British Association of Urological Surgeons standards for management of acute ureteric colic
A. Tsiotras, R Daron Smith, I Pearce, K O’Flynn, O Wiseman
Journal of Clinical Urology 2018. Vol. 11 (1) 58-61

Projected Session (All adult patients)

- Once waiting list cleared:
- 217 Patients added June to December 2017
- Average of 31 patients per month
- Average of 8 (7.75) patients per week

ESWL session multiplier of x1.5

- Therefore 12 (11.6) patients per week
- Therefore 12/3 = 4 sessions per week

If multiplier of x2

- Therefore 16 patients per week
- Therefore 16/3 = 6 (5.3) average sessions per week (range 5 – 7 sessions per week)

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

South Eastern patients

- 49 patients in 7 months
- 49 X2 treatment multiplier = 98
- Therefore 14 patients per month
- Average of 3.3 patients per week
- Therefore 1 sessions per week to meet demand, with no Southern Trust emergency patients treated, with x4 patients per session

Projected week

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
am	ESWL	ESWL (South Eastern Trust)	ESWL	MDM	ESWL

Current funding for x2.5 sessions per week (7.5 patients)
Southern Trust need 5 sessions per week (3 patients per sessions)
South Eastern Trust x1 session per week (4 patients per session)
Need x6 sessions
Waiting list likely to increase when waiting list time decreases, patients may move over from URS list to ESWL. Extra sessions therefore add to account for this possibility, mindful extra session in future needed as population increases, age and obesity rises as will stone presentations.
Therefore x7 sessions needed, extra funding for x4.5 per week needed (with the South Eastern paying for x1)
(x2.5 funded at present)

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Staffing

- Session needs,
  - X1 Staff nurse, Health Care Assistant, Radiographer

  - Based on 7 sessions, dedicated staff to unit,
  - Sister dedicated to Stone Treatment Centre
  - X2 Staff Nurse (flexible to work in Thorndale unit)
  - X2 Health Care Assistant (flexible to work in Thorndale unit)
  - X 1 dedicated radiographer to Stone treatment Centre

  And continued rotation of x3 radiographers as required

  Or x2 dedicated radiographers

Future

- Stone Treatment Centre
- ESWL waiting time of 2 weeks elective and daily (mon-fri) emergency ESWL available
- Dedicated nursing staff to the unit
- Nurse specialist for long term follow-up/high risk stone formers
- Dietician clinic for high risk formers and dietary modification

Future

- Sessions available for dedicated trust use other then the Southern Trust, with payment to the Southern Trust
- Cross border working
- Dedicated team to the Stone Treatment Centre, with teaching, training and research opportunities, giving a **Highly skilled and dedicated staff, providing highly effective ESWL treatment and follow-up to renal and ureteric stone patient.**

Many thanks

This is a team project,

Involving:

Mr Young and Consultant Team

Martina Corrigan, Laura McAuley, Paulette Dignam,

Hazel McBurney, Bronagh OShea, Bernadette Mohan, Wayne Heatrick

Nuala Mulholland, Mairead Leonard, Justin McCormick, Kate McCreesh, Martina O'Neil

Proposal for ADEPT Management Project in Southern Health and Social Care Trust

Aim

To establish and develop a satellite Urology Service in the first instance in Daisy Hill Hospital this is to include Outpatients, daycases and some suitable inpatients.

Background

There is a General Surgeon with a Urology Interest in Daisy Hill Hospital who is retiring. This will mean that there will no longer be any urology service available locally for the Newry and Mourne Population.

The Project

Start with a baseline to find out the views of the Consultant Team and then work at establishing and setting up the service in Daisy Hill. Then auditing at how this is all achieved, using Manpower, Equipment, Facilities available etc..

Below are some of the outcomes that it is anticipated will come from this project:

- Clinical engagement not only from Urology but from General Surgery.
- Developing pathways for suitable elective patients so their operation can be carried out in Daisy Hill Hospital
- Developing pathways, guidance and information on Urological Procedures for emergency patients and therefore preventing inappropriate admissions or reducing length of stay because there will be guidance on what should be done for various conditions.
- Release Main Theatre time in Craigavon Hospital so that team can concentrate on more major cases that need to be done in Craigavon Hospital, therefore ultimately reducing the waiting times for Urology Surgery.

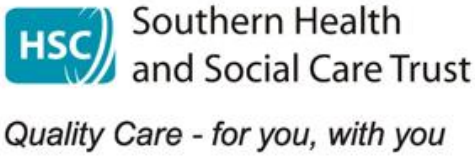
The skills gained from this project will be transferable and will mean that there can be a satellite service can be enhanced in South West Acute Hospital (currently the Urology Team travel to do outpatients and are keen to commence daycases there as well, so if there was time then this process could be rolled out to this facility.

The learning and outcomes could be shared with other Trusts in Northern Ireland.

The successful candidate would be monitored and mentored by Mr Haynes and Mr Glackin (Consultant Urologists) and Mrs Corrigan, Service Manager for Urology.

Stone Treatment Centre

Improvement Project



Contents

1. Extracorporeal Shockwave Lithotripsy (ESWL)

ESWL is a method of using shockwaves applied to the back of a patient to treat kidney stones and ureteric stones (ureter is the pipe which drains urine from the kidney to the bladder). ESWL is undertaken with pain relief and no anaesthetic is needed unless the patient is a child, and is most commonly conducted as a day case. The alternative for stone treatment is ureteroscopy and percutaneous nephrolithotomy (PCNL), both of which require general anaesthetic and are conducted in a theatre setting.

2. Rationale

The overall lifetime risk of renal or ureteric calculi is 10-15%, the male to female ratio is 2:1 and the peak age of presentation is 30-50 years. The recurrence rate can be high, with up to 30% of cases recurring at 10 years and 90% of cases recurring at 30 years.

The Southern Trust has an on-site lithotripter providing a maximum of 3 ESWL sessions a week, with each session treating a maximum of 3 patients, giving a total of only 9 patients per week. There is currently no capacity or model for emergency ESWL. Occasional Paediatric list in conjunction with Belfast and adult patients from the Northern and South Eastern Trusts are also accommodated. The lithotripter is therefore not used for 11 out of a possible 14 daytime clinical sessions.

The average waiting time for first elective ESWL session was 9 weeks, with the longest single wait at 55 weeks as of October 2016, but the waiting time was rapidly increasing as demand increased.

Currently all emergency stones needing treatment are operated on via the emergency list. For patients who are suitable, emergency ESWL may be a more cost effective and potentially less morbid modality for treatment. Ureteric stone patients who are admitted as an emergency have been recommended to be treated within 48 hours from the decision to treat (Wiseman, 2017).

Selected patients could be removed from overburdened inpatient elective Ureteroscopy waiting lists if ESWL capacity was increased. This could potentially provide a more cost effective modality compared to use of the operating theatre and requirement of a general anaesthetic.

3. Project aim

1. To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust.
2. Provide stone treatments recommended by NICE, BAUS and EAU
3. Provide patients with informed choice

In order to meet the demand for ESWL the waiting list needs to be reduced and then maintained at a reasonable wait. Imaging of patient's stone must be recent to avoid re-imaging or difficulty in identifying stone location for treatment, which can only be achieved with a short wait for treatment. The desired wait time will be set following the service evaluation and visit to a 'Gold Standard' service centre.

4. Hypothesis

Patient numbers per session can be increased by reviewing and improving the process currently in place. Extra sessions per week can decrease the overall cost of the patients treated for renal and ureteric stones by decreasing the number treated by the more costly emergency theatre and elective theatre sessions.

5. Objectives

1. Review and appraise current service set-up for ESWL. Including equipment, clinical area, staff, referral, follow-up and discharge of patients. Recording of treatments and any further investigations and stone prevention.
2. Identify current funding parameters for ESWL and potential funding
3. NICE and EAU guidelines for stone treatments in relation to current practice and application to any changes
4. Obtain costs of ESWL vs Emergency ureteroscopy surgery vs Elective ureteroscopy surgery in the Southern Trust
5. Review emergency surgery conducted over 9 month period that could have received ESWL had it been available
6. Evaluate 'Gold standard service'. How do other NHS hospital work regarding onsite ESWL including follow-up and prevention. How do the top European centres implement their ESWL service.

7. Project Scope

The project will encompass the patient pathway of stone diagnosis to treatment and discharge for those patients suitable for ESWL in the Southern Trust. It is outside the scope of this project to provide a service for stone prevention and follow-up of recurrent or high risk stone formers. The theatre practise of alternative treatments for stones, ureteroscopy and PCNL, will not be part of the project, although recommendation for type of stone treatment patients receive will be reviewed as part of the service evaluation on how patients are selected for ESWL.

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8. Project Sponsor

The overarching sponsor is the Medical Director and his Executive Team. Keeping the Medical Director Richard Wright copied into important e-mails to drive the project forward is fundamental, as well as regular face to face meetings with project update presentations. The project heavily involves the Urology team especially Mr Michael Young as clinical lead and Martina Corrigan as Urology Manager and daily/weekly engagement is crucial. It is a necessity for the project sustainability and eventual outcomes to be supported that the groups of people mentioned thus far are kept regularly up to date and are in agreement with actions.

9. Project Team

In order to fulfil our aims for the Southern Trust the team will have a constant core team of staff who work at the Craigavon Stone Centre. Team members who are going to deliver the service are vital for inclusion, as they will drive the improvement, sustain the improvement, and hopefully continue future improvement. The team can learn together the methodology of improvement science, the need for improvement and not just change. There will be interaction required from other departments in order to fulfil the aims and objectives and the need for the team to be flexible to incorporate other personnel when required. The team in fundamental for success, especially in a National Health Service setting, where the varied skill sets and experience can be utilised, but without a team effort no project in the NHS can succeed as barriers will occur. The Medical Director and executive team will be kept informed and utilised as the project requires. In order to meet certain objectives input will be required from Estates, Trust architects, Pharmacy, IT, Radiology, Accident and Emergency and the remainder of the Urology Consultant Team.

The Core Team:

Mr Michael Young : Urology Clinical Lead and Project Lead

Mr Matthew Tyson: Project lead

Mr John O'Donoghue: Urology Consultant

Martina Corrigan: Manager for Urology

Saba Husnain: Staff Grade Urology Doctor

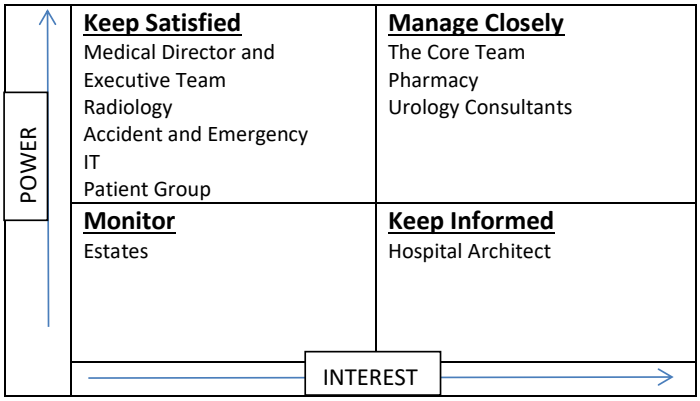
Laura McAuley: Staff Grade Urology Doctor

Paulette Dignam: Secretary and Administration

Hazel McBurney, Bronagh OShea, Bernadette Mohan, Wayne Heatrick: Radiographers

Nuala Mulholland, Mairead Leonard, Justin McCormick, Kate McCreesh, Martina O'Neil: Nursing Staff

Stakeholder Evaluation



10. Approaches and Measures (Method)

To help plan the project improvement and due to the complexity of the task, driver diagrams were constructed. (Royal College of Physicians Ireland, 2012)

Goal/Aim	Drivers	Project/Activity
To meet the demand for (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust	More ESWL to reduce the demand on main theatre for Ureteroscopy and Laser to Stone	Prove ESWL treatment is more cost effective then main theatre Ureteroscopy
	Reduce the waiting list for ESWL by increasing activity	Time and Motion study of ESWL treatment session
	Increase number of patient treated per day with ESWL, allowing for emergency ESWL	Evaluation of current service
	Reduce the demand for outpatient appointments	Visit Scottish Lithotripter Centre a recognised high volume centre volume
	Staff motivation and buy in of project aim	Regular team meetings
	Identify method to stop patients having outpatient appointment prior to ESWL treatment, to reduce patient wait for ESWL	Patients booked directly for ESWL treatment from diagnosis of stone

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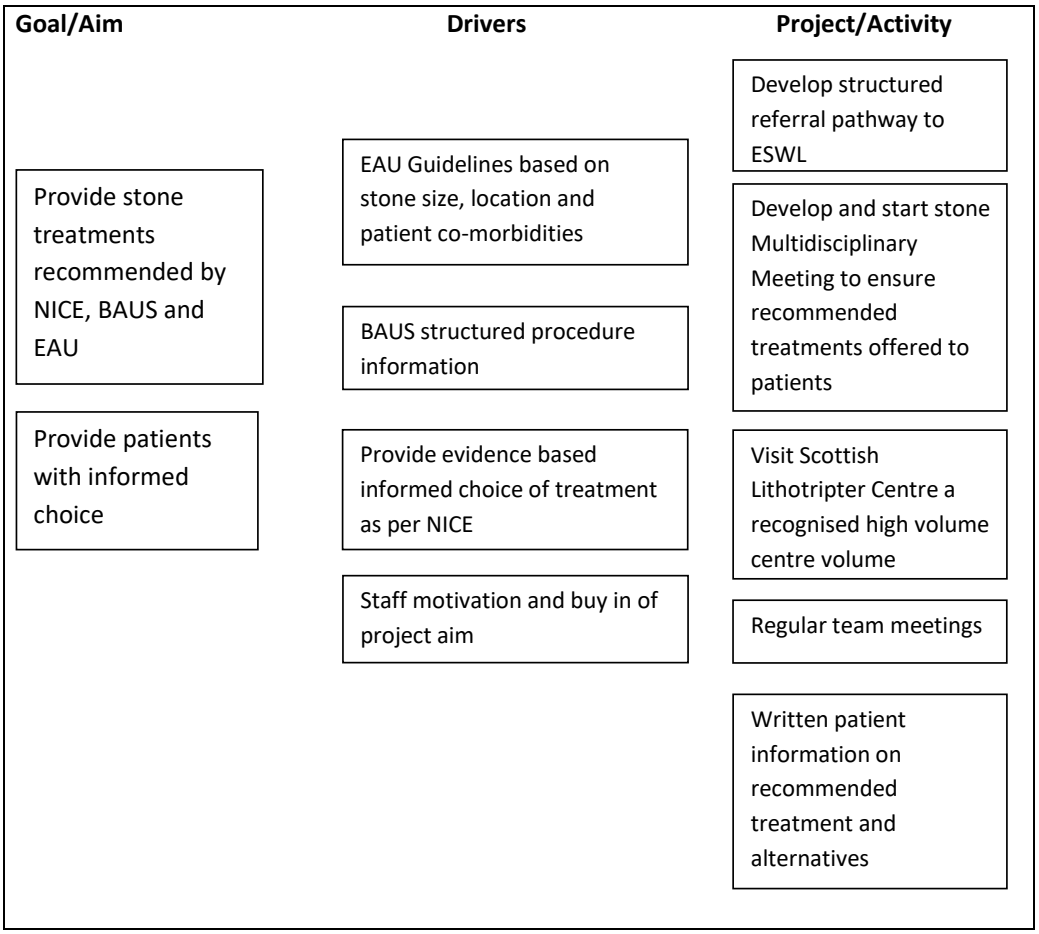


As highlighted by the driver diagram a **service evaluation** is a must and was the first step, this included the **patient pathway**, **time and motion study** of ESWL treatment session and infrastructure of the Stone Treatment Centre. This was followed by **a visit to the Scottish Lithotripter Centre** to see first-hand the processes of a high volume ESWL centre, and to determine what lessons could be relayed to the Southern Trust.

A 2 hour **Team Meeting** every Thursday morning was an opportunity for planning and review of **PDSA cycles**, keeping the team up to date, role and responsibility setting as well as motivating team members to the aim and learning.

Patient questionnaire following receiving ESWL treatment, as well as **patient and staff interview** of ESWL treatment sessions.

Data Collection and Review of Patient notes to record how many patients who received Emergency Treatment for Kidney Stones could have undergone ESWL. An analysis of the

cost implication of Emergency ESWL vs Emergency Ureteroscopy and Elective ESWL vs Elective Ureteroscopy.

Process measures will reflect the steps involved in the patient being identified and referred to the Stone Treatment Centre, such as the referral pathway, including the structured referral form, as well as the process and number of the patient(s) on the day of treatment.

Structure measures will reflect the staffing and equipment required for the Stone Multidisciplinary Meeting (MDM), and the ESWL treatment sessions.

Outcome measures will be assessed on proving the changes are improvements, these will be in keeping with the ethos of 'High Quality Health Care' (Southern Health and Social Care Trust). In relation to the overall aims quantitative outcomes will be measured as a reduction in the waiting times for patient to receive ESWL and the provision of Emergency ESWL. Quantitative review of Stone Meeting outcomes in relation to guidelines as per European Urology and quantitative patient questionnaire on 'informed choice on treatment of their stone'. Finally there is a chance to prove an economic benefit from the project, with quantitative outcome evidence that increasing funding of ESWL stone treatments saves money to the Trust overall. As noted by Donabedian outcome measures will be the 'ultimate validators' of the effectiveness and quality of this project (Donabedian, 2005)

Balances are important, so that no change or improvement has a direct or indirect negative consequence. An example for this project would be ensuring that by increasing the number of ESWL sessions that patients are successfully treated with ESWL for their stone, and only a minimal number require further treatment by Ureteroscopy in main theatre. This will be determined largely by the correct, guideline orientated selection of patients for the most recommended treatment for their stone.

11. Data Collection (Results)

1. **Service Evaluation**

The service evaluation looked at the patient journey from diagnosis of a ureteric or renal stone to an end point of completion of treatment of the stone. The evaluation was conducted using observation of patient pathway, interview of staff and patients and questionnaire of patients receiving ESWL treatment.

Summary of evaluation findings:

Summary of Service Evaluation August 2016

1. **Patients were most commonly diagnosed with kidney or ureteric stone in Accident and Emergency using NCCTKUB.**
2. **There was no Trust guideline policy on who, how or when to image when presenting with possible renal colic.**
3. **Referral of patients from Accident and Emergency was either by telephone call to registrar on-call or hand written free hand referral to consultant on call for outpatient follow-up.**
4. **Only 56% of patients had serum calcium checked (within the previous year) for referral of emergency treatment (Ureteroscopy and Laser in main theatre as emergency ESWL was not available). Serum calcium needed for potential risk of developing stones, and if raised a rare cause of morbidity and mortality (World Health Organisation , 2015). Only 37% of patients had their serum Uric acid checked, if elevated another possible cause of kidney stones.**
5. **Patients referred for outpatient review were seen in Outpatient Appointment prior to any stone treatment commencing**
6. **NO Emergency ESWL was available**
7. **The wait for ESWL was 9 weeks (and increasing)**
8. **Day of treatment for ESWL Stone Treatment Centre consisted of:**
    a. **3 patients treated per session (half day), 9 patients per week. Staff present for treatment X1 Staff Nurse, X1 Health Care Assistant, X1 Radiographer, On-call Doctor called to prescribe medications.**
    b. **Dedicated Stone Treatment Centre for ESWL, with modern Lithotripter**
    c. **Data from the staff interview indicated they were enthusiastic, dedicated, and eager to improve service, they had a good knowledge base and were eager for further learning and to share learning so far. Themed comments were 'need to reduce waiting list', 'imaging need to be up to date for day of treatment, images of stone diagnosis were often out of date due to the long wait for treatment', 'medications prescribed in advance of treatment as delays were being caused by waiting for doctor to prescribe'.**
    d. **The themed responses from the patient interviews were 'difficulty in finding the Stone Treatment Centre', 'long wait for treatment', 'nowhere to safely store personal items, no lockers', 'no dedicated changing room', they did also comment on 'excellent staff', 'kind staff', 'tea and scone post treatment' was most appreciated.**

e. The Post ESWL pain questionnaire highlighted the need to provide breakthrough pain medication for those who had pain during treatment, so effective treatments could be given. Pain medication was based on Piroxicam 20mg and Paracetamol 1g pre-treatment, with no breakthrough medication.
f. The Time and Motion study highlighted long period of time needed by nurses in the current method of working to consent and prep patient for ESWL, with some reaching 45 minutes. There was down-time of the Lithotripter whilst the nurse undertook the consent and checks. There was no dedicated room to consent patient and do pre-ESWL checks, the patient was in the same room as the patient who was being recovered from previous treatment, separated by a curtain, and thus confidentiality was an issue.
g. The discharge letter from ESWL treatment was a handwritten note, with a further formal dictated and typed letter weeks to months later.

9. Follow-up of treatment was a further outpatient appointment for patient.

2. **Visit to Scottish Stone Centre Edinburgh**

Summary of Visit to Scottish Stone Centre, Edinburgh, 14-15 November 2016

1. Patient Journey followed
   a. Structured referral to Stone Centre was viewed
   b. All referrals were reviewed and stone treatment recommended at Stone MDM. Urology Stone Consultants and Treating Radiographer were present at the meeting. Dictation was used to instruct which pre-formed letter to send to patient. Patients were booked direct to treatment as required by radiographer present.
   c. Letter for recommendation for stone treatment was sent to patient
   d. Patient arrives within a 2 week wait for ESWL treatment
2. Day of ESWL treatment
   a. Treatment staff included x2 staff nurses and x1 radiographer
   b. Medication was pre-prescribed (Diclofenac 100mg PR and Oral 1g Paracetamol)
   c. Breakthrough medication was available (IV Opiate)
   d. Discharge information was sheet given to patient
   e. Follow-up imaging was booked on completion of treatment by radiographer, to be viewed by Urology Consultant and further or alternative treatment planned as required.
3. Number of Patients treated
   a. 2 week max wait
   b. Capacity for emergency patient to be treated daily
   c. 3-4 patients were treated per session, and all sessions were filled.
   d. Centre ran 5 days a week (Monday to Friday)
4. Staff Interviews noted radiographers are dedicated to work only at the Stone

Treatment centre and have 'developed large skill and knowledge base', 'multiple publications have evolved from the centre', feel working full time at Stone Centre 'provides a dedicated, skilled team' to providing patient treatments, the model allows for 'minimal wait from diagnosis to treatment, thus reducing the possible re-presentation to Accident and Emergency'.

3. **Recommendations following Service Evaluation of Southern Trust Stone Treatment Centre and Visit to Scottish Stone Centre**

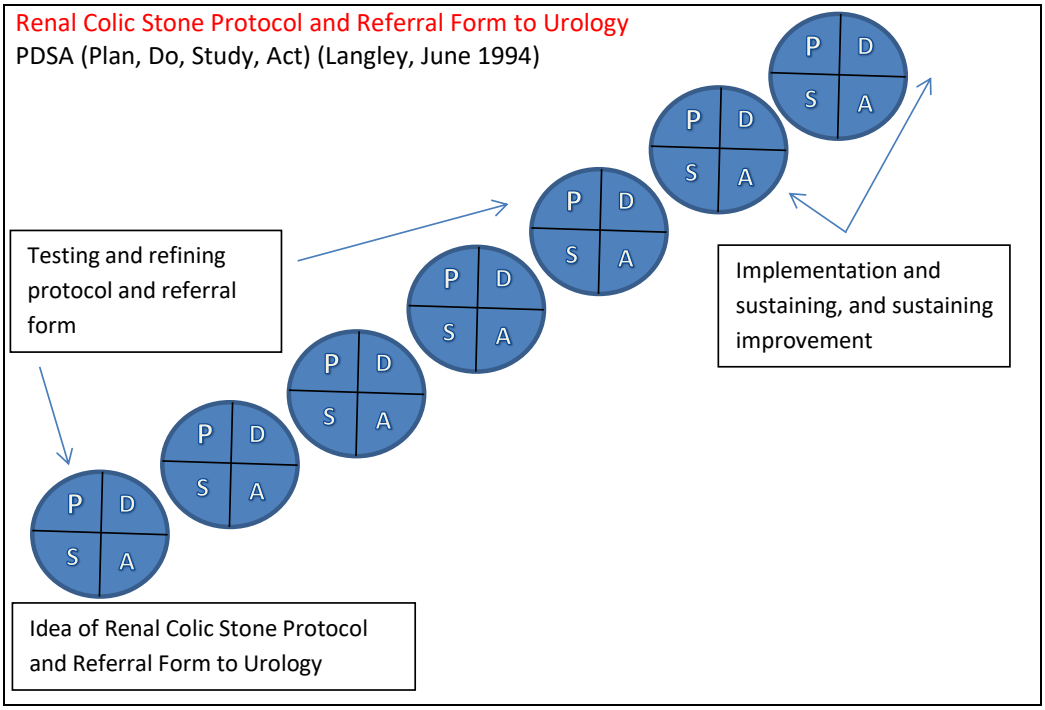
Recommendations for Craigavon Stone Treatment Centre

1. Need for Southern Trust Protocol on whom and how to image possible renal colic (Stone presentation) patients in Accident and Emergency.
2. Need for structured referral to stone treatment centre, including all information needed to recommend stone treatment at a Urology Stone MDM.
3. Need weekly Stone MDT meeting, with administrative support and dedicated meeting space with imaging available and Electronic Care Records. Pre-prescribe medication for ESWL treatment.
4. Information pack to patient on outcome of Stone MDM for recommendation of treatment of their stone, informed choice, consent form, map to ESWL Stone Treatment Centre, ability to see Doctor in Outpatient if patient doesn't want to proceed to treatment or ask further questions.
5. Decrease the wait for ESWL treatment to 2 weeks, so imaging is not out of date and prevent re-presentations to Accident and Emergency.
6. Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment
7. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
8. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
9. Have architectural drawing proposal on how to alter Stone Treatment Centre to also provide private consultation room for patients, and area to change and keep personal items secure.

4. **Renal Colic Protocol and Stone Referral Form for Southern Trust (pdsa cycles)**

The service evaluation and visit to the Scottish Stone Centre highlighted the need to provide the Southern Trust with a Renal Colic Stone Protocol to help Doctors in Accident and Emergency decide on when to image, how to image, blood tests required and how and when to refer to Urology. The referring doctor should complete a structured Stone Referral Form so all information that is a necessity is provided, so a treatment option can be recommended to a patient from Stone MDM. The Thursday Morning team meeting was utilised as a platform for ideas (plan), invited speakers from other specialities and distribution of work (do) and review (study), to eventual implementation (act).

The Renal Colic protocol and Urology Stone Referral Form needed input and agreement from Urology, Accident and Emergency and Radiology departments. Background work was required to ensure all recommendations were evidence based and fitted with current guidelines for all specialities involved (C. Türk (Chair), 2016). Numerous PDSA cycles (X7) (Langley, June 1994) were required in order to agree on the current forms which are now in active use. The current forms can be viewed in the appendix.



5. **Stone Multidisciplinary Team Meeting (MDT) benefits**

The Thursday morning team meeting evolved in to the Stone MDT.

The Stone MDT model allows a much greater through put of patients then a single doctor seeing a patient in clinic. It benefits the patient as they are discussed amongst a group of healthcare professionals, with an evidence based treatment of their stone recommended. It means the time from diagnosis to treatments is reduced. The MDT model was based on the Scottish Lithotripsy Centre model, and relies on organisation for the weekly meeting.

The weekly Thursday MDT has discussed up to 30 patients in a meeting so far. The meeting will eventually incorporate new patient referral in the first part, then review of follow-up imaging in the second part of patients who have completed their ESWL treatment to ensure their stone(s) have been successfully treated, then a template letter confirming this could be sent.

Patients have already been given their diagnosis of a stone and location when they presented, usually to Accident and Emergency. The outcome of MDT, if conservative treatment or ESWL then patient information pack can be sent so they can proceed directly to treatment or further imaging. All the information needed to make a decision on a patient in included in the Urology Stone Referral. There is always the option to see the patient in Outpatient Clinic if the option needs further discussion, such as Percutaneous Nephrolithotomy, or significant co-morbidities, although these are the minority.

Urology Stone MDT

Benefits:

1. **Platform for discussion of complex patients, what is their most suitable management and by whom. The full range of therapeutic options can be discussed**
2. **A+E referrals can be reviewed and patients placed for appropriate treatment with only complex patients or high risk patients having outpatient's appointments. (All patients could be offered an outpatient appointment if wish to discuss their MDT outcome further, prior to any treatment).**
3. **Shorten delay to treatment with direct booking.**
4. **Decrease number needing outpatient appointments, thus saving money.**
5. **Patients may be happier not to see doctor in outpatients if their case has been discussed with the experience of multiple healthcare professionals then just one in clinic.**
6. **Education platform for staff.**
7. **Time to disseminate any quality improvements cycles, audits or concerns and compliments.**
8. **Any clinical trials, allow suitable discussion and allocation.**

9. **Potentially greater continuity of care.**
10. **Improved and more efficient coordination of the stone service.**
11. **Improve communication between care providers and develop clear lines of responsibility.**
12. **Improve resource management and efficacy, such as on site lithotripter (minimises paper work on treatment days, allowing increased capacity).**

Disadvantages:

1. **Some may see discussion of straight forward cases as unnecessary, (if patients are booked direct without discussion at MDT, then data capture is required for audit purposes)**
2. **Meeting only held once a week, some patients will need treating prior and not go through MDT.**

Potential Cost Savings of Patients being booked directly to treatment for ESWL

Cost of New Outpatient Appointments = £250
Cost of Follow-up Outpatient Appointment = £170
Combined total of = £420 per patient

Number on waiting list for ESWL = 233

- Potential cost saving of £97,860 in appointments if directly booked and followed up with imaging and letter
- On average 31 new patients booked for ESWL per month (average June to December)
- The number of ESWL patients increases year on year as stones become more common due to diet factors, increases in obesity and aging population, as well as potentially global warming (stones are more common in warmer climates)
- The potential savings will therefore increase year on year by utilising the MDM model.

6. **Patient Information Pack** (see appendix)

Following an MDM discussion, the patient is placed on the correct, guideline recommend pathway for treatment of their stone. The outcome of MDM is communicated to the patient in a letter, with the majority of letter a standard template to save administrative time, see appendix. Those patients selected for ESWL treatment of their stone are also sent an information pack on the treatment.

The information pack was developed from first reviewing the Scottish Stone Centre patient information, an internet search of other centres patient information on ESWL and the British Association of Urology consent for ESWL (British Association of Urological Surgeons , 2016).

From listening to the patients we included a map, and a plan set in place to review patient's satisfaction on ease of use to arrive at their destination.

The documentation went through a number of PDSA cycles, taking around 6 months to reach agreement with the MDM Stone Treatment Group, until a version was ready for sending to patients. The next PDSA cycle will be to study the evaluations of the information from the patient group.

From the time and motion study the information pack was designed to decrease the time taken to pre-admit a patient before they commence their ESWL on the day of treatment. **This would help in time saving on day of treatment and allow an extra patient to be added to the treatment session, such as an emergency patient.**

The information pack includes: a. MDM letter outcome (template letter)

b. Information and consent on ESWL

c. Map on how to find Craigavon Stone Treatment Centre

d. Advice on discontinuation of medication pre-treatment and when to re-start

The Next PDSA cycles

The patient information pack sees a number of PDSA cycles running simultaneously (Langley, June 1994).

a. **Patient feedback questionnaire on contents on patient information pack (Study), all separate, yet linked PDSA cycles.**

b. **A repeat time and motion study to review if the patient information has decreased administration time for admission of patient prior to treatment.**

c. **Though MDM and pharmacy involvement to ensure medication advice sheet stays up to-date. Periodic review date set, and awareness of pharmacy to notify of updates.**

7. **Extracorporeal Shockwave Lithotripsy treatment session**

Recommendations were made following the service evaluation, patient and staff interviews, and patient post-treatment questionnaire

Recommendations and outcomes for Craigavon Stone Treatment Centre

1. **Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment**
   Patient information pack and pre-prescription of pain medications. Follow-up time and motion study to be conducted.

2. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
   Reviewing the data needed for inclusion into a discharge letter, for immediate discharge and follow-up, the letter went through a number of PDSA cycles through the stone MDM and day of treatment.
   We moved from a hand printed discharge letter to an electronic generated letter, allowing a standard letter to be generated, with all necessary information required for completion.
   The letter had to be quick (less than 5 minutes) and easy for the author to complete.
   Following meetings and successful lobbying of the Electronic Care Records team (Northern Ireland regional Electronic notes) we achieved access and upload of the discharge letter. The letter can now be uploaded to Electronic Care Records straight after its generation, and allows a printed copy to the patient.
   The patients General Practitioner (GP) had previously received a typed discharge letter some 6 weeks following the patient's treatment. The standard electronic uploaded discharge summery immediately following treatment meant the additional letter to the GP was no longer required**.** The electronic generated discharge therefore prevented any further secretarial input, and thus saving money.

3. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
   A literature review was conducted on the Stone Treatment Centre long standing use of Piroxicam prior to ESWL treatment. The data suggested that the NSAID diclofenac may~~be~~ provide a more successful pain relief than Piroxicam 20mg.

Prospective data on treatment parameters and pain scores were collected on the pre-ESWL medication Piroxicam and paracetamol given to patients on the day of treatment. From reviewing patients receiving 20mg Piroxicam and 1g paracetamol, compared to those who could only receive paracetamol due to Piroxicam contraindication there was no benefit of receiving the addition of Piroxicam compared to paracetamol alone.

Following the evidence collected and literature review, the pain medication was changed to pre-ESWL Diclofenac Potassium 100mg oral and paracetamol. The work included the input from the pharmacy team, who also consulted the literature and evidence available. The Stone Treatment Centre will now collect data on the pain medication change to Diclofenac Potassium 100mg oral and paracetamol, to ensure a change has been an improvement.

Patients contraindicated to NSAIDS could receive codeine phosphate or tramadol.

A breakthrough pain medication was highlighted in the review. Following investigation work, Penthrox (3mg Methoxyflurane**)** was identified as a possible solution. The medication required for breakthrough pain relief had to be administered by a staff nurse only, with no doctor present. The Scottish Stone Centre used an opiate based breakthrough medication to achieve adequate stone treatments for patients requiring additional pain relief. The Craigavon Stone Treatment centre is staffed by a radiographer, staff nurse and health care assistant, and thus not suitable for opiate administration, which requires x2 staff nurse to check the medication. Options were explored for the provision of a second staff nurse, but were restricted by cost and availability of a second staff nurse.
Penthrox is a recognised pain relief and used widely in Australia, especially by Emergency Departments and Paramedics, and is safe to be administered by a single staff nurse, with very few contraindications. A medication New Product Application was successfully passed by the Hospital Drugs and Therapeutics board, which included a literature review of the current evidence (see appendix). The board required evidence of the effective use of Penthrox as a breakthrough pain relief for ESWL, for 50 patients, data collection currently ongoing.

4. Have architectural drawing proposal on how to alter Stone Treatment Centre to also provide private consultation room for patients, and area to change and keep personal items secure.
The Stone MDM team and hospital architect reviewed the recommendation and official hospital architectural plans were drawn. We were unable to expand the floor print of the centre, but in moving several plasterboard walls, a changing room for patients and suitably sized consultation room could be constructed. This left a recovery room, which doubles as the Stone MDM room on a Thursday morning, and the treatment room for ESWL. See Appendix for the plans, which have been approved and are on the Hospital waiting list to be undertaken.

We involved the hospital estates team to ensure the ventilation to the room was suitable. Calculations for the use of Penthrox for air changes were undertaken and

the number of air-changes was easily improved by re-calibrating the system.

11. Leadership Approach

The NHS Healthcare Leadership Model provided a structured road map for leadership with a view to Improvement of a service, through the nine dimensions of Leadership Behaviour (NHS, 2013). Using the model we started by Inspiring a Shared Purpose with the Stone Treatment Team on a vision of where the centre could improve for the benefit of the patient. It was also important to listen to each member of staff in helping to develop and reach their individual goals, such as the request to be involved in research and development of the centre (Research Nurse/Radiographer funding application), the aim of a radiographer to learn treatment of distal ureteric stones with ESWL (Staff sent to Edinburgh Stone Treatment Centre to observe and learn).

Data collection was important, so changes could be made following the evaluation of the information gained, and improvement could be measured in a quantitative method where possible, such as the improvement to the pain medication. It was important though to collect the data as a team and through the weekly team meeting, analyse and act through improvement science methodology, such as the numerous PDSA cycles, time and motion studies, patient questionnaires.

It was important to work collaboratively with other teams, such as Accident and Emergency and Radiology when it came to initiating the improvements to the diagnostic and referral pathway for renal and ureteric stones. The Stone Service is intrinsically connected to the wider Health Care Service and so important to build strong, workable, strategic relationships with other departments involved in the patient journey of stone diagnosis through to treatment. We took time to understand the issues affecting other departments and addressed any concerns of the new referral pathway. With the interconnectivity of the other departments involved, we had to share the vision early, and highlight the benefits this would produce for the Stone Service, for the patient and for their own departments.

It was important to keep the team united, focused and motivated on the task in hand. The weekly meeting helped bring the team together and allowed a platform for staff to air their views on aspects of the project. The provision of the meeting with tea/coffee and croissants in a room away from any active clinical duties, helped staff to openly discuss the issues in play and feel part of the team and want to contribute. Setting the right environment to succeed is fundamental for team working and achieving the aim, and there is much we can learn from how the commercial world interact and achieve the best from their staff (Deloitte, 2016).

Developing and encouraging progression of staff enabled the project to achieve the improvement aims. Developing the staff, developed the service, developed the teams skills in improvement science, giving evidence based results.

Presenting our results to the Hospital Senior Team allowed the request for further funding to develop the Stone Treatment Centre and to be on the waiting list for structural layout improvement to the Centre. By demonstrating our results on how we could decrease waiting times for stone treatments, decrease the need for outpatient appointments, cut the cost of emergency stone treatments, decrease the waiting time and cost of discharge summery from Stone Treatment Centre we hope to highlight to the Senior Team to the need and importance of the Stone Treatment Centre.

Eric Dishmans TED talk on 'health care as a team sport', a personal view through his own renal disease, and the need to be pro-active on healthcare, take the patient on the journey with you and empower them to understand and prevent their disease or disease progression (Dishman, 2014). In a stone context, treat the stone and prevent recurrence, but the patient needs to understand their stone disease. The Stone Treatment Centre improvement model will progress in the future to prevention strategies by utilising patient groups along with a Stone Treatment Centre dietician to prevent recurrence of their stone disease.

Many different staff groups were involved or impacted by the project, including Urology, Radiology, Pharmacy, Accident and Emergency, Estates, IT, Administration and Management. Leadership of the project was based on the 'Developing Collective Leadership for Health Care' Kings Fund paper (Michael West, 2014). The project needed a 'post-heroic' model of leadership, and so we undertook collaborative leadership, to create a positive environment where ownership of the implementation and success or failure of the project is a shared responsibility and mission. Using a collaborative leadership model and the inherent aims of the project a 'high concern for people and high concern for productivity', the most work with content staff was achieved (Blake R R, 1991).

The work of Parish (C, 2006) identified that a broad range of leadership styles (directive, visionary, affiliative, participative, pace-setting and coaching leadership) are demonstrated by a successful leader. The range of leadership styles still needs to be relevant to a modern Health Care Setting, with an overarching theme of collaboration…. 'Coming together is a beginning, staying together is progress and working together is success' (Ford)

12. Outcome and improvement measures

The improvement project is a continuum and not a single finish point. Much was achieved and improved, and the more success will follow.

Aim	Result Outcome	Quality Improvement method and evidence	Future
1. Emergency ESWL	Ability to provide a forth treatment on ESWL treatment session	• Time and motion study • Weekly team meeting • Cost analysis vs Main theatre (Potential saving of £874500 over 5 years)	• Funding application for further sessions
2. Meet demand for ESWL elective sessions	Funding application with evidence submitted for extra sessions	• Cost analysis vs Main Theatre (ESWL saves potential £1248 and £2235 per patient when compared to day case and inpatient Theatre Ureteroscopy) • Ability to book patient directly from Urology MDM • Reducing Outpatient appointments	• Await outcome of funding • Provide sessions for other trusts in Northern Ireland/ Cross boarder
3. Provide stone	• Urology	• PDSA cycles	• Patient

treatments recommended by NICE, BAUS and EAU 4. Provide patient with informed choice	Stone MDM • Evidence based stone pathway • Patient information leaflets • Chance to discuss in person	on paperwork and Stone MDM • Patient interviews	questionnaire • Further PDSA cycles
As a result of original aims			
a. Patient discharge summery	• Electronic and printed paper version on day of treatment	• Decreased discharge summery time from weeks to immediately following treatment • Saved administration and medical cost and time	• Improvements planned to the electronic discharge sheet for 2019
b. Improvement to Stone Treatment Centre Building layout	• Architectural plans and successful buildings work submission	• Time and motion study • Patient interviews • Staff walk around	• Await building works
c. Stone diagnostic and referral pathway	• Currently in use • Evidence based	• Patient now having calcium and uric acid checked and point of care • Appropriate information now gained for decision of treatment of stone	• Currently paper version • **Should aim for electronic referral on Electronic Care Records**
d. Stone MDM	• Patients discussed	• Evidence based	• Needs administrative

	weekly via A+E referral pathway • Faster decision and review of patients stone disease then waiting for outpatient appointment	treatments • Staff education • Patient information and education • Saves on Outpatient appointments (saves £420 per patient booked for ESWL)	personal dedicated to Stone Treatment Centre
e. Pain medication for ESWL	• Changed to Diclofenac Potassium • Trial of Penthrox breakthrough medication	• Study on Piroxicam ESWL pain medication, led to change to Diclofenac	• **Patient pain questionnaire on diclofenac and Penthrox for evidence of effectiveness of use, results awaited**
f. Application for Stone Treatment Centre Research post	• Application accepted for research funding	• Ability for collecting and analysing Stone Treatment and medications	• Await and plan for start of research project, including staff recruitment

13. Project sustainability

The continuation of the project is through the collaborative team model established, and will be steered in the correct direction by Urology Clinical Lead Mr Young , Staff Grade Ms Laura McCauley and Martina Corrigan, with help from all of the Stone Treatment Team. The project is and will always be team approach.

The increasing obesity epidemic, ageing population, sedentary lifestyle and potentially global warming (increasing temperature with poor fluid intake) highlights the importance of this project, not only to meet the demand for current stone patients, but to build capacity for the future increase. It is a project therefore that cannot be ignored.

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15. Appendix

a. **Ureteric and Renal Stone Pathway (guidance and referral form)**
b. **Urology Stone Multidisciplinary Meeting**
    - **i. Patient Pathway Stone MDM**
    - **ii. Patient Information Pack**
        - **iia. Template Letters**
        - **iic. Patient Information and Consent Form**
        - **iib. Anticoagulation Pathway**
c. **ESWL Treatment Day Protocols**
d. **ESWL Medications**
e. **Craigavon Area Hospital ESWL TMS i-sys Sonolith lithotripter Adult Protocol**
f. **Business Case Proposal**
g. **Research funding proposal**

a. Ureteric and Renal Stone Pathway

Including guidance for pathway and referral form

Ureteric and Renal Stone Pathway

Southern Trust Hospitals

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

Note: Male >50yrs, no history of renal stones, then consider AAA pathway

History Suggestive of Renal Colic? THEN DO THE FOLLOWING

- Urine dipstick including pH
- Pregnancy test (12 to 55 years)
- Patient observations
- FBC, U&Es, CRP, Calcium and uric acid

(Same day imaging if single kidney, infection, AKI)

Not Pregnant and >18 years old

Non Contrast CT Urinary Tract

Ureteric stone or obstructing kidney stone

Is there any:
1. Infection (? SEPSIS 6)
2. Acute Kidney Injury
3. Uncontrolled pain
4. Ureteric stone >6mm
5. Diabetes
6. Immunosuppression

Yes → Discuss with Urology

No → Complete Outpatient Stone Referral Form

Non-obstructing Stone in Kidney, not ureter

Evidence of Pyelonephritis

Yes → Consider admission if necessary (See Hospital/ NICE guidelines)

No → Consider alternate cause for pain

AND

For the stone finding, complete Stone Referral Form

<18 years old

USS RENAL TRACTS

Hydronephrosis OR highly suspicious of stone, OR Urological abnormality, Discuss with Urology.

Pregnant

Discuss with Obstetrics

USS RENAL TRACTS

Discuss with Urology
Consider NC MRI Renal Tracts

Negative Imaging

Consider alternative cause of pain

(Non-visible haematuria on urine dipstick: Notify GP to re-check and refer if needed as per NICE guidance)

Pathway next due for REVIEW July 2018 Stone MDM

Completed form send to Urology Consultant on-call, Craigavon Area Hospital

Ureteric and Renal Stone Referral

Urology, Craigavon Area Hospital

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

Please refer to A+E protocol for referral guidance:

Uncompleted forms will be returned to referring Doctors

Patient identification (sticker)

Referring Doctor: _____

Referring unit: _____

Date of referral: ___ / ___ / 20___

Patient Phone number:_____

Physical or mental disability? **Yes** **No**

Presenting symptoms: (circle)

Side of stone: Left Right

Side of Pain: Left Right No pain

Visible haematuria Yes No

Acute Medication given from A+E:

Imaging modality: (circle)

NCCTKUB* **USS KUB/ NC MRI**

(*CT Urinary tract) **(If <18 yrs or pregnant)**

Findings:

X ray KUB done: Yes No
(Indication: if stone not visible on CT scout)

Past medical History: (circle)

Solitary Kidney **yes** **no**

Abdominal Aneurysm: **yes** **no**

Pacemaker: **yes** **no**

If yes, type_____

ASTHMA: **yes** **no**

Cardiac Stent: **yes** **no**

Date of stents_____

CKD Stage IV or V: **yes** **no**

Current Gastric Ulcer **yes** **no**

Malignant hyperthermia **yes** **no**

Symptomatic heart failure **yes** **no**

Other past medical history:

-

-

ALLERGIES: (circle) YES NO

Drug:

Anticoagulants:

Immunosuppressive agents:_____

BLOODS

Creatinine:_____ eGFR:_____

Corrected Calcium:_____ Uric acid:_____

Haemoglobin:_____ Platelets:_____
White Cell Count:_____ CRP:_____

Urine dip stick:

pH:_____ Blood:_____
Leucocytes:_____ Nitrites:_____

Pregnancy test Positive Negative
(circle)

Completed form send to Urology Consultant on-call, Craigavon Area Hospital

Ureteric and Renal Stone Referral

Urology, Craigavon Area Hospital

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

Radiology:#

It would aid stone management if the radiologist were to record

1. Stone size
2. Stone location
3. Stone attenuation
4. Skin to stone distance
5. Hydronephrosis
6. Congenital anomalies
7. Extravasation
8. Stranding

Based on AUA guidance http://www.auanet.org/guidelines/imaging-for-ureteral-calculous-disease accessed August 2017.

b. Urology Stone Multidisciplinary Meeting

Time: 09:00 Thursday mornings

Location: Stone Treatment Centre, Craigavon Area Hospital

Urology Consultants, Staff grade, STC Sister, Radiologist, Radiographer, Secretary

Stone meeting agenda to be produced by the Urology Staff Grade or Fellow attached to the unit. Urology referrals to be reviewed and checked for accuracy, then work list generated on ECR. Any forms missing vital information to be returned to sender unless delay may impact upon safety of a patient, in which case organise to see patient urgently.

Patient Details	**Imaging modality and stone details**	**Meeting outcome**	**Specific Tasks**
Example 343234321	NC CTKUB 01/01/17. 7MM upper ureteric stone	ESWL	Stop rivaroxaban 2 days prior

The imaging modality and stone details can be cut and pasted into the diagnosis part of a **letter template**, pending on meeting outcome decision.

Patient pathway to be determined at meeting, see table 1.

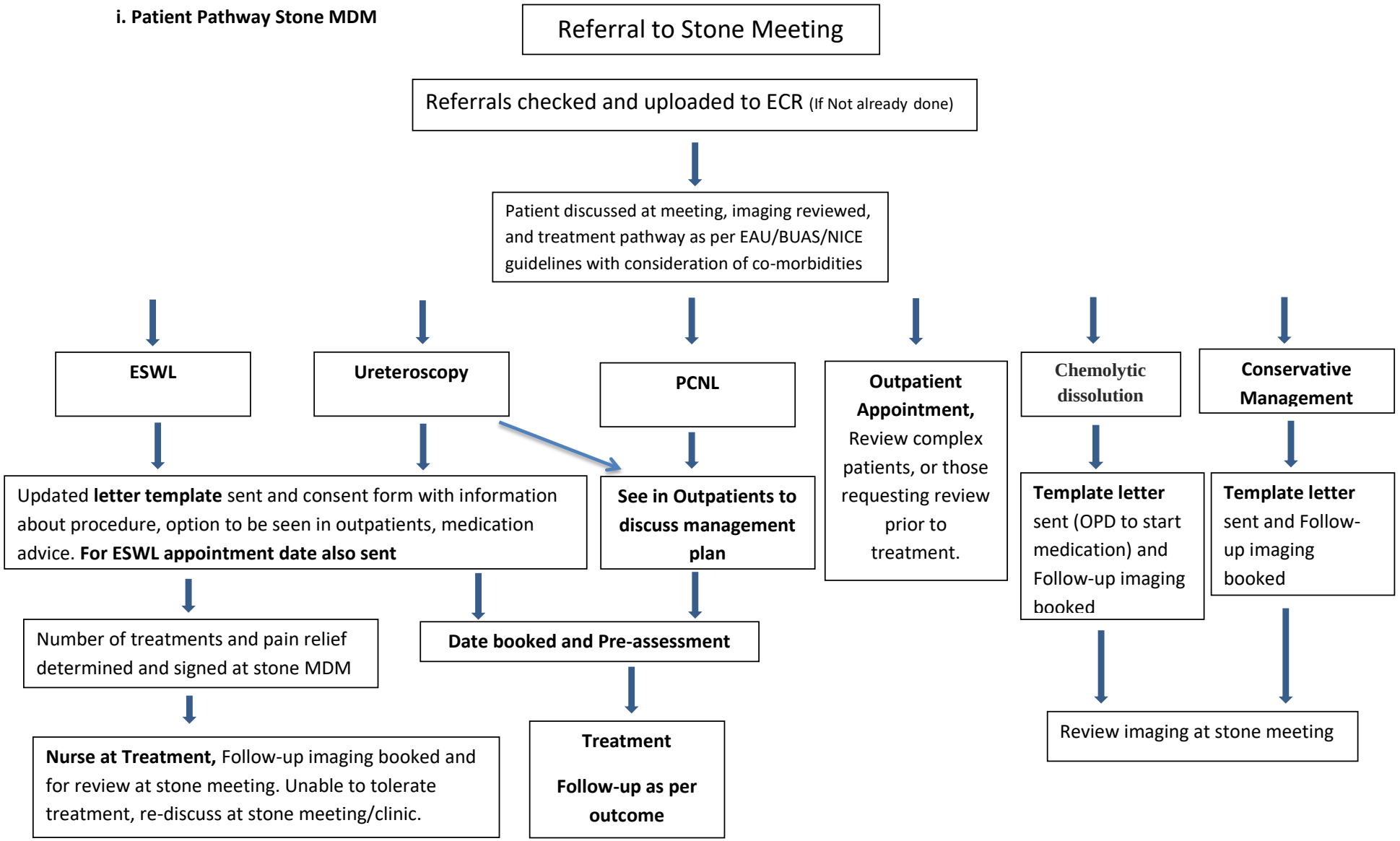
ESWL booking is organised at meeting. Appointment date, meeting letter (template as above), consent form, patient information, and **anticoagulation medications advice** sent out following meeting. The secretary can organise letter at time of meeting, since only the imaging modality and stone details need added to template. Alternatively the meeting outcomes can be forwarded to the secretary following meeting conclusion.

ESWL Radiology request completed at meeting containing: 1. Stone side and location
2. Number of ESWL sessions
3. Follow-up imaging planned

Dictation for complex patient may be needed and should be ready for use.

Medications for ESWL can be signed for each patient, Pharmacy to provide pre-printed drug cards to save time on prescribing and ensure clarity of prescription. Pre-printed outpatient script for take home medication. Allergies and contraindications are checked on referral, ECR and again on day of treatment by nursing staff prior to administration.

i. Patient Pathway Stone MDM



ii. Patient Information Pack

Patient Letter and Information Pack

The Urology MDM allows for direct template letter to be sent to the patient, explaining they have been discussed by the multidisciplinary panel and which treatment pathway has been advised.

Patients who are not suitable for direct treatment pathway will be called to clinic to discuss management, these will include all PCNL and ureteroscopy (at present) patients and those deemed the highest risk for any treatment.

The aim of the pack is to decrease the number of patients seen in clinic, yet providing the patient with reassurance they have been reviewed by the stone MDM and provided with a fully informative pack containing,

1. Letter explaining MDM OUTCOME and Imaging findings
2. Modified BAUS information leaflet and consent form (to bring on day of treatment sign last page)
3. Anticoagulation schedule for those on anticoagulants
4. Map for Blood room and Stone Treatment Centre

Pre-assessment: All patients listed for ureteroscopy and PCNL. ESWL patients deemed high risk on anticoagulation should undergo pre-assessment so clexane cover can be organised as per guidelines.

Patient Hospital Contact: The letter will contain the contact number of Stone Centre secretary, for which the patient will contact if:

1. Request OPD instead of direct to treatment
2. If date received is not suitable
3. If stone has passed (patient advised to present to GP for stone to be sent for analysis), so can be re-discussed at meeting for follow-up

Font size

The font size can be increased for any patient who has difficulty in reading and sent out accordingly by the secretary

Language

The patient information is set as English. A further copy could be provided using patient language services to translate the information before being sent. A template letter and consent form could be created for common other languages that are not English, with translator provided on day of treatment.

Dear iia. Template letter for Conservative Treatment

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

There is a very good chance this stone will pass and not need surgery/intervention.

We have organised repeat imaging in 6 to 8 weeks' time to check for stone passage, the x-ray department will contact you with a date. However, if you are unwell in the interim, especially with a high temperature, please attend your GP or A+E.

Dietary Advice

• Specific types of stone can be managed by measures aimed at the cause of your stone formation

• Generally, keeping your urine dilute & colourless reduces your risk of forming a further stone by almost one third (30 to 40%)

• In addition, a normal calcium, low-salt, low-protein dietary intake can reduce your risk of stone formation even further

If you pass the stone, please call **Paulette on** Personal information redacted by USI **Gemma on** [redacted] and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

If you have any further questions please call number above.

Your repeat imaging in 6 to 8 weeks will be discussed at the Stone Centre Meeting and we will contact you with the outcome.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

Dear Template Letter for ESWL Stone Treatment

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

The stone we are going to treat first is

We have organised for you, **Extra Corporeal Shockwave Lithotripsy (ESWL)** in order to treat your stone at the **Craigavon Stone Treatment Centre**

Date of ESWL is: (if no date given, then await appointment letter).

Please call **Paulette on** Personal information redacted by USI or **Gemma on** Personal information redacted by USI **to confirm the treatment date is suitable**

Please find enclosed with this letter:

1. *Information* on Extra Corporeal Shockwave Lithotripsy (**ESWL**)
2. ***Consent form*** **-** Following reading and understanding the information on ESWL provided, please sign consent form and **bring along to the day of treatment.**
3. ***Advice sheet*** for patients who take anticoagulation medication (BLOOD THINNERS), on when to stop before treatment and when to restart following treatment.
4. *Dietary advice* sheet to help decrease risk of further stones
5. *Map* of how to get to **Craigavon Stone Treatment Centre**

If you pass the stone before your ESWL treatment, please call **Paulette on** Personal information redacted by USI first, otherwise call **Gemma on** Personal Information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

On your treatment day please bring your consent form and all your medications (including over the counter medications). Report to check in desk on day of treatment (see map).

If however you would like to discuss the treatment on offer or possible alternatives then please call the number above to make an appointment.

We look forward to meeting you at Stone Treatment Centre for your treatment.

Many thanks

Mr Young FRCS(Urol)
Urology Consultant

Dear Template Letter for Ureteroscopy and Laser

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

We have recommended for you, **Ureteroscopy and laser, under general anaesthetic** in order to treat your stone.

We shall see you in our outpatient clinic to discuss your stone management further.

Enclosed with this letter:

1. Information sheet on **Ureteroscopy and laser to stone**, under general anaesthetic
2. Dietary advice sheet to help decrease risk of further stones

If you pass the stone, please call **Paulette** Personal information redacted by USI or **Gemma on** Personal information redacted by USI and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

We look forward to meeting you at Craigavon Area Hospital.

Many thanks

Mr Young FRCS(Urol)

Dear

Template Letter PCNL

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

We have recommended, **Percutaneous Nephrolithotomy (PCNL), under general anaesthetic** in order to treat your stone.

We shall see you in our outpatient clinic to discuss your stone management further.

Enclosed with this letter:

1. Information sheet on **Percutaneous Nephrolithotomy (PCNL)**, under general anaesthetic
2. Dietary advice sheet to help decrease risk of further stones

If you pass the stone, please call **Paulette on** Personal information redacted by USI or **Gemma on** Personal information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

We look forward to meeting you at Craigavon Area Hospital.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

Dear

Chemolytic Therapy

Patient Details: Insert here

Your kidney stone was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging demonstrated: Insert here

We have organised for you, **specialised dissolution therapy, this is medication to dissolve your stone.**

Enclosed in letter:

1. Information sheet on Chemolytic dissolution of kidney stones
2. Dietary advice sheet to help decrease risk of further stones

We shall see you in Stone Treatment Clinic to discuss starting the treatment medication in the near future.

When your outpatient appointment letter arrives, please phone to confirm.

If you pass the stone, please call **Paulette on** Personal information redacted by USI **Gemma on** Personal information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

iib Patient information and consent form

Procedure specific information should be sent to each patient when directly booked for a procedure from Urology Stone MDM. This should provide information on the treatment selected and alternatives, as well as a clear presentation of contraindications and risks so the patient can make a balanced decision themselves if they wish to proceed or not.

Further to the procedure specific information, a consent form is attached to be signed by the patient once they understand and agree to go ahead with the treatment proposed. This consent form should be brought to the day of treatment with the patient and countersigned by the nurse.

What if the patient doesn't wish to go ahead with the proposed treatment or wish to ask further questions?

A telephone number for **Stone Treatment Centre** secretary is provided on the letter template from Urology Stone MDT. The patient may contact this number and arrange an outpatient appointment or phone-call appointment for further discussion as required, prior to any treatment going ahead.

Next Page is ESWL patient information and consent form

Extracorporeal Shockwave Lithotripsy (ESWL)

What does the procedure involve?

Delivering shockwaves through the skin to break kidney stones into small enough fragments to pass naturally. This involves either x-ray or ultrasound to target your stone.

What are the alternatives to this procedure?

Telescopic surgery, keyhole, open surgery and observation to allow stones to pass on their own.

What should I do on the day of ESWL treatment?

1. Please take all prescribed medications, except blood thinners (anticoagulants), which you should have already stopped as per anticoagulant advice sheet.
2. You can have a light meal on the morning of your treatment (or light lunch if an afternoon appointment), but you should drink only water in the two hours before the treatment.
3. **Please bring your consent form and your medications on the day of treatment.** It is helpful if you bring your own dressing gown to wear.
4. We advise you bring someone with you and not to drive yourself home following your treatment, especially if you have received any medication with a sedative effect. In the absence of a chaperone we may have to restrict your medication and treatment.
5. Please leave enough time to park at the hospital if driving; it can take up to 30 minutes to find a parking space.
6. On arrival:
   a. Book into A+E reception for your ESWL treatment (see map)
   b. (If on Warfarin proceed to blood room, see map)
   c. Proceed to Stone Treatment Centre for ESWL Treatment

On arrival to stone treatment centre

1. Ring the bell, take a seat and the nurse will be with you shortly.
2. **Please tell your Health Care Provider before your treatment** if you have any of the following:
   A. Usually take blood thinning medication such as warfarin, aspirin, clopidogrel (Plavix®), rivaroxaban, prasugrel or dabigatran.
   B. Heart pacemaker or defibrillator
   C. Artificial joint
   D. A history of abdominal aneurysm
   E. A neurosurgical shunt
   F. Any other implanted foreign body
   G. An artificial heart valve
   H. PREGNANT
   J. <u>Tell Your Nurse on Arrival</u> if you have <u>ANY ALLERGIES</u>

3. You may need to pass a urine sample on arrival for analysis

4. Pain relief will be given at least 30 minutes before, and additional pain relief might be needed during the treatment

What happens during the procedure?

You do not need an anaesthetic and you will be awake throughout the procedure. We usually only use general anaesthetic for children.

You will be asked to lie on the treatment bed and your stone will be located by Ultrasound and/or X-ray. Gel will be applied to the skin over your kidney and the treatment head, which generates the shockwaves to treat your stone, will be placed comfortably against this part of your back (as per picture).

You will have a sensation like being flicked in the back by an elastic band. You will hear a clicking noise of the machine during the treatment.

Your treatment will be monitored by a Nurse and Radiographer.

You may also feel a deeper discomfort in the kidney. If this proves too painful, we can usually give you an additional painkiller.

Your treatment will normally last up to 60 minutes, with an average total stay of 2 hours in the Stone Treatment Centre.

Following the Procedure

Please feel free to ask how the procedure went and ask any questions.

Patients usually stay with us for up to 30 minutes, to be monitored by the nurse and light refreshments will be offered.

You will be given pain relief medication and a discharge letter from the nurse, which will include your follow-up plan.

At Home following procedure

1. Rest for 24 hours
2. Drink 6 pints of water a day (unless told to fluid restrict by your doctor)
3. Some pain may be expected, please take your pain relief medication when needed.
4. Expect to see blood in the urine for 3 to 4 days. Restart blood thinning medication 2 days after treatment, unless heavy bleeding.
5. If any blistering or bruising appears on your treatment side, use a soothing skin cream to ease discomfort.
6. Any stone fragments passed, please collect and take to your GP for testing.

What else should I look out for?

If you develop a fever (above 38ºC or 100.4 F), severe pain on passing urine or you cannot pass urine then attend your GP or A+E department immediately.

Driving after ESWL

We advise not to drive for 24 hours after the procedure. It is the patient's responsibility to know when they are pain free and feel well enough to drive following ESWL treatment.

Are there any side-effects?

Most procedures have possible side-effects. But, although the complications listed below are well recognised, most patients do not suffer any problems.

Common (greater than1 in 10)

- Blood in your urine for up to 72 hours after the procedure.
- Pain in your kidney as small fragments of stone pass.
- Urinary infection due to bacteria released as the stone breaks.
- Bruising or blistering of the skin.
- Need for further ESWL treatment.
- Failure to break stone(s) which may need additional or alternative treatment, especially for very hard stones.
- Recurrence of stones.

Occasional (between 1 in 10 and 1 in 50)

- Stone fragments may get stuck in the tube between the kidney and the bladder and require surgery to remove the fragments.

Rare (less than 1 in 50)

- Severe infection requiring intravenous antibiotics (less than 1%) and the need for drainage of the kidney by a small tube placed into it.
- Kidney damage (bruising) or infection needing further treatment.
- Damage to the pancreas or lungs by the shockwaves requiring further treatment.

Information based on British Association of Urology Surgeons, Patient information, Lithotripsy for stones, Published 2016.

Further Information can be viewed at:

https://www.baus.org.uk/patients/conditions/6/kidney_stones

http://patients.uroweb.org/i-am-a-urology-patient/kidney-ureteral-stones/treatment-kidney-ureteral-stones/

Extracorporeal Shockwave Lithotripsy Consent Form

Patient Sticker

Please bring on day of ESWL

I have read, understood and agree to go ahead with extracorporeal lithotripsy (ESWL) treatment(s) for my renal/ureteric stone

……. …… …….

Patient name Patient signature Date

…… …….. ……

Radiographer name Radiographer Signature Date

To be placed in patients notes

iiic Anticoagulation (Please also refer to patient anticoagulation pathway, Stone MDM)

Patients on anticoagulation medication will be identified by the structured referral form and checked on Electronic Care Record at Stone MDT (or prior by Doctor organising the list for Stone MDM). A further check for ESWL is on treatment day by the nurse, otherwise for theatre cases by the pre-assessment team.

For ESWL, patients taking Aspirin 75mg regularly there is controversy if this should be stopped or not. The BAUS patient information leaflet would appear to lean towards stopping the medication (British Association of Urological Surgeons , 2016); the team visit to the Scottish Lithotripter Centre in October 2016 noted their current practise is to stop Aspirin 75mg, 7 days prior to ESWL. Other centres are noted to continue their patients on Aspirin 75mg, but state to stop all other NSAIDs 7 days prior (Colchester Hospital University Foundation Trust , 2016).

A PubMed Search for continued daily patient use of Aspirin 75mg and ESWL was conducted. The search terms included 'ESWL' OR 'Extracorporeal Shockwave Lithotripsy' OR Shockwave lithotripsy' and Aspirin.

A retrospective study could be undertaken in Craigavon as patients who were on 75mg Aspirin, previous to this report patients were not told to stop the medication. Has there been any clinical presentation of renal haematoma or prolonged or heavy haematuria necessitating admission. Since Urology Stone MDT August 2017 the decision was made to stop Aspirin 5 days prior ESWL (Based high bleeding procedures, Southern Trust)

Information sheet on how long before any treatment a patient should discontinue their anticoagulation medication is part of the information pack and produced as part of the Stone MDM. ESWL patients should not restart anticoagulation until 48 hours after the treatment and only when urine is no longer haematuria (European Association of Urology , 2017).

Patients who require bridging low molecular weight heparin should attend pre-assessment so this is safely facilitated for ESWL, as with main theatre procedures.

Pharmacy and Haematology

Before the information is to be disseminated to patients the clinical information should also be reviewed by Pharmacy and Haematology teams. When new anticoagulants are introduced to the market, a trigger should be in place to inform the stone MDM so the anticoagulation advice sheet can be updated accordingly. Alternatively this could fall as part of a periodic review of the information pack.

List position for ESWL and Patients needing an INR

Patients who are on Warfarin therapy will require an INR prior to treatment with ESWL. Therefore they should not be placed at the start of the morning list, this is to allow their INR blood test to be taken and processed. The haematology laboratory should therefore be contacted once the INR has been sent so to be processed promptly and reduce the chance of a patient delay in treatment whilst the result is awaited.

Blood sample for INR can be collected from the phlebotomy service located next to the Thorndale Unit. The patient could either be sent to the service direct from registering their visit to the hospital at the main reception next by A+E, with the blood form left in preparation with the phlebotomy service. Alternatively the form could be collected by the patient from the Stone Treatment Centre, but this would add on much time for the patient and potential delay in INR result and thus treatment.

Process for Anticoagulation plan at Stone MDT

- If patient determined low risk for CVD then anticoagulation protocol followed and patient informed by letter from MDT when to discontinue their medication, given a blood form for pre-ESWL INR check and with instruction to ensure first INR check 5-7days after treatment restarted
- If patient determined high risk for CVD then consider postponing procedure or offering alternative treatment e.g. URS or observation
- If patient determined high risk for CVD but requires ESWL then green form completed at MDT and patient referred to Pre-operative assessment:
    - For bridging with low molecular weight heparin (LMWH), the Pre-Operative Assessment Nurse and Pharmacist will ensure the prescription is written and the LMWH is dispensed by the hospital pharmacy.
    - The pre-operative assessment nurse will inform the patient in writing of the dates of administration of enoxaparin and inform their GP about the pre-operative management of warfarin by sending them a copy of the green form.
    - Where possible, the patient / carer should be instructed on self-administration of LMWH by the pre-operative assessment nurse.
    - The post-op management must be documented on green form so that LMWH can be prescribed and dispensed by pre-op assessment in preparation for discharge with appointment made for INR check 5-7days post ESWL

On day of ESWL:

• INR should be checked to ensure it is <1.4. If INR is above this target, ESWL does not proceed and patient rescheduled

Determination of CVD risk for patient

Low Risk:

- AF with no prior stroke or TIA
- VTE more than 3months ago
- 6months after MI/ PCI/ BMS/ CABG/ stroke (12months if with complications)

High Risk: (consider ureteroscopy/ observation/ postponing of treatment instead of ESWL)

- Mechanical heart valve
- 12 months after drug eluting stent
- Target INR >3
- AF with previous stroke or TIA
- VTE in last 3months (post pone surgery)
- Antiphospholipid syndrome
- 6weeks after MI/ PCI/ BMS/ CABG (6months if complications)
- 2weeks after stroke

(MI – myocardial infarction, PCI – percutaneous coronary intervention, BMS – bare metal stent, CABG – coronary artery bypass grafting)

References:

- Sharepoint: http://sharepoint/as/clinical/Anticoagulant%20Documents/Forms/AllItems.aspx
- Alsaikhan, B., & Andonian, S. (2011). Shock wave lithotripsy in patients requiring anticoagulation or antiplatelet agents. *Canadian Urological Association Journal*, *5*(1), 53–57. http://doi.org/10.5489/cuaj.09140
- https://uroweb.org/guideline/urolithiasis/#3

Management of Anticoagulation in Patients for ESWL

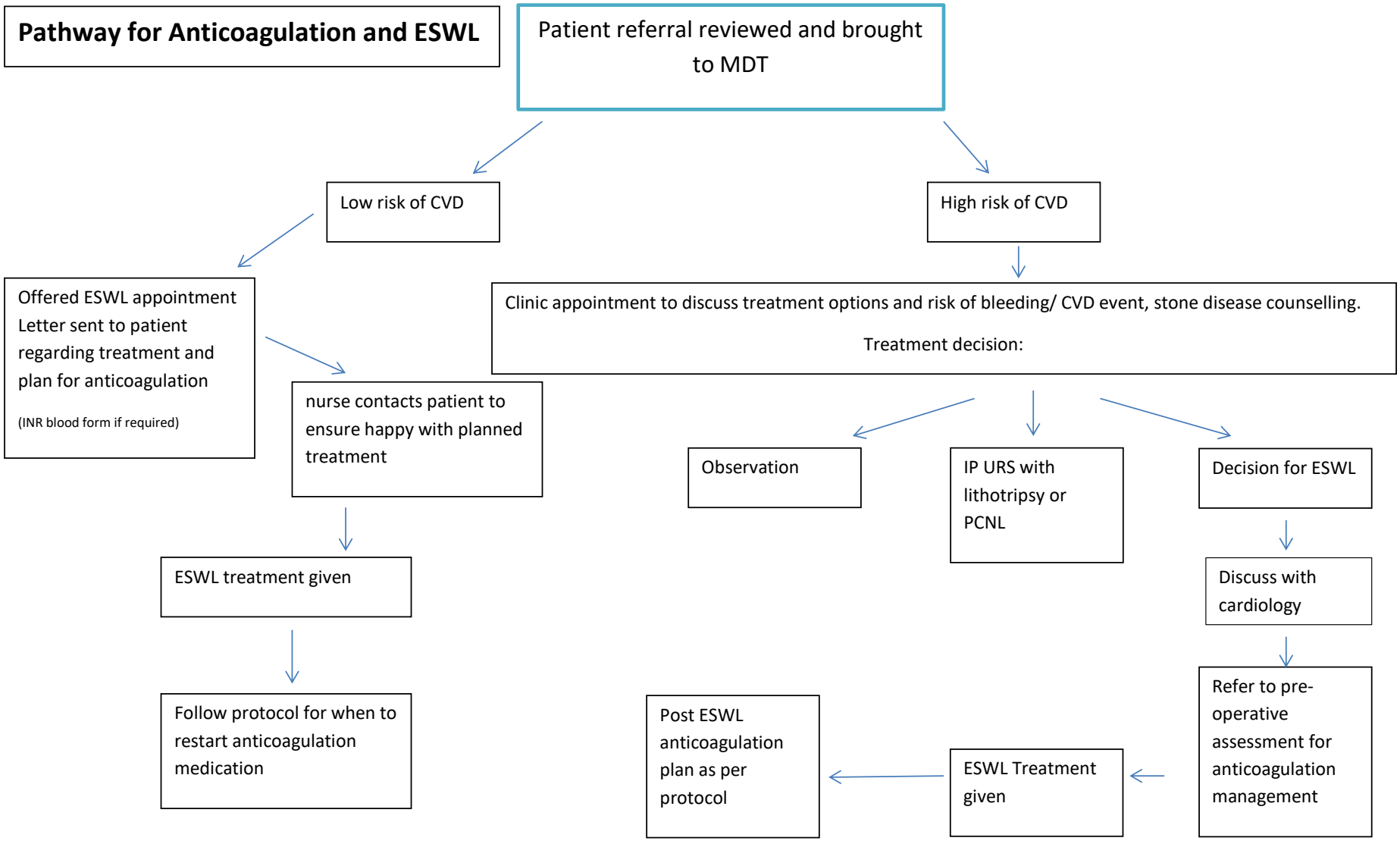
~ CrCl ≥80 stop 48hours, CrCL 50-80 stop 72hours, CrCl 30-50 stop 96hours

CVD risk	ASA (e.g. Aspirin)		Thienopyridine agents (e.g. clopidogrel)		Warfarin		Dabigatran		Rivaroxaban/ Apixaban/ Edoxaban	
	Pre op	*Post op*	*Pre op*	*Post op*	*Pre op*	*Post op*	*Pre op*	*Post op*	*Pre op*	*Post op*
Low Risk	Stop 5 days	Restart 2days	Stop 5 days	Restart 2days	Stop 5 days	Restart evening (normal dose)	Stop – rv CrCl~	Restart 2days	Stop 2days#	Restart 2 days
High Risk	Continue	Continue	Stop 5days Bridge treatment dose LMWH	Restart clopidogrel 2days Discontinue LMWH	Stop 5 days Bridge LMWH: - treatment dose (day 3 and 2 pre op) - 50% of dose day 1 pre op	Restart evening Prophylactic dose LMWH 48hours then resume treatment dose until INR therapeutic	Stop – rv CrCl~ Prophylactic dose LMWH	Restart 2days Continue LMWH 2days then stop*	Stop 2 days# Prophylactic dose LMWH	Restart 2days Continue LMWH 2days then stop*

*Do not give DOAC and LMWH together

Stop 3 days if Cr Cl <30

Pathway for Anticoagulation and ESWL



Patient Advice Prior to ESWL Treatment for Stones

Plan for your anticoagulation (blood thinning) medications: Page 1 of 2

(Please see circled which is relevant to you)

Warfarin	Please stop 5 days before ESWL Please bring the attached blood form and attend the blood (phlebotomy) room at the Thorndale Unit, Craigavon Hospital, for INR at 08:30am on the day of your treatment Then proceed to the Stone treatment centre for result review and ESWL treatment Please restart your normal dose of warfarin the evening of your treatment. **Please ensure you have an appointment to get an INR check 5-7days after your warfarin is restarted.**

Aspirin **Dipyridamole** **Clopidogrel**	**Please stop 5 days before ESWL and restart your normal dose 2 days after your treatment**

Rivaroxaban (Xarelto) **Apixaban (Eliquis)** **Edoxaban (Lixiana)**	**Please stop 2 days/ 3days (depends on creatinine clearance) before ESWL and restart your normal dose 2 days after your treatment**

Dabigatran (Pradaxa)	**Please stop 2 days/ 3 days/ 4 days (depends on creatinine clearance) before ESWL and restart your normal dose 2 days after your treatment**

Ticagrelor **Prasurgel**	**Please stop 7 days before ESWL and restart your normal dose 2 days after your treatment**

Patient Advice Prior to ESWL Treatment for Stones

If you have recently undergone a cardiology procedure and are on medication following this procedure, please contact **Paulette on** Irrelevant redacted by the USI or **Gemma on** Irrelevant redacted by the USI before you accept the appointment.

Medications/ Supplements

Unless you are informed otherwise, please continue all medications that are prescribed by your doctor.

Many herbs, vitamins and diet supplements may increase the risk bleeding during ESWL.

Certain over the counter medications may also increase your risk of bleeding.

Please stop taking all over the counter medications, vitamins, herbs and diet supplements 7 days before ESWL. You may resume taking these supplements 2 days after your treatment.

Examples of herbal remedies to be stopped[1]:

- Garlic[2]
- Ginseng
- St John's Wort
- Ginkgo biloba
- Danshen

Common over the counter medication to be stopped[3]:

- Naproxen
- Aspirin (e.g. Anadin, Anadin extra)

1. Cordier W., Steenkamp V. Herbal remedies affecting coagulation: A review. *Pharmaceutical Biology* Vol. 50 , Iss. 4,**2012**
2. Gravas S, Tzortzis V, Rountas C, Melekos MD. Extracorporeal shock-wave lithotripsy and garlic consumption: a lesson to learn. *Urol Res*. **2010** Feb;38(1):61-3. doi: 10.1007/s00240-009-0242-0. Epub 2009 Dec 15.
3. Dickman A. Choosing over-the-counter analgesics. The Pharmaceutical Journal, Vol. 281, p631 | URI: 10040592