after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

Adhere at all times to all Trust policies/codes of conduct, including for example:

- Smoke Free policy
- IT Security Policy and Code of Conduct
- standards of attendance, appearance and behaviour

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

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

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

- Take responsibility for his/her own ongoing learning and development.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE Medical Lead for Litigation Services

DIRECTORATE

July 2019

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*

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

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

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

2. Hold a medical qualification, and GMC registration

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

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

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

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

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

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

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Leadership Framework. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this framework to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. For ease of reference a copy of the Summary document on the NHS Leadership Framework is available with this advertisement. Further information may be obtained from www.nhsleadershipqualities.nhs.uk

The successful candidate will be appointed for a period of 6 months in the first instance subject to satisfactory performance.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

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

Stinson, Emma M

From: Wallace, Stephen
Sent: 15 December 2020 12:55
To: Wallace, Stephen ([redacted])
Subject: MNOTES - 15.12.2020 11:30am UHB Apprisal and Revalidation

Bill Tunnicliffe
Maria O'Kane
Stephen Wallace

BT - AMD for Revalidation, layered structure. RO is separate from the MD – soft intelligence. Takes my information and recommendations, hard intelligence. In house – 8 years ago. Trust went through structural changes. Had to make appraisal processes uniform across four legacy organisations. Issues of self-declaration, requiring the doctor to declare if they have any other licensed activities. It is entirely reliant on the honesty of the doctor. This is set by the GMC requirements. Private providers are now more concerned with practitioners information being included in appraisal and revalidation processes. ISPs are asking for sharing of information, the doctor owns the appraisal not the organisation. BT – the process is for the doctor, GMC state that appraisal is not a performance management tool. Bringing on board an **Annual Professional Review**, job planning, performance, organisational processes around the doctor. This process belongs to the organisation. The doctor will be subject to performance management via this route. MOK – will CSCG be part of professional review, BT – yes this will be included in this. Designated bodies should not burden the A&R with local processes. MOK – private sector providers – take a view that doctor is renting a room rather than responsible for their practice. Letters of good standing require doctor to assure that the outcomes are in line with what their substantive roles are. The exceptions are limited in terms of doctors who's private practice differs from their substantive role. Doctors choose their own appraiser in UHB. Ian Paterson did not declare. The coding system is not reliable to identify deviations in practice. Every appraisal summary is signed off by the AMD A&R for quality purposes. MOK do you audit your appraisals, BT – rather work on a better appraisal than deeper audit of appraisal. BT – I am an appraiser, usually difficult doctors are handled.

Stinson, Emma M

From: OKane, Maria
Sent: 09 December 2020 11:01
To: Wallace, Stephen
Subject: FW: IPR's

Can we discuss???

From: Gibson, Simon
Sent: 09 December 2020 08:44
To: Reid, Trudy; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

See below

Individual Performance Review

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: Reid, Trudy
Sent: 09 December 2020 08:44
To: Gibson, Simon; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

Simon I have a mental block, what is it?
Trudy

From: Gibson, Simon
Sent: 09 December 2020 08:28
To: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: IPR's

P>S – If you don't have one, I'm sure we could all help you put one together as a baseline document

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: OKane, Maria
Sent: 09 December 2020 08:26
To: Wallace, Stephen; Reid, Trudy; Gibson, Simon
Subject: FW: IPR's

What are iprs?

From: Devlin, Shane
Sent: 08 December 2020 11:07
To: Beattie, Brian; Magwood, Aldrina; McClements, Melanie; McNeany, Barney; OKane, Maria; O'Neill, Helen; Morgan, Paul; Toal, Vivienne; Trouton, Heather
Cc: Alexander, Ruth; Campbell, Emma; Stinson, Emma M; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Livingston, Laura; PADirectorofP&RSHSCT; Willis, Lisa
Subject: IPR's

Dear All

At our next 1:1 meetings we will be discussing IPR's for 2019/20 and 2020/21. Can I ask that you do two things in advance of the meeting.

1. Please review your 2019/20 IPR noting achievements (up until 31st March 2020) and forward to me.
2. Based on 2019/20 IPR produce for 2020/21 a roll forward of those items not achieved in 2019/20. I would then suggest a general statement, which I will prepare, to go into all IPR's with regards to managing the organisation through the COVID-19 pandemic

Given the year of COVID we have had, I think this is a fair approach to IPRs for 2020/21.

We will for 2021/22 have a modified approach and I will discuss this further.

Many thanks, Shane

Better leadership for tomorrow

NHS Leadership Review

Lord Rose

June 2015

Contents

Foreword

Early in 2014 the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, asked me to review what might be done to attract and develop talent from inside and outside the health sector into leading positions in the NHS; and to recommend how strong leadership in hospital Trusts might help transform the way things get done and to report my findings by the end of the calendar year, which I duly did. Early in 2015 the Secretary of State requested that I extend this report to consider how best to equip Clinical Commissioning Groups to deliver the *Five Year Forward View*, which had been published late 2014[1].

I started this Review in March 2014. I have met and listened to a wide range of stakeholders at meetings, briefings, visits and roundtables (details of this are contained at the end of this report). I have also read a significant amount of literature. I focused my attention on acute and secondary care (both NHS Trusts and Foundation Trusts, referred to together in this document as Trusts) as well as commissioning: there is no specific coverage here of primary care. There are specific recommendations for those in leadership positions within commissioning and provider organisations but in reality many of the recommendations are for the whole of the NHS.

I would make the following observations:

[1] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

- First, the NHS consistently delivers great service through a committed and passionate workforce of 1.38m staff in England[2]. During my Review I heard many great stories (only a few not so great). Mostly I found staff motivated and focused, often running on goodwill in a tough environment; some places felt more positive than others.
- Second, I saw and heard for myself the massive change that the NHS is embracing post 2012. This change needs to be allowed to settle down. There is genuine concern within the service that further restructuring will be imposed upon the system, which would be unhelpful. This is despite the current Government making no indication of wishing to do so. Through no fault of their own, people are often ill-prepared or ill-equipped to implement the changes asked of them.
- Third, the NHS performs an extraordinary service and is staffed by some extraordinary *people*, but the whole organisation could and should be made more effective by the application of some common-sense tactical and strategic thinking.

What I discovered and the evidence presented to me, would come as no surprise to anyone in any large organisation operating on the same scale. The NHS is not alone in facing the challenges highlighted in this Review.

There must be a shared vision; attention must be paid to its people, and those people must be helped, guided and assessed in their performance and delivery.

[2] NHS Choices, www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx

The recommendations of this Review are made in the areas of training, performance management, bureaucracy and management support.

In making them, I acknowledge that readers may feel review-fatigue; so I have kept this as succinct as possible. I also recognise that the NHS is immensely complex, and that one apparently straightforward recommendation will have many implications and perhaps unintended consequences; but because we are intimidated by complexity and scale there is equally a danger of doing nothing. The way to handle complex matters is to simplify them wherever possible. It is a risk we should take.

This Review is deliberately practical in its enquiry and recommendations. It builds on themes uncovered in the 2013 Mid-Staffordshire NHS Foundation Trust Inquiry[3] (Francis Report) and on other more recent reviews (Dalton 2014[4], King's Fund 2014 and 2015)[5] and the *Five Year Forward View* (NHS 2015); Simply put, this Review aims to make people better qualified to manage and to lead.

It is striking that the NHS has a central resource for quality but not for people, and these recommendations set out to address the fact that the people of the NHS are its main asset. What emerges is a range of recommendations (listed in

[3] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf
[4] *Dalton Review: options for providers of NHS care* (5 December 2014), www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
[5] *System Leadership: Lessons and learning from AQuA's Integrated care discovery communities* (14 October 2014), The Kings Fund, www.kingsfund.org.uk/publications/system-leadership and http://www.kingsfund.org.uk/publications/leadership-and-leadership-development-health-care

the Executive Summary and in Recommendations), from the promotion of *one vision of the NHS* to an initiative to *cut bureaucracy*: simple enough ideas, tough to implement well on the scale required, and perhaps all the more important because of that.

Everyone should know what great leadership looks like; and even though not every job will require leadership qualities, some parts of every job will. We should not try to prescribe from any particular discipline. We should aim to develop, recognise and reward appropriately leadership qualities across the whole NHS workforce. Leadership qualities should be celebrated across all disciplines and job grades.

We should also recognise that we must work with what we have. A few simple things would make a huge difference: some centralised effort on training; or helping middle managers keep their confidence and focus; or knowing that the top leaders of tomorrow may be doctors, nurses or administrators. At the start of their NHS career, everyone should have adequate training; in mid-career they should have adequate support and clear pathways to progression as managers; and top leaders should have the appropriate support and experience to enable them to make correct decisions.

From my perspective of a manager from the private sector, these recommendations are simple remedies that could make the NHS more effective,

recognising that it is neither private sector nor centralised. Clearly, a patient is not a customer in the same sense, yet any organisation with the scope and reach of the NHS requires strong leadership and management *at all levels and in all parts of the system*. Everything comes down to its people, both right now and in the future: so we must pay attention now if we are to expect results in 10, 15, 20 years. People are long-term.

The recommendations apply to the whole NHS, but they will not and cannot find universal support or answer all issues. However, a way needs to be found to implement them in what is essentially a federation. The development of people and sharing of best practice should not be left to chance. There is much good practice and good leadership out there. I urge the means to share it and to join it up so that best practice may be spread more rapidly.

The NHS is one of our society's proudest achievements, but the challenges it faces could hardly be more daunting. The NHS remains a comprehensive service, free at the point of delivery, regardless of the ability to pay, and funded from general taxation. However, rising demand and treatment costs; the need for improvement in certain kinds of care; and the state of the public finances means that "Simply doing things in the same way will no longer be affordable in the future."[6]

[6] *Government response to the NHS Future Forum report* (20 June 2011), Department of Health, www.gov.uk/government/publications/government-response-to-the-nhs-future-forum-report

The *Five Year Forward View* has a clear vision of what the future should look like; but not enough focus on leadership and skills that will be needed to implement it. I leave you with three questions related to my central themes:

- Leadership is the key to making changes stick. How is great leadership recognised across the NHS?
- How do we find and nurture the people that are needed to lead the NHS over the next 10 years?
- How do we help all NHS staff become the best versions of themselves at work?

This Review offers some answers to these questions.

Lord Rose

June 2015

Executive Summary and Recommendations

The NHS has most of the resources it needs to deal effectively with the issues identified in this review. The key strengths that the Review found include: the commitment of staff at all levels and in all parts of the NHS; the profound goodwill of its stakeholders, and the strong support of its funder, the Department of Health.

The quality of NHS clinical care, which is highly regarded, is not always matched by its ability to identify, assess, and manage its staff consistently. Some of the systems and procedures necessary for this do not exist, or where they do exist are only partially effective.

The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable. There are three areas of particular concern:

1. Vision: There is a lack of One NHS Vision and of a common ethos.
2. People: The NHS has committed to a vast range of changes however; there is insufficient management and leadership capability to deal effectively with the scale of challenges associated with these.
3. Performance: There is a need for proper overall direction of careers in management across the medical, administrative and nursing cadres.

Many of these problems are chronic and have been unaddressed over an extended period and by different Governments. Clearly, some of these recommendations are of a strategic nature; others tactical and operational. Several are interrelated and overlapping, as one would expect them to be in a complex organisation.

Recommendations:

There are two pre-conditions that must be met before any of these recommendations can be effected: These are simple and profound:

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and Clinical Commissioning Groups.

and

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values, to be published, broadcast and implemented throughout the NHS.

Training:

R3: Charge Health Education England (HEE) to coordinate the content, progress and quality of all NHS training including responsibility for the

coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

R8: Require senior managers to attend accredited courses for a qualification to show that consistent levels of experience and training have been reached across the NHS. On completion of this course they will enter a senior management talent pool open to all Trusts.

Performance Management

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own development needs.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

R13: Merge the oversight bodies, the Trust Development Agency (TDA) and Monitor.

R14: Spend time, on a regular basis, at all levels of the NHS to review the need for each data returns being requested and to feed any findings to the Executive and Non-Executive Teams to review.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

R16: Health and Social Care Information Centre (HSCIC) should develop an easily accessible Burden Impact Assessment template and protocol.

Management Support

R17: Create NHS wide comment boards. Website and supporting technology to be designed and implemented to share best practice.

R18: Set minimum term, centrally held, contracts for some very senior managers subject to assessment and appraisal.

R19: Formally review Non-Executive Director (NED) and CCG lay member activity (including, competence and remuneration); and establish a system of volunteer NEDs from other sectors.

Background to the Review

The NHS has recently undergone one of the largest and most radical changes in its 66-year history in the form of the 2012 Health and Social Care Act ("the 2012 Act")[7] and (two years earlier) *Liberating the NHS*[8]. The 2006 Act as amended by the 2012 Act is the legislation in force at the time of this Review.

This wave of change was designed in part to remove day-to-day management of the NHS from the centre of Government. GPs would commission services and the National Commissioning Board (now NHS England) would be given a mandate from Government that sets out the strategic direction in the form of objectives it must achieve; this would limit micromanagement of the NHS by the Department of Health and distance management of the NHS from Government.

The 2012 Act changed the landscape of the NHS fundamentally. Previously the Secretary of State for Health oversaw the NHS through 10 Strategic Health Authorities (SHAs) that in turn oversaw 151 Primary Care Trusts (PCTs). These PCTs commissioned services from hospitals, GPs and all others providing front-line NHS care. The 2012 Act increased the level of oversight by replacing SHAs and PCTs with a number of new bodies including NHS England which includes four regional commissioning offices, a number of Commissioning Support Units and 27 NHS England Area Teams which oversee Clinical Commissioning Groups (CCGs). Money flows from NHS

[7] Health and Social Care Act (2012), www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[8] *Equity and Excellence: Liberating the NHS*, (12 July 2010), www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

England directly to the CCGs which then purchase care in hospitals, Mental Health and Community Services. Specialist services and primary care services are commissioned directly by NHS England, though this too is changing. Local Authorities can also commission some public health services. New levels of accountability were also created. Devolution of accountability away from the centre of government will take time to work.

Clinical Commissioning Groups (CCGs) are autonomous statutory bodies accountable to their members through a governing body. They work closely with other organisations such as local Health and Wellbeing Boards and NHS England. While CCGs are independent, there are a number of duties that they must fulfil which are set out in the [NHS Act 2006, as amended by the] Health and Social Care Act 2012. In late November 2014 some restructuring of NHS England took place with the 24 area teams outside London being replaced by 12 sub regions[9].

Background to the General Themes:

This is a time of extraordinary and rapid change, and this above all else shapes the evidence gathered here. A clear picture emerges of an organisation with many strengths and opportunities both to control the present and to plan for the future. But the picture also includes significant

[9] www.england.nhs.uk/2014/11/28/director-appointments/

shortcomings in the management of staff, and of a lack of local strategic oversight indicative of broader issues in the NHS.

This ought to be a time for great transformation *without structural reorganisation*: the NHS is facing both urgent and important issues. There is an urgent need for more efficiency savings, increased pressure on services from an aging population with multiple needs, and there are the unintended consequences of medical progress such as people living longer with multiple conditions. There are both risks and opportunities.

In funding, for example, the NHS has been rated by the US Commonwealth Fund as the most efficient health care system in the developed world: the NHS scores highest on quality, access and efficiency; it spends the second-lowest amount on healthcare among the 11 nations surveyed (£2,008 per head).[10] Yet the NHS is now being asked to make further massive savings of the order of those that Sir David Nicholson set out for 2011-2015[11]. There is estimated to be a potential deficit of £30bn by 2020-2021.[12] This is placing NHS staff under greater pressure.

The *Five Year Forward View*[13] is welcome and commonsense. It focuses on three things: *managing demand*, *improving efficiency* and *additional funding*. This thinking has helped to shape the context in which this Review made its

[10] *Mirror, Mirror on the wall, 2014 update: How the US health system compares internationally* (16 June 2014), The Commonwealth Fund, www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
[11] www.stockport.nhs.uk/websitedocs/2010_11_25_Item_6.PDF page 2: *Department of Health Business plan 2011-2015*, (8 November 2010)
[12] *The NHS belongs to the people: A call to action*, (July 2013), NHS England, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
[13] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

findings. The *Five Year Forward View* brings a long overdue emphasis on prevention and a continuing and renewed commitment to patients being given more control of their own care. As many have pointed out, it is an "adapt or die" message.

The *Five Year Forward View*[14] recognises that there is a funding gap, a need to join up primary care, social care and acute care and show a practical route to making things more efficient. The vision set out will likely cost an extra £8bn, on top of the £22bn efficiency savings the NHS may be able to make on its own, to implement:

> "If the NHS achieves all the efficiencies identified in the plan – an extremely tall order in itself – leaders say that an extra £1.5bn a year above inflation will be needed, or around £8bn in total, to eradicate a £30bn deficit"[15].

The *Five Year Forward View* sets out the need to move away from the short-term answers into longer term more radical solutions. However, it does not dwell on the most important resource alongside money: people.

The story is the same in the 2012 Act. This put clinicians at the centre of commissioning, freed up providers, continued to empower patients, and brought the NHS, public health and adult social care together for the first time in Health

[14] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/
[15] British Medical Journal (1 Nov 2014)

and Wellbeing Boards. The 2012 legislation created a number new structures, including CCGs, and enhanced roles for the Care Quality Commission; and removed others, including SHAs. The 2012 Act presaged radical change, and it is still too early to say if or how those changes will be successful. Yet wherever structures change, people need to be equipped to run them. Equally, the *Five Year Forward View* says little of the challenges for NHS staff from either the provider or commissioning side. A report from The King's Fund (December 2014) makes clear where some of these challenges currently sit:

> Talent management is key. The responsibility for developing future leaders needs to be taken seriously… It is important that a culture of development and support should pervade – one that allows senior leaders the time and space to try new things… one where they are free from the weight of scrutiny and blame that dominates today.[16]

It lists the well-established need to fill gaps in leadership training, to establish an NHS leadership strategy and development plan, and to remove the disincentives to innovate and take risks. The King's Fund report touches on many things noted in this Review: structural uncertainty, the regulatory burden, career development, talent management, and CEO tenure, all issues which have shaped the recommendations here.

[16] *Leadership Vacancies in the NHS: What can be done about them?* (2014), Ayesha Janjua, The Kings Fund,

Findings & Interpretations

There are seven **General Themes** that emerged; the Review grouped the general themes under the following headings:

1. **NHS vision & ethos (*one vision of the NHS*)**
2. **Leading constant change (*one vision of the NHS, its People*)**
3. **Training (*one vision of the NHS, its People*)**
4. **The management environment (*its People*)**
5. **Performance management (*its Performance*)**
6. **Bureaucracy (*its Performance*)**
7. **Trusts (*its Performance*)**

1 NHS Vision & Ethos

There is a huge opportunity here. The NHS has a great story to tell; but there is no focused vision given to the NHS workforce as a whole. The full-time workforce (1.38m) has grown by 160,000 since 2000[17]. There is an opportunity and need to instill an NHS-wide vision along the lines of "shared values – locally delivered".

[17] *Health and Social Care Information Centre, Annual Workforce Census, (2013*), www.hscic.gov.uk/catalogue/PUB13724/nhs-staf-2003-2013-over-rep.pdf

There have been many initiatives announced by successive Governments, most recently the *Five Year Forward View* (2014)[18] and the Dalton Review (2014). It is the aim of this Review to complement their work and to set out the necessary skills needed across the whole NHS workforce in order to make their visions a reality.

An agreed, shared, vision would give the NHS a united ethos and a consistent approach to getting things done. This would have a direct impact on what good leadership looks like, and on how it is recognised and felt. The NHS needs to focus all the more intently on a single ethos and vision to counteract its increasingly devolved structure. This is because the NHS is essentially a federation made up of individual organisations. Each varies by size and geography; and each has an identity shaped by practice and culture. However though there may be different organisations in the system, the leadership skills needed throughout are the same.

Unfortunately at no point has the time been taken to consider the skills and talent needed to drive the NHS system forward together.

The NHS, as a whole, lacks a clear, consistent, view of what 'good' or 'best' leadership look like. In 2013, Sir Robert Francis QC set out in his public inquiry report some of the criteria for what good leadership in healthcare might be, including visibility, listening, understanding, cross-boundary thinking, challenging, probity, openness and courage. Principal among these is "the

[18] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

ability to create and communicate vision and strategy."[19] This is a set of values that need to be broadcast more effectively within the NHS.

The lack of leadership based on values throughout the NHS has led to some of the most negative comments given to the Review, including; *there is a culture of fear*; *it's all too difficult*; *there is an obsession with targets* and *it is impossible to operate in the current climate of suspicion and change*. Or *What is its plan? What is its vision?*

A lack of good, clear, leadership in some areas is concerning. Some see the NHS, both internally and externally, as full of people making excuses for poor care, passing the buck and shrugging off responsibility. Some people remain afraid to raise concerns fearing that either nothing will happen or that if something does there will be a negative consequence to it. There is a lack of basic training for leaders and managers on how to listen to people and an increased feeling of unconscious pressure being brought to bear to achieve targets at the expense of staff who are willing to raise issues. Greater emphasis is needed now on the skills and development needed to support change and to assist in the delivery of the vision set out in the *Five Year Forward View*.

However, it is not just the lack of leadership that is creating problems. While individual hospitals and Trusts can usually (and rightly) articulate their own vision, for the NHS this seems to be lacking. When people were asked: *what*

[19] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013),www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf

does a good NHS look like, what would success be? shockingly there was no single answer. Despite what was set out in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, many had no answer at all.

Innovative care models depend on people to run them, on porters, receptionists, nurses, consultants, specialists, technicians, therapists, GPs, service commissioners and many others. These care models will never become a consistent and well-understood reality across the UK unless there is a single NHS vision effectively communicated and understood by all NHS staff.

This review also found that there was no consistant clear picture for CCGs of what 'good' commissioning performance looks like. CCGs are new bodies, understandably trying to find their feet; but without such a vision their leaders will find it difficult to secure services of a high standard and, over time, to recruit and retain high quality individuals.

2 Leading Constant Change

The *Five Year Forward View* rightly says: "we detect no appetite for a wholesale structural reorganisation.[20]" This puts it too mildly: there is widespread change fatigue and an irritation that new changes are not given sufficient time to bed in.

[20] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

A lack of stability is felt across the NHS, with a deep-rooted concern over the many and varied messages sent from the centre of Government. For a number of years there have been a range of initiatives and changes of emphasis: Patient safety and quality of care (Lord Darzi's *High Quality Care for All*[21]); Financial performance (derived from the Foundation Trusts reforms); and Performance efficiency (in light of current financial constraints). In other areas of the system we have seen shifts of emphasis between Local Authority commissioning, centralized commissioning through PCTs and more recently clinical commissioning, with a strong emphasis on a lead role for GPs.

None of these changes have been supported by the deliberate development of the skills needed to deliver them. That needs to be put right, with a greater focus on the whole NHS workforce and on developing the talent and skills of its future leaders: they need to be better prepared for the daily challenges of leading a Trust, a team, a ward, a clinical or specialist group or a CCG [over the long term].

This has implications for leadership (which provides the motivation and inspiration) and management (which provides the implementation). As the Dalton Review (2014) points out, "leadership is key to change" [22]. Strong and capable leadership is key to driving transformational change and often involves taking bold decisions. More support is needed for leaders to develop large-scale

[21] *High Quality Care for all: NHS Next Stage Review Final Report,* (June 2008), Department of Health
[22] *Dalton Review: options for providers of NHS care* (5 December 2014), Theme 5, www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care

change management, strategic and commercial skills and the ability to lead in a networked or group structure are becoming more important.

This is important throughout the NHS, and especially for the relatively new CCG Chairs and leaders, so they can fully implement the vision set out in the *Five Year Forward View*. The current level of support given to CCG Chairs and other senior individuals such as Accountable Officers and Chief Clinical Officers is woefully inadequate. There is no 'step up' for these individuals: either they have the necessary leadership skills or they don't. A systematic way to identify and develop this group is needed. Some CCGs do well planning for the future but instances of this are the exception rather than the rule.

Centrally and throughout the NHS there is concern that more structural change means a greater risk to services being delivered below standard. More generally, some argue that the time to take risks was when the NHS had money, and not now. However, this Review argues that the greater risk now lies in doing nothing.

It is widely accepted that the NHS requires transformation in places: most large scale organisations do. To make changes stick, more stable management is required. There will always be those that accept change in any organisation, and those who do not. The former are invariably in the minority. Leaders must ensure that the organisation understands the

necessity to change, and must find ways to bring their staff along with them. However, to do this, time and head-room are essential.

There are signs of growing frustration amongst those in CCG leadership roles at their inability to 'make a difference': some commented that with the publication of the *Five Year Forward View* they are looking to move from commissioning to provider roles. This frustration needs addressing. The models of care set out in the *Five Year Forward View* require strong leadership throughout the system to implement the vision and change needed.

3 Training

NHS management careers depend too much on chance. Training and development are often sporadic. There is limited investment in systematic leadership training for staff and as a consequence capability suffers which is ultimately poor for the patient.

There are several training institutions responsible for training NHS staff,[23] and no mandatory requirement to use them. A significant number of Trusts therefore develop their own training programmes with the help of external consultants. Many of these are of a high calibre but this plurality of provision results in a lack of consistency in the level of training and development received; both depend on the organisation, the area in which it is located and

[23] For instance the NHS Leadership Academy, Health Education England, the NHS Staff College

the individual ward or part of the hospital itself. This Review has found that all forms of initial training tend to lack a consistent, cross-disciplinary approach.

The NHS recruits high calibre graduate trainees, but the numbers are far too low (approx. 100 per year). Although these trainees receive excellent initial training, they are not subsequently managed, monitored and developed. While they are successfully retained, their potential could be better optimized. Some examples of how this could be achieved could be to develop specific roles for those recently graduated, or for there to be greater encouragement for secondments to a variety of NHS posts such as in a commissioning organisation or role. There does not appear to be the level of communication required between those who may have a need for a first year graduate, the graduates themselves and the NHS leadership academy. A number of organisations commented that they would welcome a first year graduate, particularly in the commissioning sector, but were unable to secure one.

Clinical students are not taught either early enough or in sufficient detail during their training about how the NHS works. Many reported that it took them a considerable amount of time to ascertain how the NHS worked as a whole. Neither is there a clear career development structure for clinicians wanting to take on management or leadership positions. The role of Clinical Director is a key role in a successful Trust and development for those clinicians who wish to take on this challenge must be supported and encouraged. While not all will wish to take on management responsibility, there is still a need for all to be able to show leadership skills.

The key leadership relationships within a Trust are between the Chief Executive, the Clinical Director and Chief Nurse, and between the Chief Executive and the Chair. A crucial relationship also exists between the Executive and the Non-Executive Team. There is a need for each group to undergo cross functional training (that is, training not specific to one area or organisation within the NHS) together to build their capability and resilience as well as their combined ability to lead.

The CCG Chair is the lynchpin of the system. Relationships between CCG Chairs in a geographical area, and between Chairs and their provider organisations, are key relationships. Cross-functional training for local Chairs, their top teams and local providers will build better communication between them.

The level of service integration envisaged in the *Five Year Forward View* highlights an opportunity to take joint training one step further. The creation of training programmes, open to all across the health and care sector would have a significant impact on leadership, in particular on the promotion of good practice and of positive collaboration throughout the system.

The NHS Leadership Academy (NHSLA) provides extensive training for large numbers of provider staff at all levels, but does not enjoy the following or

status necessary to make it the key provider for people development in the NHS. If it is to enjoy that status it needs to be bulked up and given the appropriate credibility and status to deliver. This might best be done under the aegis of another organisation such as Health Education England (HEE): at present the NHSLA is too light for heavy work and too heavy for light work. The NHS Staff College delivers similar leadership training to a diverse group of people including executive and ward teams. It too does not currently have the status or scale necessary for it to become the key provider for people development in the NHS.

Together the NHS Leadership Academy and the NHS Staff College working with other key leadership organisations (the NHS Staff College in particular already works with the British Military) should be able to develop and accredit a number of tailored courses, offered in a variety of lengths to suit the needs of the individual (such as a number of courses the NHS Leadership Academy currently provides) and/or organisation. All must be of a recognised and uniform standard.

Training across the NHS should be more mobile, flexible and agile. A variety of locations are needed with oversight from a single organisation. Training could be provided from other public facilities (eg military, education) already known to provide high quality leadership training.

Senior management development needs to be better served – both for the development of those from within the NHS and those recruited externally. Just

as graduate trainees need to be taught about how the NHS works early in their career, so too should those coming in at a more senior level so that they become effective quickly.

Whilst there should be more, and more consistent, promotion from within, there often appear to be barriers to recruiting externally. Reasons given to the Review were that the NHS is too complicated, the pay too low, or the media perception too negative. The current "fast track" scheme appears an expensive – and as yet unproven - way to develop/attract future top talent in sufficient numbers.

The NHS needs to be more porous, encouraging managers to join from other sectors, or leave to rejoin the NHS later; yet its main effort should be in developing its own. Retaining and developing existing staff will always be more cost effective than filling from outside. The Review found no systematic approach to developing managers and leaders (as there is for instance in the Department of Health or Civil Service more broadly)[24].

There is a lack of permeability or interchange of managers between providers and commissioners, yet the *Five Year Forward View* advocates greater integration. Moreover, CCG staff with a wider demographic view of health rather than an organisational one would be advantageous. Equally, a Trust employee moving to a commissioning organisation would provide the commissioner with a better understanding of the services it procures.

[24] *Civil Service high Potential Stream; A talent strategy for the Civil Service 2013/14 – 2016/17, https://civilservicelearning.civilservice.gov.uk/sites/default/files/corporate_talent_strategy_v0f.pdf*

Much more can be done to encourage those working in CCGs to take part in courses offered by the NHSLA and the NHS Staff College. This provision needs to be supplemented by a new training programme for the specific needs of those working in commissioning.

4 The Management Environment

There is a widespread and deep-rooted perception that management is "the dark side". Doctors and nurses can be seen and often position themselves in opposition to management. This is unhelpful.

Management itself is often far too tactical in its behaviour; there is not enough strategic thinking. Great commercial organisations tend to spend more time thinking about the future.[25] The short-termism of NHS management thinking derives from two things: the need for constant regulatory data, and the fear of not being able to change fast enough.

The management structures are various and complex. What became clear is that no one model fits all circumstances.[26] In a plural management environment, two things tend to happen: first, those leaders who are best able to read the rules and interpret the system will prosper (and this may be entirely serendipitous).

[25] *Tapping the strategic potential of boards,* (2014), Bhagat, Hirt & Kehoe, McKinsey and Company www.mckinsey.com/insights/strategy/tapping_the_strategic_potential_of_boards

[26] For example: service-level chain; multi-site trust; federation, joint venture; franchise; multi-service chain; integrated care organisation.

Second, in an uncertain environment, the quality of outcome depends all the more heavily on the quality of the people.

For example, many of the best leaders are successful despite the system; or they had found a way to work it to achieve what they needed. They knew there was no single or mandated way to get things done. For the better leaders, this presents an opportunity to solve or work around a problem; but for weaker and/or newer leaders in less well-resourced areas, this presents a real problem and erodes morale.

Risk taking within acceptable clinical and commercial parameters is not encouraged, recognised or rewarded. An avoidance of failure is often noticed more than drive for innovative success.

At executive level, Chief Executives in particular need a strong team around them for support. Once a solid executive team is formed in a Trust it will often move with them; this practice should be encouraged where appropriate and viable.

Discussions during the Review highlighted the churn of Trust Chief Executives and the unsettling effect this has on Trusts. 7% of all CEO positions were reported as unfilled[27]; and the average tenure was 700 days. There is little clarity on the accuracy of tenure; but these statistics paint a picture of frequent arrivals and departures of senior leadership, of unsettled leadership teams

[27] *Leadership vacancies in the NHS* (December 2014), The Kings Fund. The report states that 7% of all trusts were without a substantive CEO which increased to 17% for trusts in special measures

and of initiative fatigue as yet another Chief Executive brings in yet another fresh approach.

Trusts in special measures or which are poorly performing often have an experienced and well respected Chief Executive brought in to turn around the Trust. However, the reality is that the centre of government does not always give enough time for a new, experienced leader to analyze what is happening, to identify any issues and subsequently to bring in a new team to stabilise any problems found before being overrun with numerous, often unnecessary and, on occasion, heavy handed inspections. These inspections often come with the expectation of *immediate* improvement and when, unsurprisingly, an immediate, service-wide improvement has not been delivered, leaders and their teams are placed at fault. To identify, analyze, rectify and implement all take time; they are not a linear process, especially as poor practice comes to light. Changing embedded culture and increasing staff morale through mutual understanding and respect takes time to deliver. Whilst there are reasons behind the increasing number of inspections, balance is still lacking. Further work needs to be conducted on reflecting the need for the Care Quality Commission (CQC) in particular to continue to respond to concerns raised to them whilst recognising the time a new CEO may need to identify problems and issues and to begin turning round a failing Trust.

By treating leaders in this position impatiently, the NHS is missing a pool of experienced leaders who could be unwilling to put themselves and their careers under scrutiny without the assurance that they will receive the time

and space to consider and effect any necessary transformation. The addition of leadership as part of the CQC inspection under its "well-led" domain, while welcome has added additional pressure/scrutiny on staff.

In essence, since the beginnings of the professionalisation of general management in the 1980s as a result of the Griffiths Report[28], authority was given to the administrators whilst delivery remained with clinicians. An atmosphere of mutual distrust persists between clinicians and managers. It is particularly noticeable in Trusts which are not performing well rather than those that are; the latter tend to be a more cohesive team. There is no unifying ethos across all disciplines. Little has been done to rectify this. There is not enough management by walking about and listening. The NHS remains stubbornly tribal.

A number of CCG Chairs reported difficulties in balancing their role as Chair and their responsibilities as practicing GPs. More should be done to support these clinical leaders. Continuing in practice should be welcomed as it strengthens the authority and credibility of the individual. Without the necessary support and headroom a similar problem emerges where Chairs are managing rather than leading their CCG.

There remains tension between CCGs and provider organisations. In part this is due to the fragmented nature of commissioning (a single hospital for example will have multiple commissioners of the same service). More should

[28] The Griffiths Report, (October 1983), http://www.sochealth.co.uk/resources/national-health-service/griffiths-report-october-1983/

be done to encourage greater collaboration and integration of working between CCGs and providers. A good example of this is in East London where a strategic programme brings together providers of acute and mental health care with the local authorities, the three local CCGs, NHS England and the TDA. The publication of the *Five Year Forward* View creates an opportunity to rethink management structures and back office services. Co-location of different area management teams would be one way to achieve this, although for reasons of geography or historic credibility it may not be possible for all.

5 Performance Management

There is little differentiation between the good, the bad and the ugly. All Trust Chief Executives are paid similarly, although those in Foundation Trusts are likely to be paid more than those in NHS Trusts (executive salary tends to increase in larger NHS organisations). The NHS is unable to clearly state and identify in specific areas what they do well and what they could do even better; and this it seems makes the job of leaders even harder. For CCGs the differentiation is even harder to see.

In terms of remuneration CCG Chairs were able to negotiate their own salaries. Without the means to understand what areas are doing well and not so well there is no way to help share best practice, to drive up performance, or to understand if a salary is appropriate for an individual in a specific area.

The Review heard that a CCG scorecard is currently under development and this is to be welcomed.

Performance management of individuals is haphazard and weak. It is too often a form-filling exercise; staff are not held to account, praised and developed in equal measure. Done well, this is a good way to improve organisational performance or quality. There is work ongoing but it does not go far enough and is not embedded throughout the NHS. The 2013 NHS staff survey results stated that 84% of staff had received an appraisal while only 38% said that their appraisal had been well structured. This resonates with what this Review heard.

Performance management means thinking about how best to train, equip and assign the right people to the right roles; it should help managers and others plan their own careers and acquire the necessary professional skills. However, throughout the NHS the phrase 'performance management' when applied to individuals is synonymous with something negative; when it should mean a communication process that occurs throughout the year between manager and employee to support both the employee's and the organisation's objectives, it can equally be considered as a regular conversation on an individual's career development.

As a whole the performance management culture within the NHS is lacking: objective setting, reviewing, and clear lines of responsibility and accountability are absent. Agenda for Change should have addressed this but more work is

still required to embed this within local management structures. Moreover, due to the infancy of a thorough performance management system in the NHS there appears to be a lack of a transparent 360 degree feedback system.

There is suspicion throughout the NHS, quite understandably, that as performance management is not consistently applied, it becomes a case of *why to me and not to them*? How often individual managers, units, wards request feedback for their staff from patients is unclear.

Closely related to performance management is talent management. There is no central talent pool or NHS-wide structured talent management scheme in place. This is the case for general management, for clinicians and for both Trusts and CCGs. The creation of a talent pool on a national scale has been attempted by the NHS on a number of occasions; clearly one size cannot fit all NHS organisations; but there must be a rational attempt to improve what there is now. While there is currently greater emphasis being placed on developing and 'spotting' talent in Trusts this report has less concern in this area than in the commissioning sector where there is not such a large pool of individuals to draw upon. There is no lack of talent here, rather there is no longer a joined up approach to both talent and succession planning. Encouraging greater flow of individuals between provider and commissioner organisations would utilise this untapped talent.

Talent cannot be managed without a single competency framework for all NHS staff. There isn't one. This absence, combined with the lack of a systematic appraisal, makes development and deployment of key talent almost impossible. Consistent use of competency frameworks and appraisals help set standards. Throughout the NHS there appears to be a marked lack of holding people to account for their performance. The NHS is still seen to routinely move staff upwards or sideways, not out, even when they're not performing. This must stop.

Clinicians contributing to this Review felt they were treated differently from general managers in that they find themselves under greater and more stringent scrutiny. Moving a poorly performing manager essentially rewards incompetence or semi-competence; although it is extremely difficult to sanction or remove a clinician, the stakes are high for that individual (he or she can be struck off the medical register). There is a need here to level the playing field.

At Board level, performance management is also vital. The quality of Non-Executive Directors (NEDs) on Trust boards appears highly variable as do lay members of CCGs. NHS Trust NEDs receive comparatively poor pay and are required to commit significant time to the role particularly in comparison to those working in a Foundation Trust. For NHS Trusts the current rate for NEDs is £6,157 and for Chairs between £18,621 and £23,600 depending on turnover. These rates can be increased by the Secretary of State for Health on an exceptional basis. Foundation Trusts are able to set their own levels of

remuneration necessary to successfully fill their posts. This means that though many NEDs are of a high calibre and are dedicated to their role, the NHS is mostly limiting itself to those with time to devote to the task; these people are often retired and sometimes lack currency in day-to-day management. This is particularly pronounced in NHS Trusts and CCGs, where there is a real need to make these roles more attractive.

There is a lack of clarity about the value NEDs bring. The key question is: *are they holding Trusts to account*? Many seem diligent; but how can their expertise be better shared across the system? How can it be amplified? NEDs need to see beyond their own institutions. This is difficult given the commitment to an individual institution and the fragmented structure of the NHS. The story is similar for lay members in CCGs.

The lack of performance management and talent management has three severe consequences for the NHS.

- First, management cannot improve without the means to do so. Yet there appears to be an embedded reluctance in asking for help; support is viewed as a weakness. There are instances of bullying in this area. There are few role models (particularly in medical management) and not enough shared leadership practices (for example, some of the best leaders leave around 30% of their time

unscheduled so that they can walk around, listen and know and understand what they are driving).

- Second, there is a chronic shortage of good leaders in the NHS. Leadership can be taught and learned. Bringing into the NHS people at higher levels is not the whole answer. Rather the NHS needs greater *diversity* by bringing people into leadership at all levels.

- Third, management standards are not recognised or applied across the organisation. For example, there are obvious inconsistencies in simple practices, systems and communication across wards and hospitals. For instance, there is a wide difference in the quality of notice, patient and ward communication boards, patient documentation, IT systems and nurse staff uniform colours.

Performance management should relate to an organisation's values. But for the NHS, there are many competing values: the NHS is stuck in a circle of *finance - quality - safety - efficiency* as operational priorities. All should be classed as an NHS priority equally. Performance must be managed throughout by means of a more balanced scorecard.

6 Bureaucracy

In 2013 *The regulation and oversight of NHS Trusts and NHS Foundation*

Trusts promised:

> "In [the] future, this division of roles will be simpler and clearer: the Care Quality Commission will focus on assessing and reporting on quality and Monitor and the NHS Trust Development Authority will be responsible for using their enforcement power to address quality problems[29]".

However, the NHS is drowning in bureaucracy. This is evident at all levels. There are two reasons for this: first, the NHS is too vertically structured; and second there are too many regulatory organisations making too many reporting requests.

The number of oversight bodies has grown as the NHS has become more fragmented and more distant from Government. Each of the bodies responsible for monitoring and compliance (eg CQC / Monitor / TDA) has its own mandate; each issues its own demands for data as well as requests directly from CCGs. This has spawned an industry of data collecting. Requests for data are often made regardless of whether the data has been collected in a different format elsewhere and irrespective of the impact on daily business. Regulators appear to be in overdrive and whilst some of this is understandable there needs to be a renewed focus on the sharing of information between regulators and for their perspective to change to consider outcomes rather than inputs.

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[29] *The regulation and oversight of NHS Trusts and NHS Foundation Trusts (May 2013), www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf*

Requests to Trusts from CCGs are often the product of a central (DH/NHS England) demand. Requests made in this manner put needless strain on all areas of the system from Trusts, CCGs and indeed NHS England area teams.

It is a commonly held belief that there are one too many oversight bodies and the findings of this Review support that view. This was also the view of the Francis Report and the thrust of one of its recommendations. Since then CQC, Monitor and NHS TDA have built closer working relationships, but there is still some way to go[30].

Monitor's role as a health service oversight body is to ensure NHS Foundation Trusts are well-led and that essential services are provided should a Foundation Trust get into difficulties, it also has a wider remit as the sector regulator. The NHS Trust Development Authority provides a similar role to NHS Trusts, overseeing their performance and governance, as well as progress toward NHS Foundation Trust status. These two bodies operating as a single oversight body would significantly clarify the NHS regulatory and accountability structure.

The Review notes that the influence of targets, regulators and inspectors is seen as ubiquitous and wearing. Bureaucratic reporting has made both individual Trusts' and the NHS' views short-term. And if short-termism also

[30] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry,* (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf Recommendation 19 – There should be a single regulator dealing with both corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts

means the lack of a long view, it is an unintended consequence of the lack of a strategic intermediary; the disappearance of the Strategic Health Authorities means there is no one to lead any region in a collaborative reconfiguration over the longer term.

Although it has been suggested that CCGs should undertake this important role, it would be unreasonable to expect that most of these relatively new organisations have capacity or authority to do so – at least for now. This means that a significant gap in regional leadership remains; many continue to mourn the loss of SHAs.

Too much is being done by numbers. Within the NHS, everyone is managing upwards by means of complying with data requests; for good leadership to flourish, they should be delegating downwards. People need to be and to feel trusted beyond compliance.

7 Balkanization of Trusts & Silo Working

There are currently 211 CCGs, 158 Acute Trusts, 10 Ambulance Trusts, 51 Mental Health Trusts and 31 Health and Care Trusts as part of the NHS federation as well as a myriad of other providers of care. The landscape of this federation has become fragmented in terms of both the numbers and activities of Trusts; within many Trusts silo working is endemic. This means that any activity within a Trust is horizontally separated from the same activity in other Trusts and vertically separated from other activities in its home Trust.

The same is true for CCGs, where there is a need for greater local and regional collaboration. Yet collaboration is more difficult in an environment that has been designed to create competition. Better communication between Trusts and CCGs would help reduce fragmentation of the landscape. There are too many "city-states" and not enough cooperation between them.

The current Trust system is inimical to collaboration; it is not a proper open market as Trusts cannot share with each other commercial information such as price with their suppliers. While their suppliers have a complete picture of the commercial territory. All recent reforms have been about devolving the system. Now there is no one system leader; so all are vying for territory. The loss of the Strategic Health Authorities, for example, means there is no mandate for system leadership, and no eye on what is happening across the system.

The Review heard that the system is creaking and that competition is causing harm, even that there has been too much competition. It is notably absent from the *Five Year Forward View*. Foundation Trusts have been a good development, but left to their own devices and without a framework for competition and cooperation, they are part of a system that is dangerously centrifugal. There is a need for a new balance between competition and cooperation to be considered for the good of the patient and for good practice to be more widely shared.

There are two classes of Trust. The rich have got richer and the poor poorer.

Big has become beautiful and bigger Trusts are becoming richer and therefore more successful with few exceptions. There is no predisposition to close that gap.

Given that Trusts tend to work in isolation from each other, Chief Executives reported the difficulty in being given the room to make decisions that benefit their *regional* health economy but are against the Foundation Trusts' (in particular) best interest. In some cases, the best decision in local health terms has exposed the Foundation Trust to scrutiny from Monitor.

Trusts are resolutely separatist, silo organisations; often they think tactically rather than strategically. They are therefore not keen to lend out staff, and consequently both the individual and the organisation feel unable to grow (this is a particular problem at middle management level). Chief Executives expressed concern over the challenge of taking on the more difficult Trusts: they saw them as isolated outposts with no central protection.

There are a number of notable collaborations[31] within the commissioning landscape in particular in and around London. The NHS must consider these, and other, areas of best practice and look to share and disseminate lessons learnt. There is no place in the vision outlined by the *Five Year Forward View* for individualistic, separatist Trusts and CCGs.

[31] For instance http://www.swlccgs.nhs.uk/ and http://integration.healthiernorthwestlondon.nhs.uk/,

In summary

First, change in the NHS is constant, at times radical, unwelcome and uncertain. Second, over time the NHS has become more devolved, more market-like, more local, more distant from the Department of Health, and hence more fragmented. Third, patients have a greater voice, as do regulators like the CQC and Monitor; each with their own priorities and demands.

These three clear observations place huge demands on NHS staff, on doctors, nurses and administrators alike. None are fully trained or equipped for the extra uncertainty brought about by constant change, the extra complexity brought about by the proliferation of NHS Foundation Trusts, the introduction of CCGs and the increased demands for data and performance metrics brought about by a regulated approach.

This has produced a critical leadership tipping point in the NHS. This point has coincided with a set of internal and external challenges. The answer is not more management but better leadership; not more attention to resources but more focus on how to handle change and uncertainty. The NHS is operating with unprecedented levels of demand, and with limited funding, and its people are under pressure not previously felt. There is an undeniable and urgent need for all NHS leaders to be more visible and to be seen as embodying the culture and values of the NHS. A value-based leadership culture is noticeably absent.

There is a feeling of too many undoable jobs; of over-stretching targets given the available resources; of no time or space ("bandwidth") to think; of limited available mentoring and support; and of the intense scrutiny (top-down command and control, even comments of bullying) that is stopping staff (all types: nurses, general managers, doctors, specialists) wanting to take on extra responsibility and leadership roles.

Managing and leading in the NHS is now harder than ever; the capacity for managers to think through strategic changes and embed them is limited. There is constant fire-fighting in a data-hungry environment closely governed by targets set and monitored by regulators and inspectors. This has led to a high degree of bureaucracy and upward management which is time-consuming and often distracts leaders from focusing on patients.

The complexity and requirement for continuous reporting has caused distraction from delivering the big picture. There is a preoccupation with targets. Data collection in acute Trusts is not always appropriately managed, and there is little Board oversight. Furthermore the NHS has moved from a space of too much 'underlap' pre-Francis where one regulator assumes another is dealing with the data, to a place where there is too much overlap and duplication.

Unfortunately this is compounded by the three prominent staff groups "the triumvirate" of disciplines (Nurses, Doctors and General Managers) who often

do not understand each other's priorities. Despite the importance of clinical leadership a gulf remains between clinicians and managers; it can be hard to get clinicians to sit around a table and be accountable for the organisation as a whole.

Imagine an organisation where everyone understands and values the role of others, however seemingly small; where the main effort is clear; where local variations can apply without bureaucratic censure; where people trust each other and seek to be trusted; where delegation, training and personal and professional growth are seen as aspects of the same thing. This is what an organisation with effective leadership looks like. It is an organisation equipped both for long-term planning and also for the immediate uncertainties and complexities required of any group of people (especially a large one) that seeks to provide the full range of health care to a large and changing population.

A lack of cohesive leadership will produce an organisation where relations between staff and patients are merely transactional, doggedly contractual, obsessed with data and lacking in innovation and inspiration.

There is no less capability or capacity in the NHS than in the private sector; this Review addresses the question of how to harness them so people can give their best. The NHS has all that is needed to be an extraordinary organisation in which values produce the leadership qualities and behaviours necessary for it to thrive in the future.

Recommendations

The Review's findings shaped its seven main themes. These strategic elements are common to any organisation that seeks to achieve anything remarkable; there must be a shared vision; attention must be paid to people, and those people must be helped, guided and assessed in their performance. These themes flow through everything that is recommended here, and have a bearing on the success of all the recommendations. Most importantly, two conditions (R1 and R2) are a necessary prelude to all the recommendations. These are simple yet profound, and they set the scene for success.

1. First, *the NHS needs a collective vision.* A federation as large and plural as the NHS cannot afford to be disjointed. It must think collectively and act locally. The NHS is full of very good people, but it must do more to communicate and share good practice, celebrate success and foster a united ethos. There should be a concentrated effort to create a communications strategy in order to do this. Focusing on the positives within the NHS will bring up and drive out the negatives (it tends to be counter-productive to focus too much on negative behaviour). A collective effort depends on a collective understanding.

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and CCGs.

2. *The second prerequisite condition is cultural. The NHS needs to create a values-based culture*. A large and complex organisation can be made more effective if all of its people behave in ways that are ethically consistent, and in ways that show they share the same values and base what they do on those values. There is already the ground work for this: the NHS Constitution includes a Staff Handbook, and Trusts communicate the NHS values contained within it in a variety of ways. But there needs to be a consistency in approach. Values must be easily and quickly understood across the NHS. Great leadership must be understood and fostered in staff at every level; the three military services are good examples of how this can be achieved across an organisation. A new and more visual format will promote this.

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values to be published, broadcast and implemented throughout the NHS.

The Review's further recommendations fall into four practical areas. **Training (R3-R8), Performance Management (R9-R11), Bureaucracy (R12-R16), and Management Support (R17-R19)**. In practical terms, the Review recommends what can and must be done. These areas are inter-related: the first two focus on providing what is not yet there, and the last two on removing barriers to great performance and effective, satisfying work.

Every one of these recommendations is aimed at supporting staff and patients of the NHS. They are practical, realistic and sometimes pragmatic: in a word,

commonsense. They have to work for all concerned, and are designed to make people's jobs easier, to release potential, and to optimize performance.

There is some overlap between them but this is only in terms of impact; something to be expected in a complex organisation such as the NHS. Some of these recommendations are strategic, others are tactical and operational. There is no recommendation to do nothing: in fact, the risks of inaction (although this can be a proper decision in some circumstances) are considerable. The Review urges that 2015 must not be yet another year when these much needed changes are left undone.

Training (R3–R8)

3. *The NHS needs a central body to coordinate its training effort and resources*. The NHS is a federal organisation. The performance of its management depends on its capacity and ability to set and maintain standards in management, to set and support the right kinds of behaviour, and to share across the organisation those things that it does best. Performance management of individuals must link to core competencies, values and objectives with time set aside to discuss and central oversight of this. Support and training needs to be given at all levels to do this. There are a number of places that these universal competencies could be taken from including the CQC 'well led' competencies or the NHS Leadership Academy's Clinical Leadership Competency Framework. Other organisations that achieve this do so by concerted training overseen by a centre that can

coordinate what things are taught, why they are taught, and where and how they are taught. Without such a body and the clarity it must be charged with bringing, the NHS is at extreme risk of wasting management effort and resources. In order to make training consistent, replicable and responsive across the organisation, such a body would be responsible for a consistent training regime across clinical, administrative and nursing / ancillary disciplines. Moreover, such a training body should be set up to be alert and sensitive to changing needs, and should have at its core a 90-day cycle of training requirement set by a body of more junior or middle-ranking staff: their body informs the core what their staff training needs are, and in 90 days the core reports back; in a further 90 days, the training must be in place.

R3: Charge HEE to coordinate the content, progress and quality of all NHS training including responsibility for the coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership.

4 *People must be equipped for the changes the NHS has asked them to make.* There has been enormous change in the NHS in the last two years. This has come at a time when catalytic change has been the only constant. Yet little has been done to equip people either personally or professionally to manage change and to make themselves properly able to do what is asked of them. The NHS must help its people manage their performance by moving

towards a single competency framework – with one locus (not necessarily a central establishment) of delivery. There needs to be a single training hub to co-ordinate all aspects of training for all individuals across the NHS. There are valuable examples across the military (much could be learned from the Joint Services Command & Staff College, for example). Training must take the form of competencies across all disciplines: leadership, project management, finance, negotiation, motivation, and HR etc. To work, it must be consistent. There must therefore be a single body responsible for the coordination of all training levels, including management training in the NHS.

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE.

5. *It is important to maintain quality, pluralism and innovation in training courses,* These should be available in various locations across the country. Training courses should have status, appeal and impact for those staff taking them; they should also be substantial enough to allow people time to reflect on what they have learned, and to form cohorts with their peers. For the NHS these courses should be diverse, accredited, and flexible. This form of collective and action learning is invaluable in developing both individual and organisational competence.

There should be greater diversity of training programmes, some directed at specific organisational needs, such as those working in the acute sector or in the commissioning sector. Others should be directed at increasing collaboration across the sectors bringing together leaders from a variety of

sectors such as local government, Public Health, acute, commissioning and primary care.

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

6. *The graduate scheme is woefully small and under-powered.* The scheme needs to be reviewed, refreshed and extended tenfold with larger numbers of individuals joining each year. To produce managers who see the bigger picture across the NHS, a wider range of postings should be undertaken (NHS acute, mental health, ALBs, CCGs) with an assessment necessary at the end of the tenure to ensure consistency of standards; this approach might better support a flexible and innovative programme of graduate recruitment.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

7. *As managers progress, they must be supported by being exposed to the learning they need in order to do their job*; this learning must of course be current, but equally it should be maintained, such that there is little "skill fade" or stagnation. Exposure to other forms of management and leadership, in other sectors, would be of great benefit.

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

8. As management is identified and nurtured from within the NHS, and encouraged from outside the NHS, *standards must be maintained and benchmarked against internal and external data*. This is not a call for new measurement or burdensome reporting, but an answer to the need for consistency in performance across all Trusts. One way of achieving this is by an accredited qualification. This has two benefits: external talent can measure itself by qualifying for entry into the NHS management cadre; internal talent can, by registering for and passing this checkpoint, begin to form a *talent pool* on which the entire organisation can draw.

R8: Require senior managers to attend accredited courses for a qualification to show consistent levels of experience and training have been reached across the NHS. On completion of this course they enter a senior management talent pool open to all Trusts.

Performance Management (R9-R11)

9. *It is crucial for the future of the NHS that it creates and supports a cadre of capable, trained and current managers from all disciplines and increases its level of cultural diversity to better reflect its staff.* In order that its training effort can be rational and effective, the NHS must identify and

broadcast core management skills and competencies across the organisation and expectations for delivery at clearly structured management levels. The NHS must begin cross-disciplinary (doctor, nurse and administrative) leadership and management training earlier in individuals careers.

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

10. As a consequence of a more highly trained and self-aware management cadre in the NHS, with recognised and developed competencies, *there will be a need for some form of through-career support* to guide individuals as they progress. Individuals should be encouraged to increase their personal accountability for their training needs. Existing talent must therefore be identified and nurtured: More resource should be applied to the development of all management careers in the NHS. Training gates / experience points should be established as part of career progression. A widespread HR programme of talent-spotting, mentoring, networking and inside/outside secondment should be established.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own developmental needs.

11. In step with a more rational training programme, better career handling, and recognised leadership and management competencies, *the ways in which people give and receive praise or encouragement or advice need to be codified and made more uniform*. The Review noted that there is little

consistency in how appraisals are conducted, and this must be addressed urgently; this is in part to support the one vision of the NHS (inculcating NHS values into the training and appraisal environment), and in part so that everyone can reasonably expect the same from their appraisal, process wherever they work[32]. The best leaders give *feedback that is both constructive and thought- provoking*. Both positive and negative feedback should be descriptive – given with openness, transparency and candour. This should be built into any new framework.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy (R12-R16)

12. *There is an unnecessary burden of bureaucracy*: the NHS is justified in its complaints that there are too many organisations asking for similar returns of data for compliance and monitoring purposes. Reviews have looked into this before (the latest by HSCIC) but they need to go further. There is a need to move from a system where information is *pushed to the centre* to a system where information is *pulled from the centre.*

[32] *NHS Staff Management and Health Service Quality* , Michael West and Jeremy Dawson www.gov.uk/government/uploads/system/uploads/attachment_data/file/215454/dh_129658.pdf , Shows that a good appraisal correlates to lower levels of patient mortality and increases staff engagement

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

13. *Clarity is needed within the NHS's accountability and regulatory structure*: bringing together the two current oversight bodies the NHS TDA and Monitor would significantly contribute to this. While any further structural reform needs to be fully justified, the publication of the *Five Year Forward View* provides a stimulus to consider the future oversight model for the NHS. Furthermore, a review of the TDA is now due, as when originally established it was agreed that there would be a review into its continued existence within three years[33]. In the past there may have been good reasons for viewing Foundation Trusts and NHS Trusts differently. However, given that both sets of organisations now display a wide range of performance, it makes sense if support is provided by a single body which has the necessary breadth of experience, staff and contacts.

R13: Merge oversight bodies, the NHS Trust Development Authority and Monitor.

14. *There is an urgent need to improve the management environment by cutting bureaucracy*. As part of an initiative to make the NHS less bureaucratic, and to clean out its attic, the whole organisation needs to undertake an effectiveness review to simplify, standardise and share best

[33] http://www.legislation.gov.uk/uksi/2012/901/memorandum/contents

practice. Further, there is a need for a 'good housekeeping' review of necessary / unnecessary data returns to be taken periodically and an effectiveness review to take place to simplify, standardise and share best practice in data management. Committee work and administrative burden must be lessened. Non-Executive Directors in Acute Trusts would be well placed to consider the level of reporting requested and to communicate concerns around feasibility of requests to the organisation concerned. They could also be instrumental in considering the level of data needed to discharge their duty in holding the Trust to account.

R14: Spend time on a regular basis at all levels of the NHS to review the need for each data return being requested and to feed any findings to the Executive and Non-Executive Teams to review.

15. *The NHS must know how to recognise the good, the bad and the ugly*: this can be achieved by annual appraisals and merit awards, all matched against a single vision and ethos. The NHS requires a *consistent balanced scorecard* in which each critical area is given equal prominence. Through enhanced performance management at all levels and in all disciplines, the NHS should be able to identify both the good and poor performers and be able to seek new ways of working together to accomplish strategic goals.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

16. This Review has commented on the specific level of data burden felt by Trusts from data requests from CCGs. Many of these requests are driven

directly by NHS England and the Department of Health (DH). A greater level of independence and power should be given to CCGs by means of an accountable SRO (at either Director of Commissioning, Chief Information Officer or Caldicott Guardian level) for ensuring that data requests are not creating additional burden on the system and are necessary and proportionate. It would be their responsibility to ensure that for each data request a Burden Impact Assessment had been produced by the initial requestor (NHS England or DH) and to share it on demand from a Trust Board when discharging their duty to review all requests.

R16: Health and Social Care Information Centre (HSCIC) to develop an easily accessible Burden Impact Assessment template and protocol.

Management Support (R17-R19)

17. *The NHS must simplify, standardise, and share best practice*. The NHS can and must make use of its diversity and scale by sharing experience and best practice. People must be able to talk between Trusts, organisations and across distance. This will break down barriers between organisations, inform managers, doctors and nurses, and above all benefit patients by bringing the collected wisdom of the organisation to bear on their treatment. This will make the spread of best practice more consistent, more urgent, and more speedy. Individual NHS organisational identities should not shirk sharing

between one another, and between sites; nor should they be a barrier to asking for help.

R17: Create NHS wide comment boards. Websites and supporting technology to be designed and implemented to share best practice.

18. Some senior managers and senior leaders will be attracted to turning around poor Trusts. *The NHS needs a team of turnaround specialists ready to apply their expertise to failing Trusts – an elite cadre of known and trusted individuals* implicitly trusted by the regulators, and paid centrally. In order to do so, they need time to assess the situation, assemble their team, and execute their strategy. In order to give good leaders the headroom and protection needed to take on the more challenging Trusts the TDA and Monitor should consider creating a shared resource of individuals willing to be on two year fixed term contracts able to work in an agile manner, deployed to a variety of Trusts.

R18: Set minimum term centrally held contracts for some very senior managers subject to assessment and appraisal.

19. *Trust boards, their Non-Executive Directors and CCG lay members must be better trained.* Research by McKinsey & Co across 770 companies in commercial and not-for-profit sectors showed that better performing boards spent over twice the amount of time than poorly performing boards when it came to talent management, performance management and strategy[34].Trust Executive and Non-Executive Teams require a training programme to allow

[34]McKinsey Quarterly (2014, Number 2), McKinsey and Company, www.mckinsey.com/~/media/mckinsey/dotcom/insights/sustainability/mckinsey%20quarterly%202014%20number%202%20issue%20overview/mckinsey%20quarterly_2014_number%202.ashx.Page 14

them to develop as a cohesive group of leaders. Consideration must be given to increasing the base level of remuneration as standard across NHS Trusts in order to increase the number of potential candidates. This is the same for CCG lay members. The time commitment of Non-Executive Directors and lay members can be extensive, and there is a need to review the expectations of a NED, or the way in which they are brought into the organisation. For instance a single NED job could be shared between two people, shorter terms of employment could be examined or a system of volunteer NEDs from other parts of the health service or other sectors could be considered. There is a role for Boards in Leadership Development and this should be fully explored. A talent pool of potential NEDs and lay members should be considered for the future.

R19: Formally review NED and CCG lay member activity (including, competence and remuneration) in line with the CQC Well Led initiative; and establish a system of volunteer NEDs from other sectors.

Acknowledgements / References

Acknowledgements

The questions asked of me by the Rt Hon Jeremy Hunt MP

- What more could be done to attract top talent from within and outside the health sector into leading positions in NHS hospital Trusts, and;
- How strong leadership in hospital Trusts can be used as a force for good to transform organisational culture

were by necessity wide ranging and focused on acute Trusts. However during the course of my review I found that leadership challenges in the NHS are not confined to these areas alone. I therefore welcomed the request to consider the whole system, following the publication of the NHS's Five Year Forward View.

I hope that my recommendations can be taken as a blueprint going forward for the NHS as a whole, whatever part of the system.

Over the course of the Review, I have had the opportunity of visiting many health care organisations across the length and breadth of the country, including Foundation Trusts, NHS Trusts, Mental Health Trusts and CCGs.

In each location I met with many enthusiastic, dedicated and passionate people, administrative, medical and nursing staff at all levels. These people work incredibly hard and through difficult times, yet were prepared to find the time to meet with me and openly share their thoughts and views on leadership across the NHS. They have helped shape this review and their contributions have been invaluable.

I have met with a number of health sector experts, too many to name here but I would like to thank them all, including those from the Kings Fund and the Nuffield Trust, for giving their considered opinions.

I would like to thank the Care Quality Commission, Monitor, Health Education England, NHS Leadership Academy, Trust Development Agency, NHS England, NHS Confederation and the Foundation Trust Network.

I must also acknowledge Sir David Dalton (Salford Hospital), Sir Robert Francis QC and those individuals from the Shelford group. The wealth of experience and understanding that they shared with me has been instrumental in delivering this review and they each have provided me a valuable insight into the intricacies of the NHS.

Andrew St George (Aberwyswyth University and Cass Business School) has been my source of broader knowledge and information on leadership challenges and has been key in bringing together this report; my thanks go to him.

Lastly thanks must be given to officials at the Department of Health who have been a great source of support, guidance and knowledge to me during this process, to David Thorpe and especially Joanna Edwards who was a tireless source of help and coordinated the many moving parts of this report.

Thank you to each and every individual from the organisations below and their patients who gave their time so generously to speak to me individually and in roundtables. Your insights were invaluable.

Airedale NHS Foundation Trust
Hampshire NHS Foundation Trust, Basingstoke Hospital
King's College Hospital NHS Foundation Trust
Medway NHS Foundation Trust
Sherwood Forest NHS Foundation Trust
Buckingham NHS Trust, Amersham Hospital

Birmingham Children's Hospital NHS Foundation Trust
Calderdale and Huddersfield NHS Trust
North Cumbria Hospital visit
Hertfordshire Partnership University NHS Foundation Trust
Camden CCG
Waltham Forest CCG

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David Behan (CEO, Care Quality Commission)
David Bennett (CEO Monitor)
Ian Cummings (CEO, HEE)
Sir David Dalton (Chief Executive Salford Hospital, author of the Dalton Report)
Giles Denham (DH Director, Leadership)
Dr Michael Dixon (Chairman NHS Alliance)
Nigel Edwards (Chief Executive, Nuffield Trust)
David Flory (CEO, TDA)
Sir Robert Francis QC (Author of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry)
Sir Malcom Grant (Chairman, NHS England)
Dame Barbara Hakin (COO & Deputy CEO, NHS England)
Professor Aidan Halligan (NHS Staff College)
Professor Chris Ham (CEO, Kings Fund)
Chris Hopson (CEO, FTN)
Professor Sir Bruce Keogh (Medical Director, NHS England)
Sir Alan Langlands (Vice-Chancellor University of Leeds)
Clare Marx (President, Royal College of Surgeons)
Dr Keith McNeil (CEO, Cambridge University Hospitals)
Dame Gill Morgan (Chair, NHS Providers)
Sir Robert Naylor (CEO, University College London Hospitals NHS Foundation Trust)
Sir David Nicholson
Una O'Brien CB (DH Permanent Secretary)
Professor Sir Mike Richards (Chief Inspector of Hospitals, CQC)
Ed Smith (Deputy Chairman, NHS England)
Dr Julia Smith (NHS England)
Jan Sobieraj (Managing Director, NHS Leadership Academy)
Simon Stevens (CEO NHS England)
Rob Webster (CEO, NHS Confederation)

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The King's Fund Ideas that change health and care

Mr Shane Devlin
Mrs Vivienne Toal
Dr Maria O'Kane

22nd February 2021

From the Chief Executive

The King's Fund
11-13 Cavendish Square
London W1G 0AN

Tel 020 7307 2400
www.kingsfund.org.uk

Dear Shane

Re: Support for the senior management team/board

Thank you very much for your time over the past fortnight; it was a pleasure to meet you all. I am now writing to provide a summary of what we jointly proposed and to set out our terms. These are enclosed.

If you are content with the proposal and terms, I would be grateful if you could email me to confirm that you wish to proceed on this basis.

Kind regards,

Sally Hulks
Senior Consultant, The King's Fund

The King's Fund: Proposal for Southern Health and Social Care Trust, Senior Management Team/Board support

Your requirements

The King's Fund last worked with the Board of the Southern Health and Social Care trust in November 2018. Since then the trust has experienced an extraordinarily challenging time, largely as a result of the extreme pressures of the pandemic, but also with other serious clinical issues, which in turn generate high levels of scrutiny, plus ongoing changes in senior personnel.

The pressure of leading through Covid-19 is ongoing and unlikely to subside fully for some time. Nevertheless, the new Chair has taken up her role recently and, whilst there will be further Executives retiring shortly, it seems important now to pause, give time to taking stock as a leadership team, to reconnect with each other, in order to lead the organisation forward. There is a need to explore collectively your approach to leading the wider team into the next phase, how best to continue to drive a culture which focuses on safety and quality in the current context.

You have suggested the work starts with two pieces of support:

Commented [WS1]: Is there potential for phase 3 which might be the 3 elements below

1. The provision of 1:1 coaching for Directors who would like to take up the offer;
2. 3-4 half-day or full day-workshops for the Senior Management Team (SMT) and the full Board;

The focus of the workshops will be informed by initial 1:1 inquiry conversations with each member of the Board.

Anticipated Outcomes

As an output of the proposed engagement it is envisaged that the Board members will be in a position to commence developing plans to strengthen leadership within the Trust to support and drive an culture of safety and quality that will include:

- Strengthening service-level thinking for improvement including developing integrated collective leadership structures
- Regaining the ability to refocus on medium and long-term goals that are strategically clear and develop meaningful frameworks for decision-making
- Developing internal structures that can proactively develop longer term initiatives in response to the changing health and social care environment, including the ability to review and adapt these plans and strategies to make sure they remain relevant and achievable.

Our approach

Coaching provision

The King's Fund has a team of qualified executive coaches on our permanent faculty and within our associate network. Below I have listed the bios of coaching colleagues who would be delighted to work with your Directors; we ensure everyone has choice in who they work with. Our costs per coaching session are set out in the Fees section below. We suggest a set of 4 sessions, each 1.5 hours via Zoom, as the initial commitment.

Inquiry interviews

We recommend a core team of two King's Fund faculty to lead the work with the SMT and the Board: i) George Binney, who has a wealth of experience working at senior levels across health and care sector; and ii) Tricia Boyle, who worked with you previously and can act as the golden thread to look back/forwards and retains a sound understanding of your specific challenges. Their bios are listed in the section below.

Given the pandemic has forced the senior team to work relentlessly on operational delivery issues within their own areas of responsibility, at the expense of time spent working together, we suggest the work starts with 1:1 telephone interviews with each member of the Senior Management Team, plus other Board members, as appropriate, in order to hear each person's perspective on priorities and energy for the work. The interviews would be conducted by George and Tricia via telephone/Zoom and take 45 minutes per person.

Workshops with SMT and full Board

The inquiry, facilitated by George and Tricia, would inform the focus for an initial 3-4 half-day or full-day workshops, taking place bi-monthly, perhaps starting with the SMT, if helpful, and then extending to the full Board. In the Fees section below, we have costed one full-day workshop by way of example.

You want the process to provide space to reflect carefully on the past year, to understand how each of you feels, given the demands that have been made of you, to explore what it takes now to lead the Trust forward. Your aim is to reconnect with the Trust's purpose, values and behaviours that have been stretched under recent pressures, to ensure you can go forward collectively to reengage the wider leadership and lead in ways which create a psychologically safe environment for all, to explicitly support a culture of continuous safety and quality improvement.

Logistics

- Platform – Our preferred platform for delivering virtual group sessions is Zoom because of the enhanced functionality it offers over MS Teams. Your team members would need to be able to access Zoom from a suitable device in a quiet location.

- Administration – We will provide Zoom links ahead of each session and technical support during the sessions, as appropriate.

The team

The core Faculty team

George Binney, MA, MBA, Barrister

George is an experienced coach and a long term, confidential adviser to a number of senior people in business, the voluntary sector and the Department of Health and Social Care. He specialises in working with powerful women who are in senior leadership roles.

He started his career in business, working as a finance manager and director in GEC and Courtaulds and a consultant for McKinsey & Co. In the last 20 years he has focused on helping senior professionals – doctors, scientists and lawyers – become more effective leaders. Between 2008 and 2018 he was the Ashridge Director of the National Institute for Health Research's Leadership Programme. He also led Ashridge's leadership development and research strategy work with the World Health Organisation. George is an Associate of The King's Fund.

He has:

- Worked with an NHS Trust chief executive and her executive team to help develop the sense of common purpose
- Supported the chief executive of a Government agency by acting as a mediator and resolving tensions between board directors.
- Helped many doctors and scientists to make the transition from "expert" to "expert and leader"
- Supported the development of common cause among a dozen senior individuals leading development, internationally, across a number of health organisations.
- Has advised a number of chief executives on succession planning.
- Coached participants in the Health Foundation's 'Generation Q' Programme to develop leaders of service and quality improvement in the Health Service.
- Has also done extensive individual and group development work in leading international law firms and in commercial companies like Anglo American, Nokia and Reuters.

George is an accredited coach with Ashridge/Hult. He has an MA in history and law from Cambridge University, an MBA with distinction from INSEAD and is a barrister.

Publications

George has researched and written extensively on the realities of leading in large organisations. His books include *Leaning Into The Future*, *Changing the Way People Change Organisations,* Nicholas Brealey, 1995; *Living Leadership - A Practical Guide for Ordinary Heroes,* FT Publishing, 2012 and *Breaking Free of Bonkers - How to Lead in Today's Crazy World of Organisations,* Hachette 2017.

Patricia Boyle

Tricia is an experienced consultant and coach. She has 20 years' experience of external consultancy work in government departments, local authorities, voluntary and private sector organisations and 10 years' experience leading an internal consultancy team of organisational development specialists in a Scottish health board. She has worked extensively at board and senior management levels and with teams in difficulty, with start-ups, restructures and mergers. She has also delivered development in business-school environments to tailored and open, mixed organisation groups.

Tricia's work at The King's Fund includes directing the 'Leadership for Consultants' programme and the 'Care homes, housing, health and social care learning network' and Leading Breakthrough conversations programme. Current and recent consulting work includes the Blood Transfusion services the UK and Ireland, Kettering General Hospital, Manchester University Hospital FT, University Hospital Southampton, Surrey Heartlands CCG, Humberside, Leeds and Wakefield Primary Care systems.

Tricia's experience inside the NHS is extensive, working within and across acute, community and corporate divisions on service breakdowns and turnarounds, improvements and transformations, restructures and closures, new hospital building projects and service moves. She has worked in several Scottish boards by invitation of their senior teams to work on particularly challenging issues and geographies using dialogue methodologies to encourage constructive conversations for organisational change, turning around difficulties where there has previously been a chronic lack of progress.

Tricia's coaching work is focused on supporting leaders involved in change projects, assisting them to see themselves and the system as clearly as possible so that they can make proactive interventions and achieve successful service developments. She has coached chairs, chief executives and senior leaders in private and voluntary sector organisations involved in health and social care integration and in NHS and local authority organisations.
Tricia is an accredited Ashridge/Hult coach has a Masters degree in Organisational Consulting and is registered with the British Psychological Society in the use of psychometric instruments and is accredited in dialogue with the Kantor Institute

The coaching team

We also offer the bionotes of some of our team of Executive coaches.

Deborah Homa

Deborah is part of the leadership and organisational development team and has more than 25 years' experience in the health care sector. For the past 15 years, she has worked as a consultant and strategic adviser to NHS organisations and boards, most recently as a partner in an international consulting practice. She began her career as an NHS management trainee and has held director posts acute, commissioning and mental health organisations.

Deborah is passionate about supporting organisations to develop compassionate cultures that deliver high-quality care. Her interests include using occupational psychology and evidence-based approaches to develop leadership, OD strategy and OD interventions that make a demonstrable difference for staff and patients. She is experienced in team development and facilitation, and leadership and organisational development working with groups ranging in size from small teams to whole organisations.

Lindsey Masson MSC, BSc, DPM

Lindsey has been a coach and consultant for 25 years, working with a wide range of private and public sector clients. Lindsey previously led Ashridge Business School's Custom & Consulting business, and held a range of roles at Ashridge including Director of Executive Coaching. She particularly works in the areas of strategy development, change, leadership and one-to-one and team coaching. She has also been a tutor on Ashridge's Coaching for Organisation Consultants programme and Consulting and Change in Organisation programme. Lindsey coaches chief executives, directors, senior managers and high potentials across a wide range of sectors and on an international basis. She focuses on providing practical support that compliments both the individual and the organisation within which they find themselves working. Lindsey often finds herself coaching other female leaders, supporting them as they transition and helping them find their authentic voice in the organisation.

She is an Ashridge accredited coach and previously has been an Ashridge accreditor of coaches, as well as a developer and accreditor of coaches for BBC, British Airways and ADIA (Abu Dhabi Investment Authority).To support her practice, Lindsey has monthly supervision, she is Level 2 BPS qualified and uses psychometric instruments in her work as and when appropriate.

David Birch BA, PGCE, MSc, PG Cert Supervision

David is an executive and team coach, facilitator and supervisor who brings over 30 years' experience to helping individuals, groups and organisations make a difference to the world.

David's practice is founded on the understanding that change occurs within and through relationships. He combines expert coaching skills, psychological insight and creative embodied methods to help his clients explore the most pressing issues, however tricky and awkward they may be. His business background and professional training means that he is alert to the political and psychological dimensions of the work, enabling his clients to gain insight into their assumptions, motivations and impact on others. Over time, this builds the self-awareness and resilience needed to respond positively in what are often complex, emotive scenarios. He is comfortable working in a range of settings including retail, engineering, tech, creative, finance, healthcare, professional services, public sector and not-for-profit organisations.

He will sometimes accompany his clients in their workplace, or interview colleagues and other stakeholders to gather rich qualitative feedback.

Examples of recent coaching assignments include:

- The executive team at a UK university
- The partners at a private equity firm
- The executive team at an NHS Trust
- The CEO and founder of a technology business
- The COO of a challenger bank
- General Counsel at a government organisation

David holds postgraduate degrees in organisation consulting, integrative psychotherapy and coaching supervision and is accredited as a mediator by the Law Society. He is a trainer, supervisor and accreditor of executive coaches to Masters level at Ashridge and is sought after as an author and conference speaker on the subject of coaching and coaching supervision. He holds British Psychological Society Level A and B certificates of competence in psychometric testing.

Ben Fuchs

Ben is a Senior Consultant in leadership and organisational development at The King's Fund. He has been a practicing psychologist for nearly 30 years, developing people, teams and organisations. He works with healthcare leaders and leadership teams who are facing strategic and cultural challenges, often within a pressured environment of complexity and uncertainty. He has also worked in community development, leading conflict resolution projects with former adversaries in Nicaragua, Mexico and Northern Ireland.

Areas of Expertise:

- Leadership Coaching: Works with leaders at their 'growing edge,' to build confidence, explore implicit assumptions and to navigate the complexity of power and cultural dynamics in organisations and systems.
- Leadership Development: Facilitates experiential learning of practical skills and tools to close the gaps between leaders' intentions, their actions and their results.
- Leadership Team Development: Develops teams to increase psychologically safety, address difficult issues, and to work collaborate.
- Conflict Management: Helps to resolve tensions, promote mutual understanding and find win /win solutions.
- Culture Change: Helps to identify and shift the mind-sets, patterns of communication and behaviours that impact both the staff and service user experiences.
- Stakeholder Engagement: Brings together diverse perspectives, creates generative dialogue and develops common ground for effective action.
- Equality, diversity and inclusion: Helps leaders and organisations address the drivers of inequalities and develop proactive approached to increased equity.

Ben holds an MA counselling psychology and has undertaken professional training in Coaching, Group Dynamics, Conflict Resolution, Appreciative Inquiry, Harvard Negotiation, Process-Oriented Psychology and MBTI. He is also a qualified supervisor of coaches and consultants.

Fees and expenses

The costs below will give you an indication of our price structure. We will be happy to give a more specific price once you decide on numbers for each aspect of the possible activities. We are happy to do the work in stages, co designing the shape and style of the work with you, based on the findings of the initial data gathering interviews.

Coaching	Units	Unit cost	Total cost
Coaching per person 1:1 coaching, 4 x 1.5 hours via Zoom	1	Commercially Sensitive Information redacted by the USI	
TOTAL COST per person			

Board Development	Units	Unit cost	Total cost
Inquiry 1:1 inquiry interviews with SMT/Board members 2 consultants, 1 day each (6 interviews per day each)	2	Commercially Sensitive Information redacted by the USI	
TOTAL COST inquiry			

Delivery per full-day workshop 2 consultants			
0.5 day each co-design with yourselves	1	Commercially Sensitive Information redacted by the USI	
1 day each delivery	2		
Administrative/technical support	1		
TOTAL COST per workshop			

Payment details

Please provide the details below of who and where the invoice should be sent to. The invoice (including fee and expenses) will be issued after the event.
Name and job title:
Invoice address:
Work email:
Phone:
Generic accounts payable email address:

Purchase order number (if applicable):

Service agreement – terms and conditions

Cancellations:

All cancellations should be confirmed in writing before the event.

In the event of the customer cancelling or postponing confirmed delivery dates, any costs and expenses already incurred by The King's Fund prior to cancellation or rescheduling will be chargeable regardless of when cancellation takes place.

In the event of a last-minute cancellation (5 to 1 working days prior to the programme/ event date), The King's Fund reserves the right to charge 100% of fee and expenses already incurred.

Intellectual property:

In performing their obligations under this agreement, the parties shall not knowingly infringe the Intellectual Property Rights of any third party. Where there are known to be prior rights or rights of third parties in any customer property or other material to be supplied to the Fund by the customer, the customer shall obtain prior written consents before passing the customer property to the Fund for the purposes of performing the Services.

Any Intellectual Property Rights and know-how generated or developed by the Fund in the course of the provision of the Services including in the deliverables whether vested, contingent or future shall belong to the Fund and shall not be assigned to the customer unless expressly agreed in writing and detailed as an annex to this Agreement.

The provisions of this Condition shall apply during the continuance of this Agreement and after its termination howsoever arising, without limitation of time.

The King's Fund

Stinson, Emma M

From: Best, David <Personal Information redacted by the USI>
Sent: 18 December 2020 09:21
To: OKane, Maria
Cc: Johnston, Julian; Wallace, Stephen
Subject: RE: Indepdendent Medical Examiner

Maria

Excellent news. Over the Christmas period we have decided to pause reviews and we will recommence in the first week of January. The IMEs are meeting on 4 January and we will consider how best to include the Southern Trust and from which date.

As a first step, could you confirm a lead doctor for both Craigavon and Daisy Hill. We will then liaise with them around the practicalities of what is required. We have developed an information sheet for dissemination to medical staff and essentially, we just need that to be distributed and for doctors to be aware that the process is starting. We will confirm a start date, following our meeting with the IMEs on 4 January.

Thanks

Davy

From: OKane, Maria Personal Information redacted by the USI
Sent: 18 December 2020 00:12
To: Best, David <Personal Information redacted by the USI>; Johnston, Julian <Personal Information redacted by the USI>
Cc: Wallace, Stephen <Personal Information redacted by the USI>
Subject: FW: Indepdendent Medical Examiner

Dear Julian / Davy,

Further to the meeting held with the Stephen and Damian last week regarding the newly established regional Independent Medical Examiner role the Southern Trust would be pleased to participate in the next phase of the project.

Can you advise what steps we need to take to commence this?

Regards
Maria

Dr Maria O'Kane
Medical Director

Southern Health & Social Care Trust archive all Email (sent & received)
for the purpose of ensuring compliance with the Trust 'IT Security Policy',
Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department [redacted]

Cervical Cytology Service – Position paper - Feb 2021

Background

The Trust's Cervical Cytology Service is delivered through Craigavon Area Hospital (CAH) Cellular Pathology Laboratory. The service typically supports primary screening for 24,000 smears per year. 6000 of these smears also require further verification by a senior Biomedical Scientists (BMS) in the lab.

In the last three years, the service required additional sessions to keep up with demand, supported by waiting list funding from Health & Social Care Board. In recent months the service has lost three WTE BMS to other Trusts and backlogs are now accruing. In addition to the imbalance between service demand and capacity, additional NI Cervical Cancer Audit Framework requirements have been introduced which are putting additional pressure on the service.The current position is not sustainable and this position paper sets out a proposed more viable way forward for the service in the context of Pathology modernisation.

Pathology Modernisation

The Pathology Modernisation program is progressing through the regional Pathology Network chaired by Jennifer Welsh (Chief Executive – Northern Trust). It is recognised that in future there will be some changes to how laboratory services are delivered across Northern Ireland as a region. Whilst most cellular pathology services will remain unchanged and continue to be delivered on their current locations, a small number of service areas will be delivered by either one or two laboratories. Cervical Cytology Screening is one of those service areas.

Primary HPV testing will eventually replace Cervical Cytology screening as a primary screening tool and this policy change will consequently mean a smaller number of locations are needed to deliver the future service. The Southern Trust Laboratory Team accepts that change is inevitable and that Cervical Cytology will not be delivered here in the future. Therefore we are seeking to proactively manage this change whilst supporting staff through the process and focusing on a robust and sustainable SHSCT Cellular Pathology service model.

Target areas for CAH Cellular Pathology service development include:

- Support and expand Radiology in Rapid Onsite Evaluation Diagnostics.
- Increase capacity in biopsy reporting for elective and unscheduled care.
- Digital Pathology and Advanced Roles for Biomedical Scientists to support Consultant workforce shortages.
- Develop and deliver training programme for advanced BMS roles.

Primary HPV Testing

NI is the only region of the UK not to have rolled out primary HPV testing within cervical screening. Primary HPV testing is more sensitive than cytology which means it is less likely to miss pre-cancer compared to cytology. Cytology is a suboptimal test relative to what is available and a policy decision to move to primary HPV testing has been awaited in the region for several years.

As we deliver the screening programme by cytology rather than HPV testing, Quality Assuring the service is difficult as no national benchmarking will be available in the future. There is added risk at present and until a policy decision is made to introduce primary HPV testing this risk continues. To mitigate this risk co-testing could be considered and adopted (where all smears have both cytology and HPV testing done) however, the PHA does not currently support this move. Co-testing would mean little change to patient pathways as the colposcopy referral rate in SHSCT is high already. There would be a small additional financial cost of a HPV test.

Demand and Capacity

There is currently insufficient capacity available in the cellular pathology service to meet demand. Despite a significant amount of additional screening having been done, backlogs can accrue thus introducing clinical risk. The current staffing model for Cervical Screening is as follows:

Table 1:

Staffing	Sessions / WTE	Role
Consultant Sessions	3	Consultant Pathologist reporting / MDT
Band 8A BMS	0.5	CSPL
Band 7 BMS	2.5	Primary screening and checking
Band 7 BMS	0.5	Primary screening

This current staffing model in **Table 1** provides capacity for 12000 smears to be screened and reported by the Cervical Cytology Service at SHSCT. The demand currently however is, based on 2019 cervical cytology workload, around 24,000. The additional numbers were supported at financial risk through overtime.

The current deficit in capacity is resulting in backlogs and delays in reporting resulting in reduced turnaround times. Currently the training of cervical screeners is paused and recruitment of staff to support our service here is not an option. As a short to medium term solution, through the regional cellular pathology escalation process, it is proposed that 12,000 cervical cytology specimens are sent to Cellular Pathology in the WHSCT for primary screening and reporting through an SLA / contract. This proposal will ensure the safe delivery of the Cervical Cytology Service at the proposed reduction of the current workload. The WHSCT are agreeable to this proposal.

Cervical Cancer Audit Review

New Framework

The Northern Ireland Framework for the Audit of Invasive Cervical Cancers and Disclosure of Findings was published in 2019 and applies to all new cervical cancer diagnoses from the start of 2019 onwards.

This requires the Trust to carry out a review of the cervical screening history in all women diagnosed with cervical cancer. This involves a review of any previous screening test (cervical cytology), diagnostic test (biopsy) and any clinical treatment or management (colposcopy).

In most cases there is either no adverse review finding or minor review findings within the limitations of screening, classified as Category 1 and 2 outcomes respectively. In all these cases the patient is written to and advised that the audit review is complete and the outcome disclosed to patients where they require this, including invitations to meet with the Trust to discuss if necessary.

However, sometimes a more serious error is found (Category 3 outcome) and if such an error is found it is usually within the screening test, where a patient has received a false negative result – this is when the test result says you don't have a condition, but you actually do.

In the specific circumstances of this audit review of cervical cancer patients we will identify some women who were previously told they had a negative or normal smear test when in fact pre-cancer changes were present. These changes could have been treated and prevented cancer from developing.

The Framework asks for a specific standard to be applied when defining the audit outcome – *'Did staff carrying out the screening or diagnostic test do so to a standard that most staff could be expected to achieve?'* Applying this means for the Southern Trust around 3 women per year diagnosed with cervical cancer will have a previous false negative result. These are then required to be investigated as a SAI.

Every year in which cytology has been used as the primary screening test will have this outcome. Since it usually takes around 10 years for cervical cancer to develop the Trust will have to continue to undertake this audit until at least 2030 adding an additional year for each year that passes where HPV is not introduced to replace cytology as the primary test.

SHSCT New Framework outcomes 2019 and 2020

The Trust has completed the new framework approach for the 2019 patient cohort. There are three category 3 outcomes for 2019 and these are being investigated as Level I SAI. The review team has been established and the process to engage with patients has begun. This new framework approach has a significant additional administrative time commitment, acknowledged in other Trusts also, which is unfunded. So far there are no Category 3 outcomes for 2020.

Cervical Cancer patients 2009 – 2018

Prior to the Framework above Trusts had been asked to carry out a review of the cervical screening history in all women diagnosed with cervical cancer. The Medical Director of the Public Health Agency wrote to Trust Chief Executives to ask that this be done for all cases diagnosed from 2009 onwards and that the NHS cervical Screening Programme guidance (*'Disclosure of Audit results in Cancer Screening, Advice on Best Practice')* was to be followed. In 2014 a laboratory specific protocol was introduced but largely resulted in little change to the audit review.

Whilst this audit review has been done in the Southern Trust 2009 – 2018 but there is no evidence of patients having been told it was happening and subsequently very few instances of disclosure of outcomes.

This issue has been put to the Directorate of Legal Services (DLS) as questions below:

Questions to DLS

1. Considering the *'Disclosure of Audit results in Cancer Screening, Advice on Best Practice'* guidance drawn to the attention of Trusts in 2009:

Between 2009 and 2014 did the Trust have a duty of care or any obligation to patients in respect of this audit of invasive cervical cancers?

(a) To ensure patients knew the audit was being undertaken *and*

(b) To disclose the results of audit reviews for those who asked to know the outcome?

2. Considering the *'NI Protocol'* Trusts was asked to follow in December 2014:

From then onwards did the Trust have a duty of care or any obligation to patients in respect of this audit of invasive cervical cancers?

(a) To ensure patients knew the audit was being undertaken *and*

(b) To disclose the results of audit reviews for those who asked to know the outcome?

3. Does the Trust have a duty of care or obligation to now retrospectively disclose the results of all audit reviews were a patient consents to know the outcome?

Response from DLS:

The Trust owes a duty to the patients from 2009 onwards to advise that an audit of their screenings has taken place and disclose same where the patient consents.

Governance and Patient Safety

The current service model for cellular pathology is not sustainable and will inevitably change as the pathology modernisation work progresses. The new NI Cervical Cancer Audit Framework will add pressure to the team, which they are not currently able to deliver. It is in this context that now is the time to change the service model – committing to cellular pathology activity that is deliverable and safe, as well as refocussing on the development of different parts of the service in the context of the pathology modernisation programme.

In conclusion

We need a sustainable service model for Cellular Pathology which takes cognisance of regional pathology modernisation and focuses on the parts of the service that will be delivered from SHSCT Cellular Pathology Laboratory.

It is acknowledged that cervical cytology as a service area will not be delivered from the SHSCT in the long term. We are seeking to proactively manage this change whilst supporting staff through the process and focusing on the development of development of other services in the context of pathology modernisation.

In the short to medium term it is proposed that the following actions are progressed to address the issues / risks highlight in this report:

- **An SLA is established with the WHSCT to support delivery of the SHSCT cervical cytology service** pending regional progress on a policy decision. Our current staffing model provides the capacity for 12000 cervical cytology specimens to be reported by the SHSCT cellular pathology laboratory. We propose sending 12000 cervical cytology specimens to the WHSCT for screening and reporting through the establishment of an SLA. This SLA would also free up time to allow us to deliver the Cervical Cancer Audit Review Framework. *The cost of this arrangement will be c£115K*. The SLA can commence on 15 March 2021.Previously this need would have been met through a combination of additionality, support from other Trusts or through high cost locums screeners, therefore this plan would be broadly in line with costs from previous years.

- Primary HPV testing is a more sensitive test and will eventually replace cervical cytology as a primary screening tool. NI is the only region of the UK not to have rolled out primary HPV testing. It will be difficult to quality assure our service as no national benchmarking will be available. We acknowledge the false negative risk of a cytology based test screening programme and that NI is currently at variance with UK and ROI. **Until a policy decision is made to introduce primary HPV testing in Northern Ireland It is proposed that we commence co-testing from 15 March 2021. The cost of this arrangement per year is estimated to be up to £100K**

- **The team are requesting that the Trust formally raises the issue of disclosure for the patients during the period 2009-2018 with the PHA** - this could equate to approximately 30 patients. The Trust should indicate to the PHA that we plan to make contact with these patients; however it would be preferable if this was coordinated regionally.

Phase	Action
Phase 1	• Patient Safety Data and Improvement Manager, Band 8a **Being Recruited** • Senior Manager Risk & Learning, Band 8b **Complete** • Datix Manager Band 6 **Being Recruited** • Patient Safety Strategy Manager, Band 7 **Being Recruited** • Project Manager Band 7 **Being Recruited**
Phase 2	• Corporate Clinical Audit Manager, Band 7 • CSCG Training Officer Band 7 • Morbidity and Mortality Manager Band 6 • Directorate Clinical audit and patient safety posts Band 5
Phase 3	• Datix Admin, Band 4 • Risk and Learning Admin Support Band 4 • Training admin Support Band 4 • Business Partner posts Band 5

Belfast Health and Social Care Trust

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JOB DESCRIPTION

POST: Patient Experience Officer

LOCATION: Belfast Trust (multiple sites)

BAND: 4

REPORTS TO: Patient Experience Manager

RESPONSIBLE TO: Co-Director Risk and Governance

Job Summary / Main Purpose

The Belfast Trust vision is to be one of the safest, most effective and compassionate health and social care organisations and the Trust aims to be in the top 20% of high performing care providers in the UK by 2020. To help to achieve this aim, one of the key improvement objectives for the Trust is that we will provide real time feedback to teams from our patients and service users.

The postholder will work as part of Real Time Patient and Service User Feedback Team that are responsible for capturing the experience of patients and service users that are inpatients in our care. Information is collected from patients and service users using a questionnaire whilst also documenting any comments regarding their experience whilst in our care. Patient feedback is very beneficial to individuals and teams to highlight the excellent care they provide and also for suggestions of how we can improve. There are 25 questions based around 10 domains in the patient experience questionnaire.

The postholder will also collect key safety information and information relating to the medication that patients and service users are receiving. This information, taken from patient notes, will provide assurance on the safety and quality of care we provide and also highlighting areas for improvement. This data will be uploaded to the NHS Classic and Medication Safety Thermometers so the Trust can benchmark against other NHS organisations.

https://www.safetythermometer.nhs.uk/

The information collected both on the patient experience and the safety information is returned to the ward or unit in a report within 24 hours.

Main Duties / Responsibilities

For each of the following, the postholder will;

Service Delivery

- Be responsible for the collection of patient experience data relating to the various elements of the patient experience real time feedback programme, completion of all questions and gathering free text comments.
- Be required to use high level communication skills to elicit as detailed information as possible from patients and service users. For example, using communication skills to tease out their views on any particular issue. It is essential that feedback is complete and accurately conveys the views of the service user and is not a partial answer which would be then difficult for the team to act upon.
- Be required to use their communication skills to prompt service users to provide feedback in the free text comments relating to any of the domains where the postholder has judged that more detailed information would be valuable for the ward/unit.
- Be required to use their communication skills to prompt service users to provide feedback in the free text comments that summarises and emphasises the key themes of the feedback they provided, e.g. to highlight and name individuals or to emphasise the areas where they feel improvement is needed.
- Be responsible for the collation of information to complete the NHS Medication Safety Thermometer and the NHS Classic Safety Thermometer audits. This will involve searching patient notes and medication documentation to complete the different audits.
- Be responsible for the upload of audit data to the NHS Improvement website in relation to the NHS Medication Safety Thermometer and the NHS Classic Safety Thermometer. This is done direct from an app or by uploading the audit results to the website from excel.
- Be responsible for the extraction of analysis reports and provision to the wards from the NHS Safety Thermometer website.
- Be responsible for the development of real time patient feedback reports following patient interviews. The postholder will collate the feedback into a report format and provide to the ward/unit. This includes collation of patient comments.
- Use judgement and analytical skills to determine if there is an important safety issue or an issue concerning the patient's well-being that needs to be raised immediately with ward staff.
- Contribute to the development of a patient experience improvement plan as required on a ward.
- Upon request meet with the ward/unit team to provide overall feedback on any issues raised by patients and service users and to give more detail or answer any queries the team have.
- Support the ward/unit teams in the development of improvement plans linked to the feedback received from patients and service users.
- Provide advice, guidance and practical support in eliciting the views of patients, service users, carers and the public.
- Support staff to involve patients, service users, carers and the public in their patient experience activity.
- Produce information regarding the quality of care delivered in the Trust.
- Submit patient and service user feedback and data collected in a timely fashion each day.
- Be responsible for the collection of patient safety data on wards to enable submission to the NHS Classic Safety Thermometer.

- Be responsible for the collection of patient medication data on wards to enable submission to the NHS Medication Safety Thermometer.
- Contribute to the development of guidelines and policies to support the collection of patient and service user feedback and safety data.
- Constantly seek to improve the real time patient and service user feedback programme.

Collaborative Working

- Liaise with clinical and non-clinical staff regarding the patient experience real time feedback programme.
- Raise any clinical safety concerns to the ward sister or relevant manager.
- Use negotiation and persuasive skills when discussing patient experience issues with a range of professionals to achieve improvements to patient outcomes.
- Build relationships with the various wards and units assigned to the postholder to work collaboratively to improve the patient experience.
- Communicate effectively any patient experience issues with all grades and disciplines of staff including senior and clinical staff in a ward or unit.
- Act as a mentor for new employees into the team.

General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's Smoke Free Policy.
- Carry out their duties and responsibilities in compliance with the Health and Safety Policies and Statutory Regulations.
- Adhere to Equality and Good Relations duties throughout the course of their employment.
- Ensure the ongoing confidence of the public in-service provision.
- Maintain high standards of personal accountability.
- Comply with the HPSS Code of Conduct.

Information Governance

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including e-mails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Employees are required to be conversant and to comply with the Belfast Health and Social Care Trust policies on Information Governance including for example the ICT Security Policy, Data Protection Policy and Records Management Policy and to seek advice if in doubt.

For further information on how we use your personal data within HR, please refer to the Privacy Notice available on the HUB or Your HR

Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognizes the key principle that "Cleanliness matters is everyone's responsibility, not just the cleaners" Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff.

This includes:-

- Cleaning hands either with soap and water or a hand sanitiser at the appropriate times (WHO '5 moments');
- Using the correct '7 step' hand hygiene technique;
- Being 'bare below the elbows' when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);
- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community were relevant, in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

Clause: ***This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.***

Belfast Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE / BAND: Patient Experience Officer / Band 4

DEPT / DIRECTORATE: Medical Director's Office

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined below at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage.

You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience **Qualifications** **Registration**	• NVQ Level 4 or equivalent and 1 years' experience at Band 3 level or equivalent in the HPSS. **OR** 3 years' experience at Band 3 level in the HPSS. • English Language GCSE O Level (Grade A-C / 9-4). • Sound knowledge of Microsoft Office Suite packages.	Shortlisting by Application Form
Knowledge **Skills** **Abilities**	• Excellent planning and organisational skills, including a high level of accuracy and the ability to work to tight deadlines.	Interview

	• Excellent communication skills to fully capture the patient and service user experience and relay important information to teams. • Ability to work as part of a team and on own initiative. • Ability to develop good working relationships with officers of various grade and professions. • The flexibility to work in a changing environment. • Ability to identify problems and recommend appropriate solutions.	

DESIRABLE CRITERIA		
Desirable criteria will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these. Failure to do so may result in you not being shortlisted.		
Factor	**Criteria**	**Method of Assessment**
Experience Qualifications Registration	• Experience of undertaking audits.	Shortlisting by Application Form
Other (e.g. Knowledge Skills Abilities)	• A knowledge of the NHS Classic Safety Thermometer and Medications Safety Thermometer.	Shortlisting by Application Form / Interview

NOTE:
Where educational/professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates *and* one photocopy of same issued by the appropriate authority. Only those certificates relevant to the shortlisting criteria should be produced. If educational certificates are not available an original letter *and* photocopy of same detailing examination results from your school or college will be accepted as an alternative.

If successful you will be required to produce documentary evidence that you are legally entitled to live and work in the United Kingdom. This documentation can be a P45, Payslip, National Insurance Card or a Birth Certificate confirming birth in the United Kingdom or the Republic of Ireland. *Failure to produce evidence will result in a non-appointment*.

Where a post involves working in regulated activity with vulnerable groups, post holders will be required to register with the Independent Safeguarding Authority.

HSC Values

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role

What does this mean?	What does this look like in practice?
Working together We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibilty of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible.
Excellence We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone to help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice.
Compassion We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and wellbeing so that I can care and support others.

University College London Hospitals
NHS Foundation Trust

Job Description

Job title:	Patient Advice and Liaison Service Officer
Division:	Corporate Nursing
Board/corporate function:	Chief Nurse Division
Salary band:	Band 5
Responsible to:	Head of Patient affairs
Accountable to:	Deputy Chief Nurse
Hours per week:	37.5
Location:	Trust wide, UCH, NHHN sites

University College London Hospitals NHS Foundation Trust

University College London Hospitals NHS Foundation Trust (UCLH) is one of the most complex NHS trusts in the UK, serving a large and diverse population.

We provide academically-led acute and specialist services, to people from the local area, from throughout the United Kingdom and overseas.

Our vision is to deliver top-quality patient care, excellent education and world-class research. We provide first-class acute and specialist services across eight sites:

- University College Hospital (incorporating the Elizabeth Garrett Anderson Wing)
- National Hospital for Neurology and Neurosurgery
- Royal National Throat, Nose and Ear Hospital
- Eastman Dental Hospital
- Royal London Hospital for Integrated Medicine
- University College Hospital Macmillan Cancer Centre
- The Hospital for Tropical Diseases
- University College Hospitals at Westmoreland Street

We are dedicated to the diagnosis and treatment of many complex illnesses. UCLH specialises in women's health and the treatment of cancer, infection, neurological, gastrointestinal and oral disease. It has world class support services including critical care, imaging, nuclear medicine and pathology.

Job Purpose

The Patient Advice and Liaison Services have been established in every Trust to deal impartially with patient and public concerns on the spot and to try and resolve issues before they become more serious. PALs also provides information on Trust services to assist with the flow of contacting the NHS and acts as an entry point for people wishing to participate in patient and

public involvement. PALs acts as a catalyst for change within the NHS and uses the information from its work to effect service change and improvement.

To provide a point of contact for patients, carers and relatives in order to provide information to resolve problems and make referrals to other services in a timely way.

The PALs facilitation team consists of 4.6 PALs officers and a Lead who also has responsibility for other services as indicated. The facilitation team operates across all sites of the Trust and liaises on a day to day basis with both patients and staff at all levels in the organisation.

Key Working Relationships

Nursing corporate. Complaints team. Patient experience. All wards and departments.
Identify the reporting arrangements and job titles of the posts directly reporting to the post holder; indicate whether there is a full line management, or supervisory responsibility.
Specify other major working relationships and liaison with any other departments or external agencies.

Key Results Areas

The primary responsibilities of the post holder. The focus should be on results rather than activities. There should be between 3 and 6 key result areas or perhaps more if the job is very senior.

Main Duties and Responsibilities

- To facilitate efficiently the concerns of patients who contact PALs, by providing a professional and empathic service in accordance with agreed PALs procedures.
- To ensure patients/public receive appropriate and accurate information and assistance in respect of internal/external services, by handling enquiries in accordance with agreed PALs procedures.
- To enable the active involvement of patients/public, by identifying projects/groups which may be appropriate to their expertise, and to identify potential PALs link patients who may be willing to assist in the work of the PALs service.
- To increase patient satisfaction/ resolve problems by handling a portfolio of casework at varying levels without supervision, working collaboratively as a member of the facilitation team.
- To have a high degree of awareness and judgement to balance the requirements of client confidentiality and the need to escalate issues relating to safeguarding etc.

Communication

- To achieve resolution of patient problems brought to the service by negotiating with Trust medical, nursing, administration staff at all levels, and assisting to broker a solution.
- To ensure that staff across the Trust are aware of PALs and how patients can access the service, and that they feel supported by the service with patient issues. This is achieved by building and maintaining good working relationships with clinical and non clinical staff across directorates and their boards.
- To assist patients in a manner appropriate to their needs by analysing their problem, assessing their individual requirements and action their requests in an appropriate manner in accordance with PALs procedures.
- To ensure that those PALs contacts that request and/or need it are referred to specialist advocacy by utilising accredited and appropriate agencies in line with PALs procedures.
- To provide support for patients wishing to make a complaint about Trust services by providing information about the complaints procedures.
- To ensure that PALs link patients and Trust staff and are appropriately supported and their feedback recorded by maintaining regular contact with them. The frequency of such contact is to be patient led.
- To deliver ward and departmental surgeries so that patients/relatives/carers and Trust staff can more readily access PALs.
- To prepare and deliver presentations about PALs to Trust staff and outside agencies.

Quality

- To deal with PALs contacts in line with the agreed PALs time scales to ensure compliance with PALs standards
- To be responsible for recording all contacts in line with agreed time scales and in the agreed manner, enabling PALs to report in a timely fashion on contacts within the service.
- To maintain up to date knowledge of Trust policies, procedures, guidelines and services.
- To maintain knowledge of the role of the PALs service in the Trust majax procedure. To ensure that no person who contacts PALs will receive less favourable treatment from PALs on the grounds of their sex, marital status, race, colour, creed, religion, physical disability, mental health status, learning difficulty, age or sexual orientation.
- To receive regular supervision and appraisal with designated senior PALs officer, to increase self-awareness, ensure alignment of objectives with Trust values and goals, and towards professional and service development.

Administration

- To enable the PALs service to correctly identify possible improvements by maintain accurate, complete and timely records of PALs contacts using Datix Web database.

Planning and Organisational skills

- To assist the senior PALs officers with clinical board reports and contribute to meetings as required, to highlight issues of patient concern, working with them to develop and implement action plans to improve services.
- To assist colleagues in feeding back issues and suggestions for improvement to divisions.

Most difficult aspects of the job

- Providing an effective and consistent service to all individuals who contact PALs given that the quality and complexity of the caseload handled by each officer will vary from day to day.
- To be responsible for analysing situations and be able to negotiate/mediate successfully and impartially between staff at all levels and individuals who may be volatile/distressed/aggrieved.
- Balancing the needs/requirements of individual patients with the capacity/capability of the Trust and achieving positive outcomes.

Other

The job description is not intended to be exhaustive and it is likely that duties may be altered from time to time in the light of changing circumstances and after consultation with the post holder.

You will be expected to actively participate in annual appraisals and set objectives in conjunction with your manager. Performance will be monitored against set objectives.

Our Vision and Values

The Trust is committed to delivering top quality patient care, excellent education and world-class research.

We deliver our vision through values to describe how we serve patients, their families and how we are with colleagues in the Trust and beyond.

We put your safety and wellbeing above everything

Deliver the best outcomes	Keep people safe	Reassuringly professional	Take personal responsibility

We offer you the kindness we would want for a loved one

Respect individuals	Friendly and courteous	Attentive and helpful	Protect your dignity

University College London Hospitals
NHS Foundation Trust

We achieve through teamwork

Listen and hear	Explain and involve	Work in partnership	Respect everyone's time

We strive to keep improving

Courage to give and receive feedback	Efficient and simplified	Develop through learning	Innovate and research

University College London Hospitals
NHS Foundation Trust

Person Specification

Essential defines the minimum criteria needed to carry out the job and the job cannot be done without these

Desirable refers to criteria not essential and which successful applicants would be expected to acquire during their time in post. The desirable requirements are not taken into consideration in a job evaluation panel.

Requirements	Essential	Desirable	Assessment Criteria			
			A	I	R	T/P
Knowledge and Qualifications • Educated to degree level, or equivalent medical / nursing qualification/ experience. • Knowledge of Independent advocacy, data protection, complaints process, safeguarding, freedom of information, equal opportunities, disability discrimination, majax procedures, informed consent.	**E** **E**		**A**	**I** **i**		
Experience • Significant experience of dealing with public face to face in a variety of situations • • Experience of working in health care settings. • Experience of dealing with difficult or volatile situations.	**E** **E** **E**		**A** **A** **A**	**I** **I**		

• • In depth experience of workings of NHS/ Social care including funding streams and patient flow. • Substantial experience of handling case work.		D D	A A			
Requirements	**Essential**	**Desirable**	**Assessment Criteria**			
			A	**I**	**R**	**T/P**
Skills and Abilities • Communication and customer care • Ability to assimiliate and analyse and precis complex information and make sound judgements • Ability to balance patient expectations and Trust capacity/ capability and achieve resolution • Personal and People Development • Advanced conflict resolution skills including mediation and negotiation • Ability to liaise and work effectively with staff and public at all levels. • Ability to motivate and influence at all levels. • Ability to think laterally and find innovative solutions acceptable to all parties. **Quality and service improvement** • Ability to prepare data and presentations for a range of audiences. • Demonstrate commitment to patient	**E** **E** **E** **E** **E** **E** **E** **E** **E**	**D**	**A**	**I** **I** **I** **I** **I** **I**	**R** **R**	

care • Attention to detail • Demonstrate commitment to Trust Values and objectives linked to these in practice, and through appraisal and supervision. **Information processing/ IT skills** • Well developed computer skills and use of WP packages • Working knowledge of Datix web client rich database. • Ability to interrogate databases	**E** **E**					
Personal qualities • Excellent team working with ability to work unsupervised and to escalate concerns to senior PALs officer for advice when needed. • Ability to investigate and solve problems. And queries using own initiative. • Ability to plan and organise own workload effectively to meet deadlines in the short and long term. • Ability to deal tactfully and discretely with confidential and sensitive matters.	**E** **E** **E** **E**	**A** **A**		**I** **I** **I**	**R** **R**	
Specific Requirements Able and flexible to work at different Trust sites according to service need and requirements.	**E**			**i**		

A= Application I= Interview R= References T/P = Test/Presentation

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 9th March 21
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview:

Provide SMT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Key Issues / Risks for SMT Consideration:

- 88 Ongoing SAI's – 29 Acute, 44 MHD, 11 CYP, 4 OPPC
- 2 New SAI Notifications

Reference Personal Information HSCB Ref: Personal Information redacted by the USI patient transfer issues re CAH and -RVH Patient in CAH for renal biopsy. Patient bled post procedure, requiring extensive resuscitation. The patient allegedly transferred to RVH without an agreed specialty bed to go to. Patient was transferred and experienced an acute deterioration. Patient remains in critical care unit in RVH.Review will consider learning in relation to transfer process to Regional Centres and review of criteria of what support is provided during transfer to Regional Centre.

Reference Personal Information redacted by the USI Patient to Patient assault-aggressor has been detained and receiving psychiatric inpatient support. Review to establish learning in relation on how to identify high risk/aggressive patient potential and placement of this cohort as well as learning re local response and management.

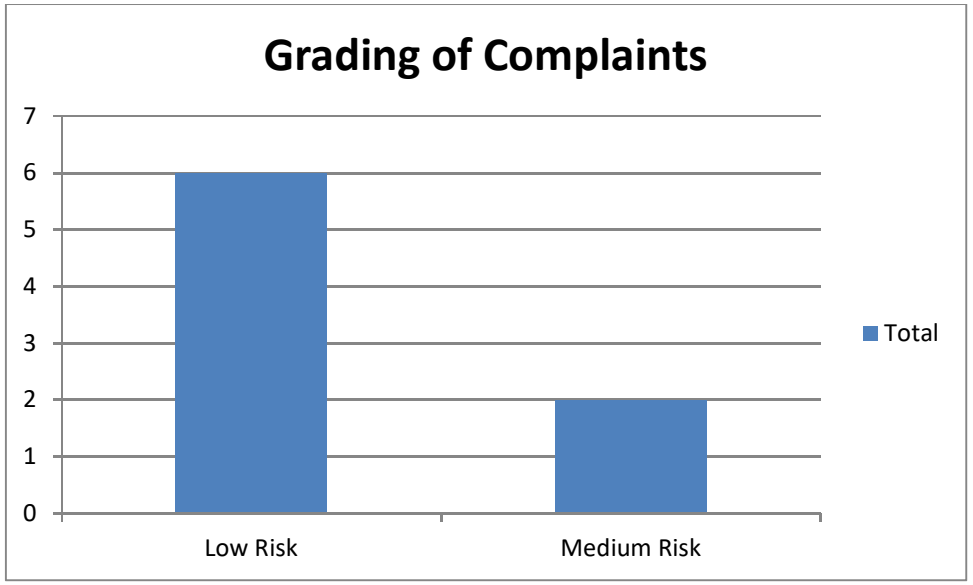
- Meeting arranged to Discuss EGR's at St Andrews Hospital who has provided care to SHSCT patients in the recent past-(UK based centre which has had recent poor performance against CQC standards.)
- 1 New Negligence Claim re alleged delay in diagnosis
- 6 Preliminary Hearings Scheduled in March 2 re self-harm, 2 re unexpected death and 1 re fail/delay in treatment
- 3 Medication Incidents
- 8 Responses sent to HSCB for Safety and Quality Reminders

Outcome of SMT Discussion:

Summary of Weekly Governance Activity 22.02.2021 - 28.02.2021

	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAI's Notification's	2	0	0	0	2
SAI Reports submitted to HSCB	0	0	0	0	0
Ongoing SAI's	29	44	11	4	88
High Risk Complaints	0	0	0	0	0
NIPSO Case Accepted for Investigation	0	0	0	0	0
NIPSO Draft Reports Received	0	0	0	0	0
Early Alerts	0	0	0	0	0

Grading of Formal Complaints Received 22.02.2021 - 28.02.2021



ACUTE DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

1. **Status of SAI's -** Summary of the status of SAI's between 22.02.2021 - 28.02.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3	Total
2	13	4	10*	29

*9 of the level 3 cases are the Urology SAI's

2. **SAI Notification**

Datix ID	Incident Date	Date reported to HSCB	SAI Description
Personal Information	26/02/2021	02/03/2021	Patient transferred from DHH to CAH for renal biopsy. Patient bled post procedurally into the renal tract requiring extensive resuscitation. The patient subsequently improved and the plan changed resulting in the patient being transferred without an allegedly agreed specialty bed to go to. Patient was transferred to urology ward post procedure and experienced an acute deterioration. He was subsequently taken to theatre to be intubated and ventilated. Patient remains in critical care unit in RVH. Relates to interface incident HSCB Ref: Personal Information
Personal Information	11/02/2021	02/03/2021	On Irrelevant redacted by the USI the patient assaulted another patient on the ward. Security and police were immediately contacted to attend. Once medically fit the patient was transferred to Beachcroft Child and Adolescent Mental Health Unit Belfast.

3. **NIPSO**

- Personal Information Accepted for investigation, Chief Executive apology letter issued to complainant.

4. **Interface Incident**

Received BHSCT Ref Personal Information: 2 Swabs lost for child in Blossom – Update –no record of the first swab. The second swab was taken, but was not requested for a rapid Cepheid by patient flow and so was processed by seegene. This result was available– however the report is against a patient record without a HCN and so is not available on NIECR. The HCN record in LABS brings up 'Infant XX, this should have been merged.

5. Issues escalated by Corporate or Directorate office at meeting

Complaint Received 25/02/2021 Personal Information –Patient attended ED Oct 2020 and had CXR which advised further CT. This was not done and patient represented in Dec 2020. CT carried out and detected lung mass.. To be brought forward to next week for update

Datix ID	Incident Date	Description
Personal Information redacted by the USI	22/02/21	CAH Trauma Ward - IV hydrocortisone reducing dose regime prescribed in 'Once only' medications section on back of Kardex by Anaesthetist. 4 doses missed by 3 different staff nurses. Head of Service is investigating the omission of critical medications.
Personal Information redacted by the USI	23/12/20	DHH ED - Personal Information old Anterior STEMI who had a significant delay in transferring from ED DHH to RVH cath lab due to delay in NIAS, review suggested a datix to enable an interface response from NIAS, Intertrust incident to be submitted NIAS
Personal Information redacted by the USI	27/02/21	DHH ED - Found white tub with foetal products presentED and and Lab HOS are investigating. Products later identified and given to family.
Personal Information redacted by the USI	24/02/21	**Recovery CAH - Patient out of theatre @ 1850hrs following Subtotal Colectomy.** 1930hrs became unresponsive after rolling and skin check, breathing became shallow and tachy 111bpm- sign of Local anesthetic systemic toxicity **Anaesthetic Head of Service .**
Personal Information redacted by the USI	24/10/20	patient attended ED 10/2020. CXR completed and discharged homeCXR report advised urgent CT Chest and follow up. This was not done and patient represented in Dec 2020 and malignant mass detected after CT.Update to be provided 11/03/2021

MENTAL HEALTH AND DISABILITY DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

6. Status of SAI's

Summary of the status of SAI's between 22.02.2021 - 28.02.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3 – No timescale	Total
17	22*	3	2	44

***Await approval from HSCB re De-escalation request for SAI** Personal Information redacted by **and** Personal Information redacted by

7. Issues escalated by Corporate or Directorate office at meeting

22nd March Meeting set up to discuss EGR's at St Andrews Hospital who has provided care to SHSCT patients in the recent past-(UK based centre which has had recent poor performance against CQC standards.)

CHILDREN AND YOUNG PEOPLE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

8. Status of SAI's

Summary of the status of SAI's between 22.02.2021 - 28.02.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

Less than 26 weeks	More than 26 weeks	Within Timescales	On Hold	Total
5	3	2	1	11

The CYPS Governance Team is in regular contact re: the 1 SAIs which are currently on hold.

9. Issues escalated by Corporate or Directorate office TBC at meeting

OLDER PEOPLE AND PRIMARY CARE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

10. Status of SAI's

Summary of the status of SAI's between 22.02.2021 - 28.02.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

More Than 26 weeks	Within Timescale	Less Than 26 Weeks	Total
2*	0	2	4

*1 SAI's is currently with Safeguarding and 1 is currently in disciplinary process

11. Issues escalated by Corporate or Directorate office TBC at meeting

Early Alert to be raised for incident in Care Home in relation to the incorrect family being contacted in relation to a dying patient.. . Member of staff involved was put on special measures and has since left the NH. Numerous apologies have been provided to family which have been accepted.

LITIGATION

12. New Clinical negligence

There were no new clinical negligence claims received: 22/02/2021 – 26/02/2021

13. Clinical Negligence Claims Listed for Hearing in January 2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
Irrelevant redacted by the USI	ACUTE	SEC	Failure to diagnose/delay in diagnosis	Personal information redacted by USI	25/04/2014	16/05/2014	Listed 22/03/2021 for 3 days. Alleged delay in diagnosis resulting in the patient having a bowel removed.

14. Vaginal Mesh Cases

The Trust has 17 open cases where the allegations relate to vaginal mesh.

Stage	Number of Mesh Cases
Letter of Claim	**1**
Discovery	**4**
Investigation	**8**
Proceedings Issued	**3**
Trial date Set	**1**

A trial date of 17th May 2021 has been set for one of the cases. This is the first case regionally to reach a trial date. LPP Information redacted by the USI [redacted]. Updates will be provided as the case progresses.

15. Urology Cases

Due to the announcement by the Minister for Health that a public inquiry is to be carried out in relation to the work of a Urology Consultant who was employed the Trust it is anticipated that there will be an increase in related medico-legal requests and litigation cases. To date no new medico-legal requests have been received which specifically refer to this matter. 1 litigation claim has been received which may be linked to this matter.

16. Coroner's Inquiries and Inquests

There were no new Coroners Inquiries received 22/02/2021 – 26/02/2021

There are currently no Full Inquest Hearings listed for hearing in March 2021

The following preliminary Inquest Hearings are scheduled in March 2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
Personal	MHD	MHS	Self Harm	Personal Information redacted by USI	30/07/2019	30/07/2019	**Preliminary Hearing - 08/03/2021 @ 1pm** Person died of suicide by hanging
Personal Information redacted by the USI	CYP	SOCIAL	Self Harm	Personal information redacted by USI	04/07/2019	04/07/2019	**PH 04.03.2021** The deceased known to the Trust's Gateway
Personal Information	ACUTE	SEC	Unexpected death	Personal information redacted by USI	30/04/2017	02/05/2017	***Proposed hearing date 19-23 April 2021*** **** Preliminary Hearing 03/03/2021**** The Coroner directed a post mortem in this case and the preliminary finding is multi-organ ailure, probable peritonitis and intra-abdominal haemorrhage following laparoscopic cholecystectomy.
Personal Information redacted by the USI	MHD	MHS	Unexpected death	Personal information redacted by USI	08/02/2018	08/02/2018	***** Preliminary Hearing Thursday 18th March 2021 at 10.00***** .*The deceased attended ED CAH via He was referred for psychiatric review in ED and was seen by Home Treatment Crisis Response who carried out a medical health assessment in the Clinical Decision Unit a management plan was put in place and he was discharged. Pt deceased the next day by suspected suicide
Personal Information redacted by the USI	ACUTE	MUC	Fail/ Delay Treatment	Personal Information redacted by the USI	11/05/2018	11/05/2018	*** PH on 03 March 2021 @ 1.15pm *** The deceased was Personal Information old and was admitted to CAH Via Ambulance with imaging consistent with as left hemispheric strokeDelay in diagnoses
Personal Information redacted by the USI	ACUTE	SEC	Unexpected death	Personal Information redacted by USI	09/01/2019	09/01/2019	Preliminary findings, 1A: Small Bowell Perforation, 1B:Strangulated Hernia II: Diabetes Mellitus II; Hypertension; Chronic Obstructive Airways Disease;Congestive Heart Failure.

17. Number of Subject Access Requests exceeding timeframe for completion.

The Medico-Legal Team are unable to comply with the General Data Protection Regulations (GDPR) 2018 in respect of responding to Subject Access Requests within the statutory time-frames. This had been due to the sheer volume of requests (which had increased by approx. 1000 per year) and a lack of staffing to cope with the demand. The Governance Committee have been advised of the ongoing back-log; it has been brought to the attention of the Trust's SIRO and placed on the HROD Risk Register. An application was made to the Strategic Investment Committee for additional funding for staff. This was considered by the Strategic Investment Committee on 27th July 2020, and approval was provided in principle. Finance are now seeking to identify a recurring funding stream for these posts.

There is currently a back-log 243 requests that are in excess of 90 days across the following areas:-

Directorate	Acute Services	MH&D	C&YP	OPPC	TOTAL
Number of Outstanding Requests	177	36	23	7	243
New requests opened 22/02/2021 – 26/02/2021	33	2	2	0	37

The back-log has increased slightly from the previous week, the week-end days are included in counting towards the 90+days and therefore impacts on the work carried out during the week. As outlined previously, the reasons for back-log include (in addition to the staffing and volume issues) - difficulties accessing notes and records, and issues relating to redaction and consent to release.

MEDICATION INCIDENTS

18. Medication Incidents between 22.02.2021 - 28.02.2021

Medication Incidents between 22.02.2021 - 28.02.2021	
Personal Information	Staff witnessed halving lorazepam tablet and putting one half in the medication dispensing pot and the other half in her pocket.
Personal Information	It appears that a New Vaccinator while under supervision this morning drew up 2 doses of air instead of vaccine. It appears The vaccinator administered air to the 2 patients. The 2 patients have been identified and advised. Additional doses provided. Vaccinator placed under clinical supervision
Personal Information	Resus Patient, GCS 7, unclear history, seizures. Pre intubation check by consultant, Desat during intubation. Following intubation noted that C-Circuit attached to Medical Air, not O2 supply. Medical air flow-meter has flap covering Christmas tree nozzle and was functioning. Await clarification of incident 11/03/2021

SAFEGUARDING

19. Link to SharePoint site regarding RQIA Notifications/Alerts

http://sharepoint/pr/perfimp/scc/_layouts/15/WopiFrame.aspx?sourcedoc=/pr/perfimp/scc/RQIA%20Notifications%20and%20Alerts/Alert%20Notice%20Board.xlsx&action=default

Current Adult Protection Investigations where there are interfaces with other processes					
	SAI	Complaint	Coroner	Litigation	Potential High Profile
MHD	2				3
OPPC	1	1	1		
Acute		2			

20. 2 Ongoing SAI in MHD where adult protection investigation was undertaken

1 ongoing complaint in OPPC where adult protection investigation has been closed. Meeting with family arranged for February.

2 adult protection investigations in Acute where there has also been a complaint. Closed

3 adult protection investigations ongoing in Acute related to pressure care.

Personal Information redacted by the USI Care Home – care and governance issues are ongoing and individual adult protection investigation is ongoing (timeline for completion 3-4 months). SHSCT are writing to RQIA to address the concerns that have been raised. Pre contract meeting has been held within the Trust before the meeting is held with Personal Information redacted by the USI Care Home

1 Ongoing Adult Protection Case

INFORMATION GOVERNANCE

21. Number of Subject Access Requests exceeding timeframe for completion.

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	9	-	11	19	-	-	1	-

These relate to Subject Access Requests which have not been completed within the legislative timescale (legal timeframe 30 days or 90 days for complex requests). These delays are in relation to the demands on Services to carry out redactions of these notes etc. In some cases there are requests which were made in 2019 and have not been progressed. In the last three months we have received three different complaints from the ICO in relation to the time taken to respond to requests.

22. Data Breaches reported to the ICO

Directorate	ACUTE	OPPC	MH&D	CYPS	FINANCE	P&R	HROD	CX
Breaches	-	-	-	-	-	-	1	-

There has been one data breaches reported to the ICO in this period. This is in relation to lost records; the Trust is awaiting a response from the Information Commissioners office. There has been one complaint received from the ICO in this period in relation to the time taken by the Trust to respond to a Subject Access Request and failure to explain redaction of notes.

NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED

23. Responses Due and Sent.

Title of Correspondence	Full Implementation Date for S&G	Directorates applicability
OPS and AS - Care Home Admission and Initial Review	Response Due 18/09/2020 – Working group meeting arranged for Friday 29th January HSCB requesting response on Action 2	OPPC
Care of Women Presenting with Post-Menopausal Bleeding	HSCB requesting response on Action 3	Acute OPPC
Process to be Followed When Preparing Syringes for Final Administration of the Pfizer Biontech Vaccine	Response Due 04/03/2021- Response sent 03/03/21	Acute, CYPS
Reissued Thrombolysis	Response Due 03/03/2021 - Extension requested	Acute,
Accessing Supported Accommodation	Response Due 03/03/2021 - Response sent 03/03/21	CYPS, MHD,
Emergency Management of Hyperkalaemia	Response Due 03/03/2021 - Response sent 03/03/21	Acute, OPPC
Delayed Diagnosis of Diabetic Ketoacidosis and Type 1 Diabetes in Children - Linked to previously issued letter SQR-SAI-2019-051	Response Due 03/03/2021 - Response sent 03/03/21	Acute, OPPC, CYPS

Maternity and Screening Revised Supersedes letter of 17 June 2020	Response Due 03/03/2021 - Response sent 03/03/21	Acute,
Planned Colonoscopy	Response Due 03/03/2021 Extension requested	Acute,
Risk of Serious Harm or Death from Choking on Foods	Response Due 03/03/2021 - Response sent 03/03/21	Acute, OPPC, CYPS
Revised Letter Unplanned Re-Attenders to the Emergency Department	Response Due 03/03/2021 – Response sent 03/03/21	Acute, CYPS
Safe Storage of Epidurals and Checking Processes for the Administration of Controlled Drug Infusions	Response Due 03/03/2021 - Response sent 03/03/21	Acute

24. Work Ongoing

- Safe use of Valproate in women of childbearing potential (HSC (SQSD)19/17 and HSS(MD) 8/2018)
  The planned meeting on 25/01/2021 has been cancelled due to COVID-19 surge pressures but the chair of the group, Dr Catherine Coyle (PHA) plans to have email discussions with the regional working group members in order to progress some of the ongoing work plan actions. Dr McKnight will share by email the SHSCT proposal for using an NIECR alert in the hope a regional consensus will be agreed.
- Care of women presenting with post-menopausal bleeding – On 15/01/2021 the HSCB responded to the SHSCT query regarding recommendation 3 – this has been sent on to the Clinical Directors and AD for IMWH for review – awaiting response to confirm if the clarity provided by the HSCB is suffice.

25. Safe storage of epidurals and checking processes for the administration of Controlled Drugs Infusions - The MDT (led by Dr Merjavy) have reviewed the alert recommendations but have a few queries in relation to auditing the Trust's current systems in processes. Whilst an audit is planned and underway to audit safe storage of epidurals under the requirements for managers, the MDT would appreciate guidance on how the staff checking responsibilities, as outlined under requirements under current guidance, can be practically undertaken.

26. S&G Received

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
Use of Plastic Bags on Mental Health In-Patient Wards	24/02/2021	LL-SAI-2018-033 (MH)	Safety and Quality Learning Letter	n/a	**18/03/2021**
UPDATE Advice for Carers and Young Carers during Covid-19 Pandemic	22/02/2021	n/a	COVID	n/a	n/a
UPDATE COVID-19 Therapeutic Alert Interleukin-6 Inhibitors (Tocilizumab or Sarilumab) for Hospitalised Patients with Covid-19 Pneumonia (Adults)	19/02/2021	HSS(MD) 21/2021	CMO Letter	n/a	Actions Required
COVID-19 Vaccines Weekly Publication of Yellow Card Safety Data	19/02/2021	HSS(MD) 20/21	CMO Letter	n/a	n/a
DoH Restraint and Seclusion Policy Definitions	18/02/2021	n/a	DOH Correspondence	n/a	**05/03/2021**

27. Regional PIVFAIT Audits

CAH	5/5 = 100%
DHH	1 / 2 =50% (non-compliant for indicators 1 (Patient identification), 2 (Glucose Monitoring), 4 (Cumulative input and output totalling and fluid balance) & 8 (Electrolyte monitoring) No action plan received.
ACUTE	1 case identified from last week - now excluded as aged 16yrs

Outstanding cases to review –6 cases, all ATICS - Sr Sherry. Await returns from CAH & DHH ED , Trauma.

AOB

28. PPE Incidents – There is currently not enough information provided within the Datix incidents to provide sufficient detail in relation to PPE.


PPE Report.xlsx


PPE Report by Coding.xlsx

29. NIPSO enquiry received 02/03/2021 re administration of vaccine complaint, information from HROD with NIPSO, awaiting decision.

Attendees: Nicole O'Neill, Caroline Doyle, Connie Connolly, Caroline Beattie, Catherine Weaver, Tony Black, Marita Magennis, Rebecca Murray, Dr O'Kane, Claire McNally, Joanne Bell, Deborah Hanlon, Patricia Kingsnorth, Jilly Redpath, Damian Gormley, Lauren Weir

Apologies: Lynne Hainey, Aaron Byrne

Southern Health and Social Care Trust

Chief Executive – Medical Director
1-1 Meeting
5th May 2021

	Item	Attachment
1	**Urology Update SAIs** • Final SAI's have been issued to the HSCB and shared with GMC. Copies are being sent to the DoH this week. Final family who suffered a bereavement has responded requesting amendments to the report (attached, being considered by SAI chair • QIP structure for Urology and Cancer services agreed. Terms of Reference being finalised this week. • Trust is pursuing ISP support for expediting patient reviews • Additional SME obtained by the Trust to support Prof Sethia review • Additional SME obtained by the Trust to conduct SCRR	Summary of Patients under the care of AO SAI Review - Patient 9 Family.docx
2	**Urology Public Inquiry** • Lookback Guidance – DoH have agreed this requires discussion at the UAG. DoH not opposed to Trust operating outside of this in the circumstances however will seek assurance that alternative arrangements are safe. • Stephen has met with Heather to form an oversight assurance mechanism, this will be presented next week. ***Resourcing*** • Fiona Davidson (8B) will be working 2 days per week overseeing work to deliver on the recommendations. This may increase to 4 days from June. • There will be a requirement to secure QI input for this work as an action plan develops • Meeting with NHS England Cancer Services peer review team to take place in next weeks to identify supports for external peer review	Regional Guidance for Implementing a Lc Policy for Implementing a Lookb
3	**Mental Health and Learning Disability** • Mental Capacity Act update • Update on regional MHLD challenges	DoLS Response 28.04.2021.docx
4	**Infection Prevention and Control** • Role of the DIPC – potential for this to be a nurse lead. Consideration of banding of this post	

5	**Nosocomial COVID-19 Mortality** • Process agreed and endorsed by regional group as the basis for all reviews. MDO team are currently gathering data to support this process	Nosocomial COVID-19 Deaths Mo
6	**Medical Leadership Proposal** • Original date delayed due to discussion with HR on T&Cs for the DMD posts, finalising Management Allowance and taxable implications • Identification of 3rd Deputy Medical Director post – Professional Governance / Appraisal and Revalidation	
7	**Appraisal, Revalidation and Annual Management Reviews for Doctors** • Monthly DMD Revalidation Oversight Group has been established to inform revalidation recommendations. • Update on the discussion with UHB further meeting planned for April – potential for Annual Management Reviews to complement A&R processes. Proposal to be develop regarding implementation of the new model. Meeting with UHB DMD Dr Nick Murphy to take place this week.	Medical Revalidation Oversight Group ToR
8	**Individual Performance Review** • Shane to discuss what will be required for IPR re Medical Director	FW IPR's.msg
9	**Hyponatraemia** • Paediatric / Surgery paper finalised • Hyponatraemia 8B appointed – David Calvin successful applicant. Post Commences being of May 2021 • Recommendation stocktake event took place at the start of April – successful outcome	Principles for the Management of Surgi
10	**SAIs in Care Homes** • Communication from Rodney Morton re management of outbreaks – challenges present, response to be issued	RE Letter re SAI Procedures .msg Personal Information Letter re SAI Procedure.pdf
11	**Crowe SAI** • Update	
12	**GMC Standards – Compliance re Surgical Rota**	
13	**MDO risk register** • Meeting to update to take place	
14	**COVID-19 Level 3 SAI Update** • Outcome of Site Visit	

15	**Obs and Gynae** • Whistleblowing Update • DHH meeting Update • Donna Ockenden Meeting 13th May 2020 • RCOG Discussion	Personal Information redacted by the USI .pdf
16	**Cervical Cytology Service** • Proposal paper • Contact made to PHA re funding	Cervical Cytology Service Position pape
17	**CSCG Staffing Proposal Update** • Two posts are commencing recruitment this month – 8a Patient Safety and 7 Patient Safety Strategy Lead • Connie retiring in July, 8B replacement post being advertised • Proposal for ringing CSCG under corporate leadership in development paused	Phase Plan.docx
18	**Unscheduled Care Centre Governance** • Clinical Governance for the UCC will sit with ED. • Meeting last Friday	
19	**NEWS2** • NEWS2 Now live from 1st May 2020	
20	**Structured Judgement Review** • SJR Training took place on the 18th and 25th March. 20 Trust doctors were trained, the training model is designed for cascade training. • John Simpson has completed his SJR review of Mental Health cases – findings to be shared with the HSCB for consideration of regional adoption.	
21	**Learning from Experience Update** • Attached	Gov Committee Lessons Learned Upd
22	**LNC Meeting 6th May 2020** • SAS Grade and Appraisal • Medical Leadership Review • Revalidation Oversight Meeting	
23	**Weekly Governance Report** • 24.04.2021 Report	Weekly Governance Report 19.04.2021 -

Patients under the care of Mr O'Brien and currently in process of being reviewed
15 April 2021

	Patient Group	Number of Episodes/Patients in Group	Reviewed to date	Reviewed by	Remaining to be reviewed	Reviewed by	Provisional date	Quality Assured	Comment
Administrative Review Only	***Elective Cohort***	*352 Patients*	*352 (Administrative Review)*	*M Corrigan*	*0*	*Needs Clinical Review*	*N/A*	*No*	***All** are part of the 2309 patients required reviewed between Jan 2019 – Jun 2020.* ***Review to date only considered administrative processes***
	Emergency Patients (Stents)	*160 Patients*	*160 (Administrative Review)*	*M Corrigan*	*0*	*Needs Clinical Review*	*N/A*	*No*	***All** are part of the 2309 patients requiring reviewed between Jan 2019 – Jun 2020* ***Review to date only considered administrative processes***
	Radiology Results	1025 Patients (1536 Episodes)	511 (Result Review)	CNS	1025	Professor Sethia	May 2021	No	
	Pathology Results	150 Patients (168 Episodes)	168 (Result Review)	M Haynes/D Mitchell	0	N/A	N/A	Yes	
	Oncology Reviews (IS)	236 Patients	200 (Face to Face ISP)	P Keane	36	M Haynes	May 2021	No	
	Post MDM	187 Patients (271	271	Prof Sethia	52 (need	M Haynes	May 2021	No	

	Patients	Episodes)	(SME Record Review)		second opinion)				
	Review Backlog	511 Patients (509 Episodes)	40 (Virtual Clinics)	M Haynes	471	M Haynes/T Glackin	June 2021	No	
	Information Line	154 Patients	6 (reviewed at clinic)	M Haynes	148	Prof Sethia	June 2021	No	
	Patients prescribed Bicalutamide	933 Patients	747 (Record Review, 26 Face to Face Reviews)	M Haynes	186	M Haynes	May 2021	No	
	Patients on Inpatient Waiting List for TURP	143 patients	0	TBA	143	Clinical Team	June 2021	No	
	Total	**4321**	**2455**		**1918**				

- Note there were a total of 2309 patients that have been identified as being under Mr O'Brien's care from January 2019- June 2020, and a number of the above have been identified as being in this cohort of patients with multi episodes, more work is being done to identify how many of these are not included in the above groups with first look at this it may appear to be in and around another 1000 patients in this group that are not included in the above

To all concerned,

We would like to advise the Trust, the Board and the Department that we are not satisfied with the findings within the report as we feel it does not capture a complete and true representation of the care that our father, Patient 9, our mothers' husband of 49 years, received from the Health and Care system since May 2019.

Furthermore, we feel that we have been put under undue pressure to respond to this report. The first zoom call we had with the Trust, on 19th February 2021, was within days/weeks of being advised of Patient 9, our father's terminal diagnosis. During that call, we were advised we would have 2 weeks to respond to the initial report. This time should have been focused on providing better end of life care to our husband/ father to enable Patient 9, our father to be as comfortable as possible so that he/we could enjoy whatever time he had left with his family. The second call, on 21st April 2021, was within weeks of the premature death of Patient 9, our father. During this call we were asked to respond as quickly as possible. We also noted a level of impatience during the call, quoting "yours is only 1 of 9 cases". At present, having lost Patient 9, our father, less than one month ago, we are still grieving and we are again being put under strain to respond within an unrealistic time frame. This report does not consider the impact that this grief has had on our mother or on us together as a family.

We are unclear as to what the Trusts expectations are in respect of a response from us. On both calls we acknowledged that O'Brien was at the centre of Patient 9's /Dad's misdiagnosis however the report clearly states that its aim is to carry out a systematic multi-disciplinary review of the process used in the diagnosis, multidisciplinary team decision-making and subsequent follow up and treatment provided for each patient. Therefore, on each occasion we spoke with the Trust we have expressed our concerns on the care Patient 9 received from the whole HSC system including the Doctors, nurses, the GP, practice surgery receptionist, surgery in house pharmacist, the MDM team and any other Healthcare professional that interacted with our father.

We have pointed out on more than one occasion that the misdiagnosis was the start of the failings experienced by Patient 9, our father but the subsequent follow up treatment was appalling and made a difficult situation even more challenging and frustrating for my father, mother and our entire family. These failings have led to our father and mother being robbed of their twilight years together and throughout the final year of Patient 9s, our fathers, life being subjected to severe pain and suffering from the mistreatment of the whole NHS. Given that we were put into this situation by the trust we would have expected above and beyond care to ensure what time Patient 9, Dad had left would be as comfortable as possible but unfortunately, we did not receive this either. We had to witness our former, strong, and proud father struggle, get weaker and become embarrassed by the situation in was left in. Our Father, a very social man began to refuse calls and visits from family and friends because he did not want anyone to see or hear him the way he was.

Within the report it states that Patient 9/Dad met the 31-day target however we feel that this is completely inaccurate and misleading. There was a delay of 15 months on Dad receiving the correct diagnosis, therefore we would dispute any targets being met in these circumstances.

Within the report it states Doctor 1 reviewed Patient 9 / Dad on the 2nd July and documented suspected cancer and the treatment he recommended to Patient 9/Dads GP however this was to be deferred until review in September. As we now know this review never took place, another failure, however we would like to know why it was deferred initially and why the GP never followed up on this.

The primary duty of all Doctors, Nurses and Healthcare professionals is for the care and safety of patients. Whatever their role they must raise and act on concerns about patient safety. However, we have seen countless failures by several healthcare professionals that first promised to do no harm; The Urology Peer Review 2017 indicated that all patients should have access to a Specialist Nurse. This was not the case and was known to be so however no mandatory audits were put in place, no investigations were opened; The Multi-Disciplinary Team recommendations were ignored however there was no accountability or requirement to follow these recommendations. Again, this practise was known but again no measures were put in place to eradicate these failings. We were also made aware the Mr O'Brien's working style, solo, was widely known within the HSC. However, this was not addressed, concerns were not raised by colleagues and no investigations were initiated by management. It is claimed within the report that management were unaware of these failures which we find unacceptable.

It should also be mentioned about the adverse impact this has had on our mother's health. Our mother has ignored her own health during this, as all her energy was used struggling to get Dad the care that he needed and deserved.

There is much more that we would like included within the report however the timeframe that we have been afforded does not allow for this. The calls we have had with the Trust and the Department have seemed to be centred on the Trusts agenda and have been of little benefit to Patient 9 / Dad or our family however we will continue to work with you on this process to ensure that no other HSC patient receives the same care that Patient 9, our father received.

Yours Sincerely,

Patient's Daughter and family.

Regional Guidance for Implementing a Lookback Review Process

Final Draft

Contents

Regional Guidance for the Implementing of a Lookback Review Process

1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have been exposed/potentially exposed to a specific hazard in order to identify if any of those exposed have been harmed, and to identify the necessary steps to ameliorate the harm (e.g. repeat diagnostic test/ investigation/ referral to relevant clinical service etc.).[1]

This Regional Guidance, along with the accompanying policy document, has been drafted in order to standardise and update the approach taken to Lookback Reviews by the HSC in Northern Ireland. It replaces HSS (SQSD) 18/2007, issued by the Office of the Chief Medical Officer on 8 March 2007.

A Lookback Review is a process consisting of four stages; immediate action including a preliminary investigation and risk assessment to establish the extent, nature and complexity of the issue(s); the identification of the service user cohort through a service review or audit of records to identify those potentially affected; the recall of affected service users; and finally closing and evaluating the Lookback Review Process and the provision of a report including any recommendations for improvement (see summary diagram of Lookback Review Process (Diagram 1) and Lookback Review Process Checklist Appendix 5).

The triggering event or circumstances under which a Lookback Review would be considered include; faulty or contaminated equipment, missed/delayed/incorrect diagnosis relating to diagnostic services, failure of safety critical services or processes, competence issues with a practitioner(s) or identification of a practitioner with a transmissible infection or underlying health problem that may impact on performance (see also Policy on the Implementation of a Lookback Review Policy Section 1 for a more comprehensive list).[2]

[1] Health Service Executive (HSE) 'Guideline for the implementation of a Look-back Review Process in the HSE'. HSC National Incident Management and Learning Team, 2015. Section 7.1 Page 10.
[2] See also 'Policy for the Implementation of a Lookback Review Process' Section 1 Page 3.

The existence of a hazard exposing a number of people to a risk of harm is not always immediately apparent. The triggering event may have been raised as a concern by a service users and/or their family/carers or it may have been highlighted by a service review/audit or it may have come to light as a result of a concern expressed by a colleague or through a Serious Adverse Incident (SAI) Review or Thematic Review undertaken by the Regulation and Quality Improvement Authority. The triggering event will alert the Health and Social Care (HSC) organisation that a number of people may have been exposed to a hazard and the need to instigate a Lookback Review Process should be immediately considered.

1.1 What does a Lookback Review Process involve?

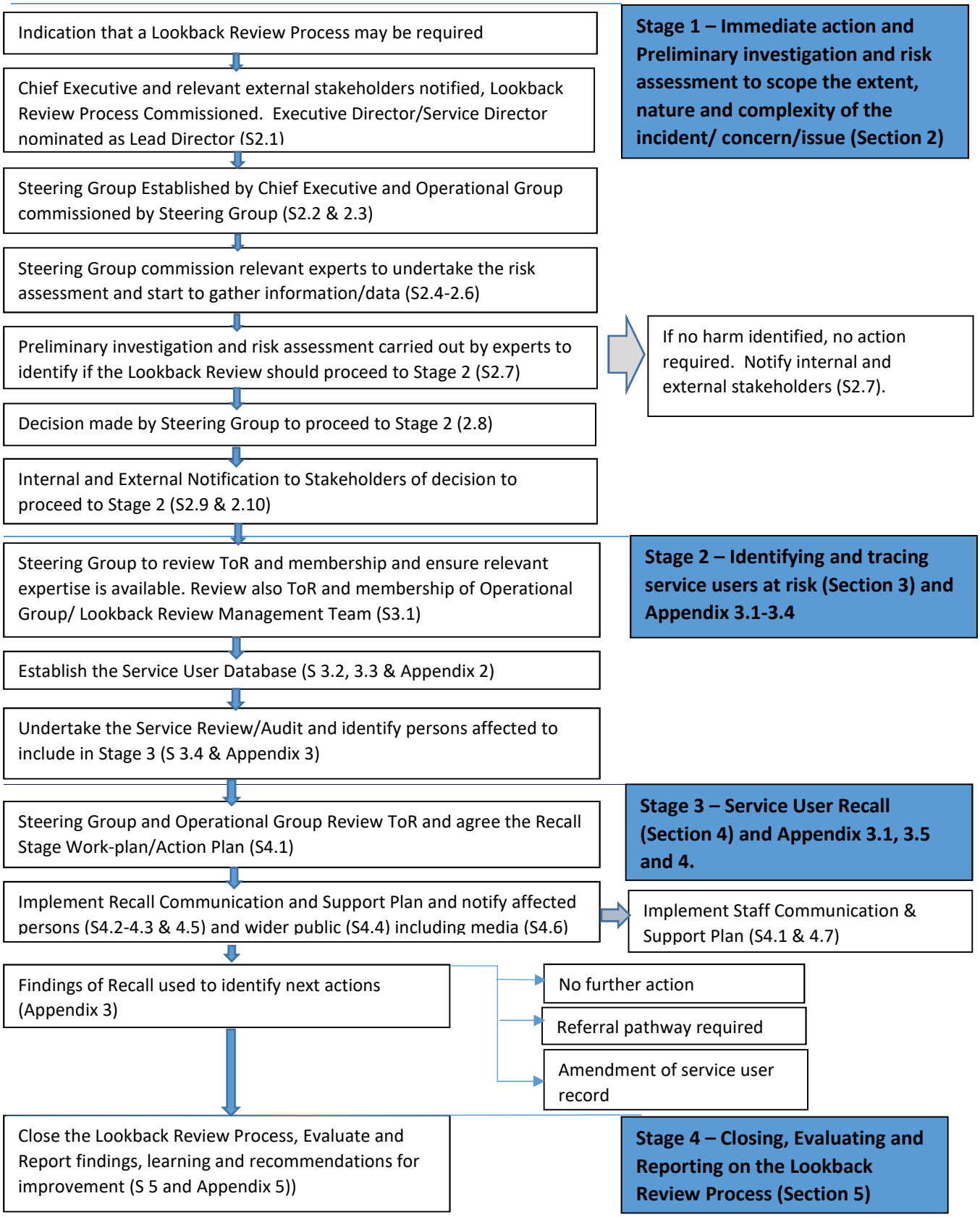
The Lookback Review Process involves:

- Identifying, tracing, communicating, and providing appropriate ongoing advice to, and/or management of, the group of service users who have been exposed or potentially exposed to a hazard and who may have been harmed, or are at risk of future harm or loss;
- Notification internally to Trust Board and to appropriate external stakeholders (see Sections 2.1, 2.9 and 2.10);
- Notification to the wider public as and when required. While openness and candour are guiding principles in a Lookback, it is essential that communication occurs at a time when clear messages can be conveyed whilst ensuring that the ‘at risk’ population has been identified and communicated with before the wider public is alerted. Relevant healthcare professionals including General Practitioners should also be identified and communicated with in advance of any public statements. This is essential to maintain public confidence and prevent unnecessary anxiety and to ensure that services can be focused on the correct group of people (See Section 4 below).

The following diagram (Diagram 1) provides a summary of each stage of the Lookback Review Process and may be used in conjunction with the Lookback Review Process Checklist (see Appendix 5). The Process, as laid out below is a step by step guide. It is important, however, that the primary focus should remain on harm and risk of harm to service users. Therefore, there will be occasions where it is

clear from the outset that a Lookback Review will be necessary and where the organisation effectively runs more than one of these stages consequently.

Diagram 1 Flowchart - Summary of Stages in a Lookback Review Process



1.3 Governance Arrangements

The HSC organisation should ensure that the Lookback Review Process is managed in line with extant Governance and Assurance Framework arrangements.[3] The Steering Group (Section 2.2) should be seen as a 'task and finish' group within the HSC organisation's Governance/Assurance Framework structure reporting to Trust Board through the Senior Management Team/ Executive Team of Trust Board. The Steering Group should commission an Operational Group or Lookback Review Management Team to take forward the operational aspects of the Review Process (unless the Lookback Review is anything other than limited in terms of nature, extent and complexity).

When scoping the nature, extent and complexity of the Lookback Review Process (Section 2.6 – 2.7) the Steering Group should evaluate and escalate the risk in line with the organisation's Risk Management Strategy. This will ensure that the risk(s) identified will be included in either the organisation's Board Assurance Framework, Corporate Risk Register or Directorate Risk Register and managed in line with the Risk Management Strategy.

The Lookback Review Process should be outlined in the mid-year Assurance and/or annual Governance Statement as required. The annual Governance Statement is the means by which the Accounting Officer provides a comprehensive explanation on the HSC organisations' approach to governance, risk management and internal control arrangements and how they operate in practice.[4] The Statement provides a medium for the Accounting Officer to highlight significant control issues which have been identified during the reporting period and those previously reported control issues which are continuing within the organisation.

1.4 Other Related Incident Management Processes including Investigations

As stated previously, Lookback Reviews are carried out in order to identify if any of those exposed to a hazard have been harmed, and to identify the necessary steps to take care of those harmed. The incident giving rise to the Lookback Review Process or issues identified as a result of the process may require review as a Serious

[3] DoH '*An Assurance Framework: a Practical Guide for Boards of DoH Arm's Length Bodies*.' April 2009.
[4] Department of Finance ' *Managing Public Money NI (MPMNI)*' AS.1

Adverse incident (SAI).[5] This will require a parallel (though interlinked) review which should be undertaken in line with Health and Social Care Board guidance [6] to identify key causal and contributory factors relating to the triggering event (see Sections 2.10 and Section 5). In some circumstances, a Lookback Review Process may have been prompted by a preceding SAI review.

The circumstances leading to a decision to implement a Lookback Review may require the HSC organisation to notify other statutory agencies such as the Coroners Service for Northern Ireland and/or the Police Service for Northern Ireland (PSNI). The reporting of the Lookback Review as an SAI to the Health and Social Care Board (HSCB) will work in conjunction with, and in some circumstances inform, the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Guidance.

A Memorandum of Understanding (MoU) has been agreed between the Department of Health (DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI).[7] The MoU applies to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the MoU apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

A Lookback Review Process may raise issues of professional competence/conduct. HSC organisations will then be required to instigate performance management, capability and disciplinary reviews or investigations in line with their internal Human Resource policies, procedures and relevant professional regulatory guidance for

[5] Health and Social Services Board (HSCB) 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents'. November 2016 Version 1.1.
[6] *Ibid.*
[7] DoH *'A Memorandum of Understanding' developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident'.* HSS (MD) 06/2006, February 2006.

example Maintaining High Professional Standards (MHPS).[8] These processes should run as a parallel process to the Lookback Review, although relevant information from one process may inform the other. In such circumstances, confidentiality in respect of the member of staff must be taken into consideration.

[8] DoH 'Maintaining High Professional Standards in the Modern HPSS'. HSS (TC8) 6/2005. November 2005.

2.0 Stage 1 – Immediate Action, Preliminary Investigation and Risk Assessment

Immediate action should be taken to ensure the safety and wellbeing of the service users.

2.1 Notification of the need to consider a Lookback Review Process

The Director of the service involved should be notified immediately that a hazard or potential hazard has been identified which may require the organisation to consider implementing a Lookback Review Process. The Director will report the issue(s) internally through the Chief Executive to the Board of Directors in line with the organisation's risk escalation processes. The relevant Director will also need to consider if the hazard might affect other HSC Organisations or private/ independent providers.

It is recognised that at this early stage there may be limited information available to the HSC organisation until information and intelligence is gathered and the risk assessment is undertaken (see Sections 2.6 and 2.7), however, in line with extant guidance, the Director should notify the DoH of the emerging issues by way of an Early Alert (see also Section 2.9).[9] The Early Alert should make clear, if the information is available, the details of other organisations/services potentially involved in NI or in other jurisdictions, the timeframe during which the issue may have been relevant and the potential volumes of services users who may be affected. The Director should also consider if the findings, given the potentially limited information could be considered as an SAI at this time (see Section 2.10). [10] If in doubt, the extant SAI guidance provides the opportunity for the organisation to declare the matter as an SAI, which can then be 'de-escalated' later.[11] The HSC Organisation will also have to consider possible notification of the event(s) to the Coroners Service for NI and/or the PSNI (see Section 1.4).

[9]Department of Health 'Early Alert System' HSC (SQSD) 5/19.
[10] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incidents. November 2016.
[11] *Ibid.,* Section 7.6 Page 21

It is also important to advise the organisation's Head of Communications/Communications Manager at an early stage so that a communication plan including media responses can be prepared in advance.

2.2 Establish Steering Group

A Steering Group should be convened as soon as possible after the disclosure of the issue of concern to develop an action plan and oversee its implementation. Depending on the extent, nature and complexity of the triggering event the Steering Group should be chaired by either the relevant Service Director or in some circumstances it may be chaired by the relevant Executive Director/Professional Lead.

If other investigation processes are in place (e.g. Capability/Performance Management Reviews) these should run as parallel processes, however, information from the other investigative processes, taking into account confidentiality and the information governance requirements that will apply to these parallel processes, may be used to inform the decision making of the Steering Group.

The Steering Group will need to meet on a regular basis to ensure that they receive feedback/ situation reports (SITREPS) from the Operational Group/Lookback Review Management Team and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared as required with internal stakeholders (Executive Team/Senior Management Team and Board of Directors) and external stakeholders i.e. HSCB, Public Health Agency (PHA) and DoH.

2.3 Composition of the Steering Group

The composition of the Steering Group will be dependent on the service involved and the nature and extent of the Lookback Review Process. The Steering Group should not normally involve personnel who may have been directly involved in the event/hazard that triggered the Lookback Review Process.

Depending again on the extent and nature of the Lookback Review the HSC organisation should consider the following as core members; a Non-Executive Director, the Director of service/speciality concerned, relevant professional Executive Director(s), Risk and Governance representative, Head of Communications, Information Technology manager, Medical Records manager and senior service representatives with expertise (including clinical and/or social care) in the services/

processes which are the subject of the Review Process, a PHA representative and an HSCB representative (in the case where the Lookback Review has been identified as an SAI, the role on the Steering Group will be clearly identified to ensure that the independence of the PHA/HSCB is not jeopardised).

The organisation may also wish to consider a member of a relevant service user representative/advocacy group is included as a member of the Steering Group.[12] In these instances, a confidentiality agreement must be signed by the service user representative. The representative should not have access to service user identifiable data. Such an agreement should be proportionate and reflect the need of the organisation to protect the information of individuals and to ensure that information disseminated is accurate, proportionate and timely and that support mechanisms are in place for service users and staff.

The Steering Group should also commission an Operational Group or Lookback Review Management team which should report to and support the Steering Group in taking forward the operational aspects of the action plan e.g. establishing the service user database (Section 3.2) and supporting the Recall Stage (Section 4).

2.4 Role of the Steering Group

Within 24-48 hours from being established the Steering Group should decide on the immediate response which includes;

- Methodology to determine the size/magnitude, complexity and nature of the risk/harm to service users/carers in order to plan an appropriate Lookback Review Process e.g. risk assessment (see Section 2.7 below);
- Determine if the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations as well as the independent sector and organisations in other jurisdictions;
- Determine the extent of notifications to the DoH, HSCB and PHA that is required, if these notifications have not already been initiated (see Section 2.1 above and Sections 2.9 and 2.10);

[12] The Patient and Client Council (PCC) is responsible for delivering and/or providing access to advocacy and support services as specified by the DoH and HSCB guidance in supporting families through a 'hub and spoke' model of service delivery working with providers of advocacy services. Other independent services may be accessed as required through the PCC, including the development of a network of available advisory services.

- Address and manage notification internally through the Senior Management Team/Executive Team to the Board of Directors;
- Agree on the formation of an expert advisory sub group comprising experts in the area of concern, relevant clinicians, and department or directorate heads to undertake the risk assessment and service review or audit . Consideration should be given as to whether or not that expertise should come from outside the organisation;
- Agree on a service user communications plan. Communication with the service user/family is a priority and the organisation should be proactive in managing the manner and timing in which affected service users receive relevant information (see Section 4.2).
- Agree on a communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected.
- Agree on a media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries (see Section 4.6).[13]

2.5 Steering Group Terms of Reference and Action Planning

The Steering Group should develop and approve Terms of Reference and establish a Lookback Review Action Plan for Stage 1 of the Process. Both the Terms of Reference and action plan should be reviewed and revised as and when the Process proceeds to the next stages.

The action plan should include as a minimum; the management of immediate safety issues, identify those who may have been exposed to harm, care for those who may have been harmed/affected, actions to prevent further occurrences of harm, a communication plan, contingency planning for business continuity of the service and plans for potential service user follow-up.

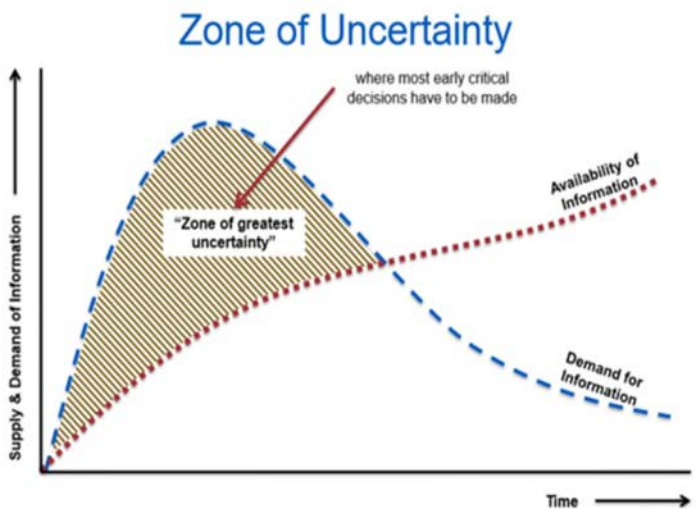
[13] New South Wales 'Lookback Policy Directive', Clinical Excellence Commission Safety & Quality, System Performance & Service Delivery, September 2007. Section 4 Page 5.

2.6 Gathering Information and Intelligence to Scope the Extent, Complexity and Nature of Harm

Key decisions have to be made at this early stage of the process when minimal information may be available to the Steering Group. Decision making should be based on a joint understanding of risk (see below) and shared situation awareness.[14] Situation awareness is having a common understanding of the circumstances, immediate consequences and implications of the triggering event along with an appreciation of the available capabilities and the priorities of the response.[15]

It is important that internal and external stakeholders are aware that the Steering Group may be required to make decisions during a time of uncertainty (or zone of uncertainty) about the level of risk or harm to service users (see Figure 1 below).[16] Depending on the extent, nature and complexity of the Lookback Review Process it can be difficult for the Steering Group to predict when it has gathered the optimum level of information to make decisions such as the decision to announce the Service User Recall stage.

Figure 1 Zone of Uncertainty

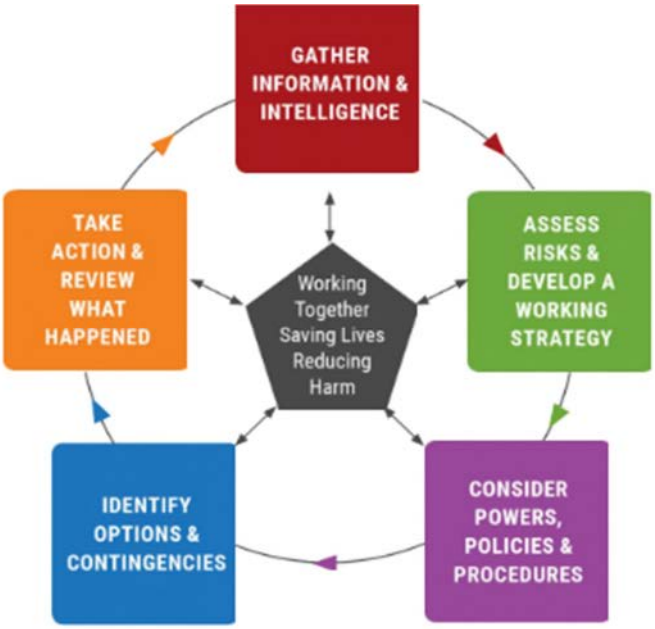


At the early stage, as above when limited information is available upon which the Steering Group will be required to make crucial decisions then a Decision Making Model, widely used amongst the emergency services as a tool, could be considered.

[14] Joint Emergency Services Interoperability Principles (JESIP) ' www.jesip.org.uk
[15] *Ibid*.
[16] *Ibid*

Tools to aid decision making include for example the Joint Decision Making (JDM) Model (Figure 2)[17] which helps bring together the available information, reconcile objectives and make effective decisions.

Figure 2 Joint –Decision Making Model



Further information and use of the JDM are available via the Joint Emergency Services Interoperability Principles (JESIP).[18]

All decisions should be recorded/logged, justified, seen to be reasonable and proportionate to the information available at the time. Therefore the Steering Group will require the services of an experienced minute-taker or 'loggist'[19] to ensure an accurate record of actions and decisions is maintained at each stage of the process.

[17] Joint-Decision Making Model @ www.jesip.org.uk/joint-descision-model
[18] *Ibid*.
[19] A term used in Major Incident Planning a loggist is the person who is responsible for capturing, through decision logs, the decision making process that might be used in any legal proceedings following an incident ' www.epcresilience.com

2.7 Risk Assessment [20]

As indicated above, the first stage in the process is to undertake a risk assessment to determine whether the scope, size/magnitude, complexity and nature of harm arising from the triggering event should progress to the next stage(s) i.e. a service user lookback and potential service user recall. In order to do this, the Steering Group should commission relevant experts to undertake this risk assessment. As above (Section 2.3), the relevant experts may include but are not exclusive to: people with the clinical or social care expertise in the services/ processes which are the subject of the Lookback Review Process, Risk and Governance Managers, and a Public Health Specialist. This will be determined by the Steering Group on a case by case basis.

A decision to undertake the completed Lookback Review Process has significant implications for service users, providers and resources. The risk assessment, therefore, should provide a thorough assessment of the chance of harm and the seriousness of that potential harm. It must be conducted in a manner that balances the need to identify and address all cases where there might be safety concerns on the one hand, with the need not to cause any unnecessary concern to service users or to the public on the other.[21]

The risk assessment should look at:

- If the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations including the independent sector;
- The potential extent of the issue and the level of exposure to the hazard;
- Evidence of harm that has occurred;
- The likelihood of future harm occurring;
- The potential and actual (if relevant) outcomes of the issue e.g. missed diagnosis/ missed return appointments for follow up etc;
- The potential impact of the issue;
- The potential cohort of service users affected (including service users of other HSC and non-HSC Organisations);

[20] HSE. *Op.Cit* Section 7.6 Preliminary Risk Assessment Page 115-16.
[21] *Ibid*. Appendix 1

- The potential impact on other service users (not in the 'at risk' cohort) e.g. potential delays in treatment and diagnosis;
- The manner in which harm would be ameliorated (e.g. repeat investigation/ onward referral for treatment).

The HSC Regional Risk Matrix and Impact Table may be used as guidance to evaluate the risk.[22] A template for undertaking a preliminary risk assessment is included in Appendix 1 of this Guidance.[23]

The Steering Group will use the information obtained from this assessment to decide if the Process should continue to the Service User Lookback and Recall stages (see Section 2.8). If there is no harm or risk to service users, the Lookback Review Process can be closed. The Steering Group will inform the relevant internal and external stakeholders. It is advised that the Early Alert is updated to indicate that the process has been closed, outlining clear reasons for the decision. The HSC organisation should consider the incident as a 'near miss' and undertake a systems analysis to establish contributory factors, learning and recommendations.

2.8 Decision to proceed to Stage 2 Service User Lookback and Stage 3 Service User Recall

The decision to proceed to the Service User Lookback and Recall stages is a difficult and complex one and should not be taken lightly. As above, the decision should only be considered in circumstances where it is indicated following careful risk assessment, which may necessitate external peer review and advice from senior decision-makers and/or others with knowledge and experience in the specialty in which the Process is being considered and with advice from those who have experience in conducting a Lookback Review Process (see Section 2.7 Risk Assessment).[24] The decision should also include consideration of the impact on other service users (i.e. not the 'at risk' cohort) for potential delays in diagnosis and treatment.

Lookback Reviews by their nature are often high-volume, involve high-complexity and high-cost (including opportunity cost which diverts time and resources from

[22] HSCB. *Op.cit*. Appendix 16.
[23] HSE. *Op.cit*. Preliminary Risk Assessment Stage pages 15 to 16 and Appendix 1.
[24] *Loc.cit*.

ongoing care.) As described above, they involve a number of stages and logistical challenges.

If a decision is taken to proceed to the Service User Lookback and Recall stages then the Chair of the Steering Group must inform the Chief Executive and Board of Directors and notify the relevant external bodies. The Early Alert should be updated (Section 2.9). If the Process has not already been reported as an SAI then the Steering Group should review the SAI criteria and take appropriate action (see Section 2.10).

The Steering Group should continue to consider any safety concerns that may arise at any stage of the Review Process which may need prompt action. Concerns may include the following:

- Taking preventative action such as the removal of the hazard [25];
- Consideration of the benefits and risks of suspending or transferring the service under review;
- Management of staff member(s)/service whose caseload is under review in line with Professional/Regulatory Guidance/HR/Occupational Health policy and procedure;
- Clinical and social care management of service users/ staff identified by the preliminary review and suspected of being adversely affected;
- Providing support to service users and staff involved.

The Steering Group should ensure that business continuity plans are considered and implemented, where necessary, including providing for additional health and social care demands which may arise as a consequence of the Lookback Review. The HSC organisation is responsible for securing service capacity and for ensuring that the necessary resources are allocated to conduct all the stages of the Review Process and subsequent follow-up processes. If the resources required exceed what is available then this should be escalated to the organisation's Board and if necessary to the Health and Social Care Board.

The Steering Group should be prepared for the fact that when a full Lookback Review Process is being considered this information can often become publicly known at the

[25] If the hazard is associated with a medical device then the HSC organisation should report this in line with Norther Ireland Adverse Incident Centre (NIAIC) adverse incident reporting – guidance and forms. October 2018 ' www.health-ni.gov.uk.

planning stage and should have a contingency plan in place for notification of affected persons and the wider public if this should occur.

2.9 Early Alert Notification [26]

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services. Events should meet one or more of the following criteria;

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*
2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*
3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*
4. *The event may attract media attention;*
5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC Service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does <u>not</u> include any deaths routinely referred to the Coroner, <u>unless</u>:*
   - *i. there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
   - *ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
   - *iii. the Coroner's inquest is likely to attract media interest.*
6. *The following should always be notified:*

[26] Department of Health 'Early Alert System' HSC (SQSD) 5/19.

i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services;*
iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

The next steps will be agreed during the initial contact/telephone call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at Annex C, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

The Early Alert must provide a succinct description which clearly outlines the key issues and the circumstances of the event. Information contained within the brief is to include:

- urgency;
- determining who has been affected and how - physical and/or psychological harm, or no known harm;
- process for determining risks;
- need for Department participation/involvement/oversight.

2.10 SAI Notification and Investigation

In some circumstances an SAI review may have triggered the Lookback Review Process (Section 1). However, often the Lookback Review will be triggered by a concern that has been raised by a service user or their family/carers or a member of staff. The Steering Group should consider at an early stage if the findings of the Lookback Review meets any of the criteria for reporting the concerns as an SAI (see also Section 7.2.1). The criteria for reporting an SAI are defined within the HSCB

Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016 at www.hscboard.hscni.net [27]

[27] HSCB Loc. Cit Section 4

3.0 Stage 2 Identifying and tracing service users at risk

One of the most important stages of the Lookback Review Process is the accurate identification and tracing of the service user cohort who have been identified as being affected by the triggering event. The HSC organisation is responsible for the identification and tracing of the affected service users must allocate appropriate resources to ensure that this is undertaken.

In the context of the Lookback Review process, this Stage involves the review of care/ processes against explicit standards and criteria to identify those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria. [28]

3.1 Role of the Steering Group –Terms of Reference and Action Planning

The Steering Group should continue to ensure the management of immediate safety issues and care for those harmed or potentially harmed by the triggering event.

The Steering Group is responsible for ensuring the identification and tracing of the cohort of service users to be included in the service user lookback and recall phases of the Lookback Review Process. The Steering Group will need a clear definition of which service users should be recalled/ offered further tests/assessments, what they should be recalled for, how test/assessment outcomes will be categorised and how each category will be managed/followed-up (Sections 3.2 – 3.4 and Appendix 3).

The Steering Group should review their Terms of Reference and Group membership at this stage and consider if additional membership from the service area/support services and from service users advocacy services are required for either the Steering Group or the Operational Group/ Lookback Review Management Team if applicable (see Section 2.3). The extent and complexity of the Lookback Review Process will determine the resources and responses required.

The Steering Group should also review the Lookback Review Action plan (Section 2.5). As required, expert advice or linkages may be also made with resources such as relevant Professional Bodies and Faculties (e.g. Royal Colleges) to assist with this stage of the Lookback Review.

[28] HSE. *Op.Cit*. Section 7.7 Page 17

The Steering Group should also consider the service user recall methodology for the next stage and further develop the Communication Plan (including the formation of Helplines/Information Lines and use of the organisation's web page to provide general information and Frequently Asked Questions and responses Section 4.4).

The Steering Group will need to meet on a regular basis to ensure that they receive situation reports (SITREPS) and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared with internal stakeholders (Executive Team/Senior Management Team and Board) and external stakeholders i.e. HSCB, PHA and DoH.

3.2 Establish the Service User Database

The HSC organisation will need to develop a service user database to collate the details of the service users that have been identified for inclusion in the service review/ audit stage of the Process. It is important to consider the output from the service user notification database at the outset. The list of service users will be needed to:

- Generate letters to service users;
- Check if service users at risk have made contact;
- Keep track of who requires further review/testing;
- Record who has had results;
- At the end of the Lookback Review Process to generate information on numbers of service users identified, further assessed and their outcomes.

The database needs to be updated, by administrative staff, on a regular, and at some stages at least on a daily basis. This will ensure the information held is the most up to date and reliable.

The database may already exist on one of the organisations Information Technology (IT) systems. In some circumstances (for example service users who have not been reviewed for a period of time), it may be necessary to check the service user details with the General Register Office for NI to identify if any of these service users have since deceased.[29] Information Technology staff are essential members of the sub

[29] General Register Office for Northern Ireland @ www.gov.uk.

team to assist in accessing existing databases/establishing databases. Specific data variables, will be determined by the nature of the triggering event and the audit methodology to be applied. If a database of service user details does not already exist then a suggested core dataset for service users at risk has been outlined in Appendix 2.

The Steering Group should give special consideration in the Lookback Review Action Plan as to whether or not the cases of deceased persons meet the inclusion criteria, how their records should be handled and how best to communicate with their relatives.[30]

3.3 Establish the Process for the Identification of Affected Service Users[31]

The Steering Group should establish and record clear processes for the identification of the service users/ staff to be included in the Recall Stage. This will include the development/ agreement of the:

- Audit criteria (criteria as to what will be considered within acceptable practice limits, minor or major discrepancy, the clinical significance of these discrepancies, and actions to be taken in each category, guided by national and international best practice, faculty requirements etc.);
- Scope of Audit (including timeframes and definition of records to be reviewed);
- Audit Methodology;
- Audit Tool;
- Instructions to ensure consistent recording of audit results;
- Instructions for analysis of audit data;
- Procedures for ensuring the validity and reliability of the audit to ensure that all auditors interpret and apply audit criteria in the same way;
- Process for the submission of audit outcomes to the Steering Group.

The HSC organisation should take account of extant guidance in relation to maintaining service user confidentiality.[32] [33] [34] The audit of service user's healthcare

[30] HSE. *Op.Cit.* Section 7.7.4, page 18.
[31] Ibid. Section 7.7.3 Page 17
[32] EU Data Protection Regulation (GDPR) 25 May 2018 @ https://eugdpr.org
[33] Data Protection Act 2018 @ www.legislation.gov.uk .
[34] DoH 'Code of Practice for protecting the confidentiality of service user information' 31 January 2012 @ www.health,n-i.gov.uk

records should be undertaken by the healthcare team who would ordinarily have the right to access the service user's healthcare records as part of the delivery of health and social care. However, if the audit team is extended to include healthcare personnel who would not have a right to access the service user's healthcare records, and consent has not been provided by the service user for these personnel to access their records, then these records must be sufficiently anonymised, such that an individual is not identifiable to those undertaking the audit.[35]

3.4 Undertaking the Audit

The Steering Group will commission the audit of the healthcare records of the affected service users as identified in Stage 1 (risk assessment). The audit methodology and tools will have been defined by the Steering Group (see Section 3.3).

The audit will involve clinical staff with the necessary skill and knowledge of the specialty involved. However, depending on the nature, extent and complexity of the Lookback Review the HSC organisation may need to commission relevant experts to undertake the audit or service review.

Again, depending on the nature of the Lookback Review the team may initially be required to screen the service users' notes/x- rays/test results etc. to establish if they are in the affected cohort. A system for the initial identification of the service users including flow charts, service review proformas and service user notification letters are contained in Appendix 3. These are examples only and are provided as reference material and should be adapted by the HSC organisation for the specific health and social care trigger event on a case by case basis.

Following initial screening and identification of service users affected, further assessment may be required.

The service user database will be used to document the service users/ staff who are included and excluded following each stage of the Lookback Review Process (see Section 3.2 above). In general, it will be used to track persons affected and to record actions, interventions and outcomes.

[35]HSE. *Op.cit*. Section 7.7.3.

Upon completion of the audit, the service review team will provide the Steering Group with the results of the audit which will inform the Steering Group of the persons affected to be included in the Recall Stage.

4.0 Stage 3 Service User Recall

4.1 Planning the Recall

Following completion of Stage 2, the Steering Group will move to the third stage, the Service User Recall Stage. The Steering Group and Operational Group should ensure that their Terms of Reference include the following; purpose of Recall, scope, method and timeframe.

The Steering Group will also establish the Recall Team(s) which will consist of experts in the subject area/ discipline which is the covered by the Lookback Review Process.

The Steering Group must agree with the Recall Team(s) a realistic work-plan with timelines that reflect the urgency and complexity of the Lookback Review Process.

The Steering Group will have to consider the following which will form the basis of the Operation Group/Lookback Review Management Team work-plan:

- Identify venue for the conduct of the Recall stage;
- Secure administrative support;
- Establish an appointment system including DNA management;
- Secure clinical and other specialist support e.g. laboratory/x-ray etc.;
- Arrange transportation of samples and results;
- Manage arrangements for assisting service users affected to attend the Recall Stage (for example car parking, site maps, signage/ 'meet and greet' arrangements, public transport, taxis, meals);
- Agree a system for recording of results;
- Ensure that counselling and welfare services are available to service users and to staff;
- Agree the communication and service user support arrangements (see Section 4.3);
- Consider the arrangements for overtime/out-of- hours working for staff.

Ideally, a liaison person/team should be appointed to oversee the seamless conduct of each attendance a service user has as part of the Recall stage, whether they are

clinic appointments or repeat tests/x-rays etc. Responsibilities would include; providing a point of contact, follow-up of DNAs , quality assurance of the Process (correct letter to correct person) and checking that the service user affected are referred into the 'system' for subsequent follow-up.[36]

Depending on the extent, nature and complexity of the Process, the Steering Group will have to meet on (at least) a daily basis to ensure they receive SITREPS and continue to have an accurate oversight of the Lookback Review at this Stage (see Section 3.1).

4.2 Service User Communication and Support

One of the most important areas of managing any Lookback Review Process is the communication with all the affected service users. When communicating it is equally important to be able to say who is not affected. The timing of any communication is critical and every effort should be made to notify the entire group simultaneously. The method of doing this will be dictated by the numbers of service users involved (see Section 4.3). Service user notification must be co-ordinated with public announcements made by the organisation. In an ideal situation service users should be contacted before a media announcement is made. However, this is not always possible given the nature/scale of some Lookback Review Processes or if there is a breach in confidentiality at an earlier stage. Where applicable, the Steering Group should identify any service user representative bodies/third sector and brief them.

The Steering Group should agree key messages to ensure consistent and accurate information to provide confidence in the process. The Steering Group should consider the person(s) best suited to communicating bad news with affected service users, their families and/or carers. A spokesperson, should be identified to act as the organisation's spokesperson and be available for interview by the media etc. Media training should be provided on a case to case basis (see also Section 4.6).

The following should be included in the service user communication and support plan:

- access to professional interpreters as required;
- a designated point of contact for service users, their families and/or carers;

[36] *Ibid.* Section 7.8.2 Page 22.

- regular and ongoing information updates provided to service users and families and/or carers;
- affected service users offered a written apology by the health service organisation;
- establishment of a Helpline/Information Line/website to ask questions and to obtain information (see Section 4.5 and Appendix 4 for practical guidance);
- affected service users who need additional consultation have these appointments expedited to allay any anxieties or concern that they may have.

Communication and support of families should include:

- identifying immediate and ongoing management needs of service users, their families and/or carer;
- ensuring that service users understand the processes for ongoing management and have written advice/fact sheets concerning this;
- ensuring that relevant fact sheets containing information on the lookback review are published on the health service inter/intranet website;
- ensuring adequate resources are in place to provide the level of service required;
- provide counselling and welfare services;
- initial communication should be direct, either face-to-face or via telephone, where the service user must be given the opportunity to ask questions.

4.3 Service User Notification by Letter

Depending on the extent of the Lookback Review Process notification may be by a letter sent to the service users affected by the issue. As above, the timing of service user notification must be carefully choreographed with any public announcement made by the organisation. If the Process has affected small numbers of service users organisations may wish to consider alternative forms of direct communication e.g. telephone calls in first instance which should be supplemented by a follow-up letter containing the pertinent information. A sample of letters has been provided in Appendix 3 for reference/guidance.

The service user letter should be signed by the Chief Executive or a Director of the HSC organisation. Service user letters should be sent by first class post in an envelope marked “Private and Confidential -To be opened by addressee only” and “If undelivered return to...(*the relevant Trust*)...”

Letters to the service user should include the following if appropriate:

- Unique service user identifier number;
- Service user information leaflet/ fact sheet;
- The website/freephone helpline number(s) and hours of opening;
- Location map with details of public transport routes;
- Free access to parking facilities;
- Arrangements for reimbursement of travelling expenses.

It can be helpful to include a reply slip with a pre-paid envelope to confirm that service users have received the letter. Alternatively, the organisation may consider using a recorded delivery service or hand delivering the letters if number are manageable.

Depending on the individual Lookback Review Process the HSC organisation may need to identify any service users under 16 and/or other vulnerable groups to write to their parent/guardian/ representative.

The Steering Group should plan for how service users who do not respond to an invitation and/or ‘lost to follow-up should be managed. The Steering Group should ensure that ‘every reasonable effort’ is made to contact all service users at risk for example by telephone or through General Practitioners. It is accepted that service users may have moved out of the region or abroad.

4.4 Public Announcement of the Recall Stage

The Steering Group will determine the timing of the Public Announcement of the Recall Stage of the Lookback Review Process. Communications management throughout the Lookback Review Process should be guided by the principles of ‘Being Open’[37] balanced with the need to provide reassurance and avoid unnecessary concern.

Recall Stage will be announced to the public by the relevant HSC organisation lead Director in line with the Communication Plan (Section 4.2 and 4.6). As stated in

[37] DoH ‘Saying sorry – when things go wrong’. January 2020.

Section 4.3, it is vital that the Steering Group strive to ensure that the Lookback Review Process is not publicly announced until all of the persons affected have been notified and a clear public message can be given regarding the extent of the cohort and those that are not affected. This is not always possible, as breaches of confidentiality may occur and therefore the Communication Plan should be prepared for this eventuality at all times.

When it is determined that communication with the public is required it should not be announced until all of the service users affected have been notified. As above it is recognised that this is not always possible. Key principles of public announcements include:

- Being open with information as it arises from the Lookback Review Process;
- Ongoing liaison with the media throughout the Lookback Review Process;
- Preliminary notification being made public where a situation requires additional time for the discovery of accurate information to be provided to service users and the wider public.

It essential that the findings in relation to the Lookback Review Process should not be released into the public domain until the Process is complete, all the findings are known and all affected service users are informed of the implications of the findings for them.[38]

4.5 Setting up a Service User Helpline/ Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of enquiries from service users, their families and the general public. It is recommended that site-specific helplines are considered for persons affected and a more general information line for the wider public. Consideration should also be given to providing information on the Trust's website for example Frequently Asked Questions (FAQs) and responses. Planning at this stage is vital to ensure that public confidence in the service is not further eroded. Guidance on setting up a service user helpline/information line are contained in Appendix 4.

[38] HSE *Op Cit* Page 20

4.6 Communication with the Media

Adverse incidents, especially those involving a service user lookback generate intense media attention. Regardless of the nature or intensity of media inquiries, information given to them should never exceed that which has been shared with the service users affected.[39]

The Steering Group should consider developing a 'media pack' (see below). The Head of Communications/Communications Manager should take a lead on developing this strategy. Depending on the extent, nature and complexity of the Lookback Review Process the Head of Communications/Communications Manager will liaise with the DoH Communications branch to seek advice on the communication strategy for the media and general public.

As part of the Communications Plan for dealing with the media, the Steering Group should:

- nominate a spokesperson for public and media communications;
- minimise the delay in response to the public and the media
- develop a media pack which should contain;
    - key messages
    - frequently asked questions (FAQs) and answers
    - draft media statements for each phase of the review process.

Media statements in relation to the issue, should be accurate and not add to the anxiety of the service users and their families/carers. Media statements should not be released prior to notification of the Lookback Review Process (see Sections 4.3 and 4.4). In the circumstances where a media statement is released it should state that a Lookback Review Process is being carried out, and immediately limit the area of concern to time period, region and service area within which the Process is being conducted. It should detail the numbers of persons affected being included in the

[39] *Ibid.* Section 7.11.2 Page 26

recall stage of the process and the expected timeframe for the completion of the recall stage, if known.[40]

The media statement should note that all service users affected have been contacted (and method of contact) and that a Helpline/Information line/website has been established, giving the opening time(s) of the line and the contact details. The FAQs can be provided to the media as well as any additional briefing information such as an information leaflet.

All media statements and briefing notes should be ratified by the Steering Group.

4.7 Staff Communication and Support

While the public will need to be reassured that every effort is being made to conduct a full and thorough review, it is essential that the involved healthcare workers are protected and supported during this time. They need to be kept fully informed at all times during the exercise. Support from a peer and counselling should be offered by the employer. This is particularly important during the early stages of the lookback review process when there will be intense media interest. One point of contact, such as the Director of Human Resources should be identified to lead on this aspect throughout the process. In the case of an individual(s) being managed under the HSC organisation's capability/performance management/disciplinary procedures then the relevant HR policies should apply. These parallel processes are not included in the scope of this guidance (see Section 1.3).[41]

A communication and support plan should be devised for staff. This should include communication and support for:

- All staff who are managing the lookback process;
- All staff working in the area of concern;
- All other staff that may be affected.

[40] *Ibid*. Page 27.
[41] DoH Policy for Implementing a Lookback Review Process Section 4.

5.0 Stage 4 Closing, Evaluating and Reporting on the Lookback Review Process

A Lookback Review Process Guideline Checklist has been included in Appendix 5. The Checklist is a memory aid only and must be used in conjunction with the guidelines.[42]

The Steering Group are responsible for formally closing the Lookback Review Process when all service users affected have been reviewed and the care of service users requiring further treatment and care management have been transferred to the appropriate service and all the service users have been written to with the outcome of the review.

At the end of any Look Back process it is the responsibility of the Lead Director/Chair of the Steering Group to evaluate the management of the Lookback Review to assess the efficiency and effectiveness of the process and to identify any lessons learned from the process. Key measures should be assessed and strategies for further improvement should be implemented and reported to the Chief Executive as required.

The findings should be included in a Look Back Review Report. The content will be unique to each Lookback Review Process. The report should be shared with all relevant internal and external stakeholders. This report should be used to form the basis of the Serious Adverse Incident Report (Section 2.10) to facilitate the dissemination of learning across the HSC as a whole.

For the purposes of a report on a Lookback Review Process the report should contain the following information:

- Introduction including:
  - Details of Terms of Reference(s) (include Terms of Reference(s) in the
  - Appendices section of the report)
  - Composition and roles of the Safety Incident Management Team
  - Composition and roles of the Audit Team
  - Composition and roles of the Recall Team
- Methodology applied to the Look-back Review Process including:
  - Methodology applied to preliminary review/Risk Assessment

[42] HSE. *Ibid*. Appendix 8.

- Clear audit methodology for the Audit Stage including:
  - Audit Criteria
  - Scope of Audit
  - Audit Methodology
  - Audit Tool
- Procedures for ensuring the validity and reliability of the Audit stage to ensure that all auditors interpret and apply audit criteria in the same way.
- Recall Stage methodology
- Communications Plan
- Information and Help Line Plan
- Plans for follow up for persons affected following both the Audit and Recall Stage

- Results/ Findings of Stage 1 Preliminary Findings/Risk Assessment;
- Results/ Findings of Stage 2 service review/ audit;
- Results/ Findings of the Recall stage;
- Actions taken to date to address findings;
- Learning and further recommended actions to address findings.

Peer review publication of issues relating to the Lookback Review Process, for instance; the development of an audit tool, logistics and communication with service users/families and staff may be of benefit and should be encouraged.[43]

[43] HSE. *Op. Cit*. Section 7.10.

Glossary

Term	Definition
Adverse Incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Audit	In the context of the lookback review process, audit involves the review of care/processes against explicit standards and criteria to identity those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria.
Clinical Review	A re-examination of a medical and or clinical process/es which has delivered results that were not to the expected quality standard.
Cohort	A group of people who share a common characteristic or experience within a defined period (e.g., are currently living, are exposed to a drug or vaccine or pollutant, or undergo a certain medical procedure) i.e. a sub-group selected by a predetermined criteria.
Contributory factor	A circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.
Database	The ability to record information for retrieval at a later date. In this instance it may be on paper if the numbers involved are small. If the numbers are large, ITC equipment and competent administration staff may be required.
Harm	1 **Harm to a person**: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent damage.

	2 **Harm to a thing**: Damage to a thing may include damage to facilities or systems; for example environmental, financial data protection breach, etc.
Hazard	A circumstance, agent or action with the potential to cause harm.
Lookback Review	A re-examination of a process(es) which has delivered results that were not to the expected quality standards.
Proforma	A page on which data is recorded. The page has predefined prompts and questions which require completing.
Quality Assurance	A check performed and recorded that a certain function has been completed. Negative outcomes must be reported and actioned.
Recall	An act or instance of officially recalling someone or something. In the context of the Lookback Review Process, the recall will involve the examination of the service user and/ or the review all relevant records in line with the Terms of Reference and will identify any deviations from required standards of care. Appropriate corrective actions will be identified as appropriate.
Risk	The chance of something happening that will impact on objectives.
Risk Assessment	A careful examination of what could cause harm to people, to enable precautions to be taken to prevent injury or ill-health.
Serious Adverse Incident	In the context of a Lookback Review Process an SAI is any event or circumstance that meet the specific criteria laid out within the HSCB Procedure for the Reporting and Follow up of SAIs 2016 at www.hscboard.hscni.net.

Service Review Team/expert advisory group	A specially selected group of individuals, competent in the required field of expertise, to perform the Lookback Review Process
Service User	Members of the public who use, or potentially use, health and social care services as patients, carers, parents and guardians. This also includes organisations and communities that represent the interests of people who use health and social care services.
Triggering Event	The initial concern(s) or adverse incident which lead to the HSC organisation considering the initiation of the Lookback Review Process.

Appendices

Template for Risk Assessment

Appendix 1

Information about the event or concern that has given rise to the need to consider a lookback review process (include information in relation to any actual harm that has been caused as a result of this issue)**:**

Information about the potential extent of the issue (include information about the number of people, number of HSC organisations that might be adversely affected by the issue)**:**

Information about the potential outcomes of the issue (include information about the potential consequences of the issue e.g. missed diagnosis / missed return appointments / harm from contaminated equipment):

Information about the risk level of the issue (include information about the severity of harm that might occur in the people adversely affected by the issue). Use the Regional Risk Matrix (Section 2.7) to evaluate the risk.

Please tick one:

Extreme	
High	
Medium	
Low	

Additional Details:

Information about the potential cohort of service users affected (number, gender, age range):

Details of Immediate Action Required

Recommendations to Steering Group regarding Stage 2 Lookback Review (include recommendations for the Terms of Reference for the Lookback Review including recommended inclusion and exclusion criteria; and for scoping audit(s) of service users that might fall within the inclusion criteria):

Details of personnel who undertook the Risk Assessment:

Name	Title

Date of Risk Assessment :

Establishing the Service User Database – Core Dataset Appendix 2

The data below is a minimum dataset, it is however subject to change depending on the individual situation. Ideally the use of an existing HSC organisation database(s) is preferred.

- Unique identifier number;
- Surname;
- Forename;
- Title;
- Date of birth;
- Sex;
- Address line one (House name, number and road name);
- Address line two (Town);
- Address line three (County);
- Postcode.

- GP name;
- GP address line one;
- GP address line two;
- GP address line three;
- Postcode.

- Named consultant;
- Date of appointment/procedure1;
- Date of appointment/procedure 2;
- Date of appointment/procedure 3;
- Procedure one description;
- Procedure two description;
- Procedure three description.

- Reviewer 1 description;
- Reviewer 2 description;
- Data entered by – identification;
- Data updated 1 by – identification;

- Data updated 2 by – identification;
- Data updated 3 – identification.

Appendix 3

Initial Identification of Service Users involved in the Service Review/ Audit Stage

See Flow Chart - Process for advising that all service users who may have been affected (Appendix 3.1 Section 1)

See Flow Chart - Process for advising all service users known to be the affected cohort (Appendix 3.1 Section 2)

The retrieval of notes/x-rays/test results must be co-ordinated with the support from Medical Records staff.

A Service Review Proforma (Appendix 3.2) is attached to each set of notes.

The service user database needs to be updated after completion of this Proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Service Review Proforma should be transferred from the front of the notes and filed into the service users' records.

Conducting Further Assessment (Notes/X-rays/Test Results etc.)

A Notes/X-ray/Test Results Review Proforma (Appendix 3.3) is attached to the front of each set of service user notes.

The service review team will undertake a further detailed audit of the notes to review the outcomes of previous assessment/scans/tests.

The service review team will then decide if previous outcomes/diagnosis were accurate.

The Proforma will be completed by the Service Review Team.

- A green or red sticker is placed on the pro forma. The **green** sticker identifies a positive outcome and that no further follow up is required - Letter D is sent to service user.

- A **red** sticker identifies a negative outcome that requires a further assessment – Letter E is sent to service user.

The service user database needs to be updated after completion of this pro forma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Notes Review Pro forma should be removed from the front of the notes and filed into the healthcare record.

Conducting Further Assessment (Clinical)

A Clinical Review Pro Forma (Appendix 3.4) is attached to the front of each set of healthcare record.

The service review team will undertake a clinical examination/test/scan etc. as appropriate to determine a positive or negative outcome. One must bear in mind that timescales for test/scan results may differ depending on individual situations.

The pro forma is then completed by the Service Review Team. A **green** or **red** sticker is placed on the pro forma.

- The **green** sticker identifies a positive outcome and that no further follow up is required - Letter F is sent to service user.

- A **red** sticker identifies a negative outcome that requires further treatment which should be managed within normal clinical arrangements – Letter G is sent to service user.

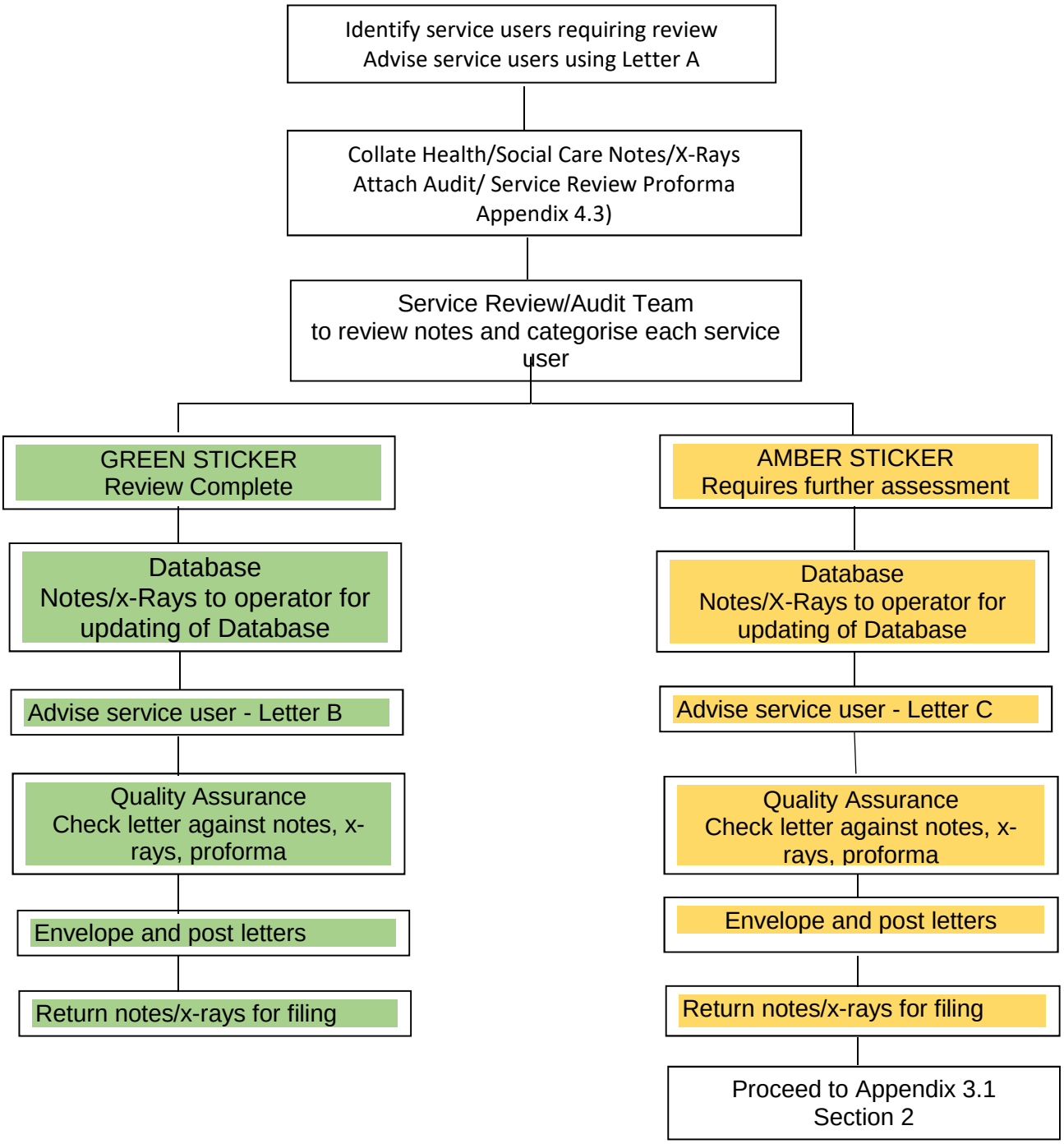
The service user database needs to be updated after completion of this proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Clinical Review Pro Forma should be transferred from the front of the notes.

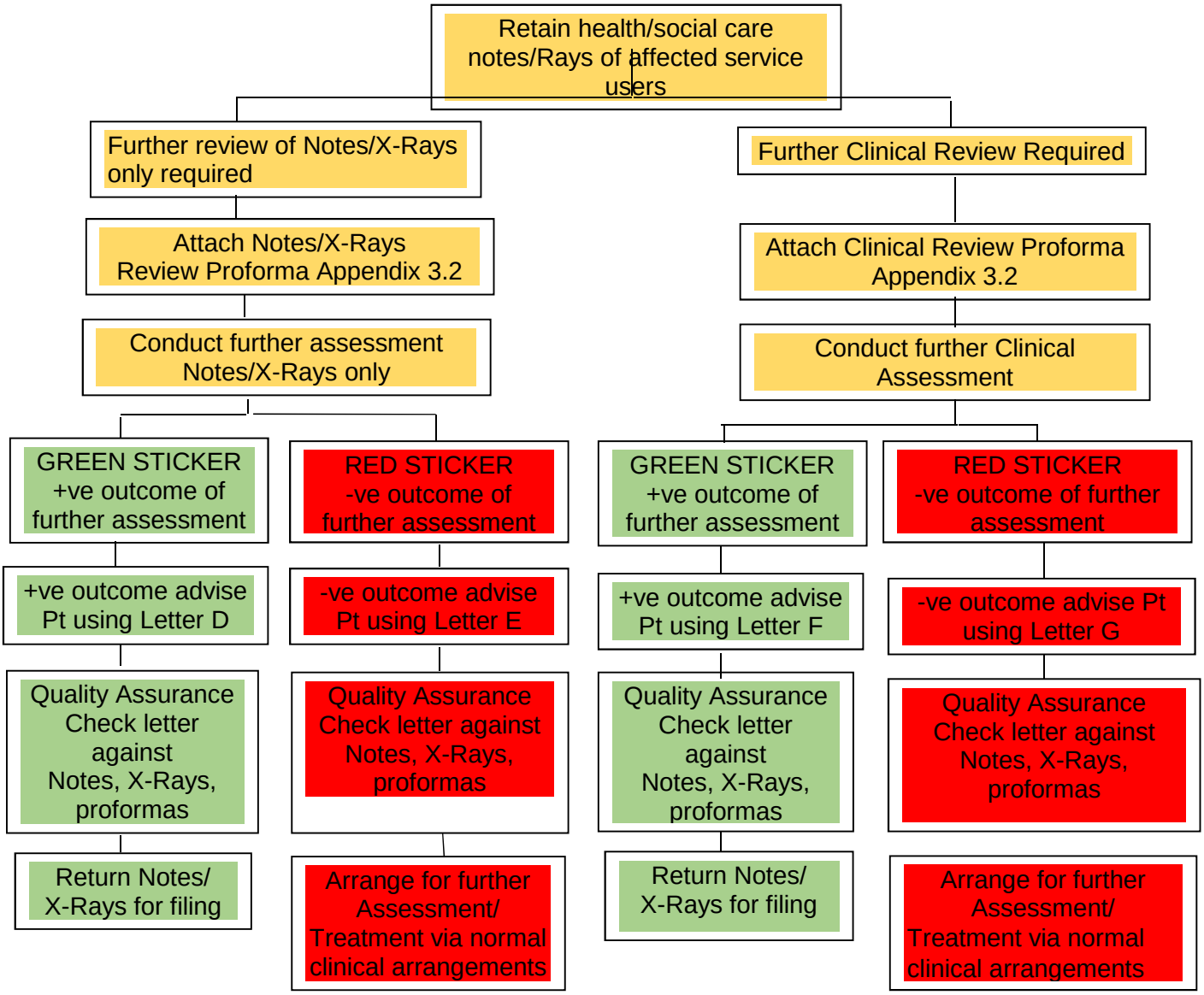
- If it has a **green** sticker attached: file into service user notes.
- If it has a **red** sticker attached: return service user notes and pro forma to admin support for processing within normal clinical arrangements.

Appendix 3.1 (Section 1) Advising service users who may be in the affected service user cohort



Appendix 3.1 (Section 2)

Process for Advising Service users known to be in the affected cohort.



Appendix 3.2 Service Review Proforma

SERVICE USER DETAILS (ATTACH LABEL)

CASENOTES REVIEWED ☐

X-RAYS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

(Give details)

DATE OF APPOINTMENT/SCAN/EXAMINATION REVIEWED ☐

REVIEWER 1

Signature & date

REVIEWER 2

Signature & date

GREEN STICKER – REVIEW COMPLETE

AMBER STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Appendix 3.3 NOTES/X RAY REVIEW PROFORMA

SERVICE USER DETAILS (ATTACH LABEL)

ADDITIONAL INFORMATION

CASENOTES REVIEWED ☐

X-RAYS/SCANS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

ADDITIONAL TESTS/SCANS/X-RAYS REQUIRED ☐

CLINICAL REVIEW REQUIRED ☐

REVIEWER 1

Signature & date

REVIEWER 2

Signature & date

GREEN STICKER – REVIEW COMPLETED

RED STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Appendix 3.4 CLINICAL REVIEW PROFORMA

DETAILS (ATTACH LABEL)

	OUTCOME	
	+VE	**-VE**
CLINICAL EXAMINATION	☐	☐
TEST	☐	☐
SCAN/X-RAY	☐	☐
BIOPSY	☐	☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED
(Give details)

	YES	**NO**
FURTHER FOLLOW REQUIRED: PROCESS INTO NORMAL CLINICAL ARRANGEMENTS	☐	☐

CONSULTANTS SIGNATURE: _____DATE:_____

GREEN STICKER – REVIEW COMPLETED

AMBER STICKER – FOLLOW UP REQUIRED
PROCESS INTO NORMAL CLINICAL ARRANGEMENTS

RED STICKER - FOLLOW UP REQUIRED
REQUIRED URGENT REFERRAL

DATABASE UPDATED ☐ (Signature & date) _____

ADMIN QA CHECK ☐ (Signature & date) _____

LETTER SENT ☐ (Signature & date) _____

Appendix 3.5 DRAFT LETTERS

Although there will be one “master” letter, you will need to generate several variants from it for different circumstances e.g. when the service user is a child.

The following are provided for suggested content only.

LETTER A: Advising of a Lookback Review Process

LETTER B: No further follow up required

LETTER C (version 1): Further follow up is required – Notes only

LETTER C (version 2): Further follow up is required – Clinical

LETTER D: Positive outcome of further assessment – Notes only

LETTER E: Negative outcome of further assessment –Notes only

LETTER F: Positive outcome of further assessment – Clinical

LETTER G: Negative outcome of further assessment – Clinical

LETTER H: Letter to General Practitioner to advise them that the service user(s) are being included in the Recall Phase of Lookback Review Process

LETTER A: Advising of a service review/lookback review process

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear < Title>

<***Title of Lookback Review Process***>

It has come to the attention of <*HSC organisation*> that < *a healthcare worker/system*> has <brief outline of the incident>.

We have decided as a precautionary measure to review each of the cases with which this <*healthcare worker/system*> has been involved since <*date range*>.

Your case will be included in this review, which will be a substantial process <*involving…..*>. We have initiated a Service Review Process and will endeavour to deal with this as timely as possible.

I wanted to inform you directly about this rather than letting you hear it through another source and I believe it is important that you are kept fully informed of the review process. We will write to you immediately after your case has been reviewed to advise you whether or not it will be necessary for you to have <*a follow up appointment/test*>.

If in the interim you have any queries, a special telephone helpline has been set up on <*freephone/Tel:xxxxxxxx*> so that you can discuss any concerns. It is staffed from <*date and time to date and time*>. This line is completely confidential and operated by professional staff who are trained to answer your questions.

Although there are a large number of call handlers, there will be times of peak activity and there may be occasions where you may not get through. In this event I would ask you to please call again at another time.

<*Enclosed is a factsheet with more detailed information, which you may find helpful*>.

Please have your letter when you call the helpline, as you will be asked to quote the unique reference number from the top of the page.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER B: No further follow up required

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <*HSC Organisation*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx / using the protocol*> and I am pleased to inform you that your <*case notes/assessment/test*> has now been reviewed and that **no further follow up is required.**

I fully appreciate that this has been a worrying time for you and I apologise for any upset this may have caused. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER C (version 1): Further follow up is required – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <HSC Organisation> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <*clinician/consultant*> has advised that **further follow up is required.** I must emphasise that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for <*name and grade of person*> to <*review notes/assessment*> and we will contact you again as soon as this is complete.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER C (version 2): Further follow up is required – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

We had previously written to advise you that <*HSC Organisation*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <clinician/consultant> has advised that **further follow up is required.** I must emphasise that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for you to be seen in <*where*> on <*date & time of appointment*>.

Our service review team will be available at this appointment to discuss the clinical aspects of your case. I have enclosed directions to <*xxxxxxx*> and information on parking arrangements.

If you are unable to attend this appointment please contact <*Tel xxxxxx*> to allow us to reorganise this for you.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER D: Positive outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

I am pleased to advise you that your case has been reviewed by <*name and grade of person*> and we would wish to reassure you that <*he/she*> is satisfied with the quality of your original <*assessment/investigation/test*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER E: Negative outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

Your case has been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that the quality of your original <*assessment/investigation/test*> was unsatisfactory.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER F: Positive outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are pleased to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **NEGATIVE**. This indicates that you have not been exposed to <*infection/illness*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER G: Negative outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **POSITIVE**. This indicates that you have been exposed to <*infection/illness*>.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of HSC Trust)

Letter H: Letter to General Practitioner (informing them of the inclusion of their patient(s) in the Recall Phase of the Lookback Review Process)

Service user name & address

Dear <*Doctor Name*>

<Title of Lookback Review Process>

<*Service Name*> recently reviewed <*Procedure*> undertaken at the hospital in <*Date(s)/Year(s*)>. This review was part of a quality assurance process as we were not satisfied with the quality of a number of <*Procedure(s)*> carried out. As a precautionary measure our medical advisors have recommended that a number of service users who attended for <*Procedure*> are offered a <*Specialty*> outpatients appointment.

Our records show that your patient <*Name*> previously attended <*name of location*> for <*name of procedure*>*.* We have written to your patient to advise them that their file was reviewed as part of this process and to offer them an outpatient appointment.

If you have any queries about this letter, please contact <*Name person and contact details*>*.*

Yours Faithfully

(Chief Executive/Director of HSC Organisation)

Appendix 4 Setting up a Service User Helpline or Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of calls from service users, their families and the general public. It is recommended that site specific helplines are considered for persons affected and a more general information line for the wider public.

The following points should be considered by the Steering Group:

- An individual, such as a senior manager should be identified to coordinate and implement the Telephone Help Line;
- A meeting needs to be convened with a small number of individuals, with the necessary knowledge of the speciality, to establish the necessary systems to support the helpline/information line. It may be that Lead and Specialist Nurses are ideally placed to assist at this crucial stage of planning;
- Information Technology staff are essential members of this team to assist in establishing databases and the necessary technology. A senior member of staff from the Telephone Exchange is invaluable at this stage in planning.

Identification of Venue for Helpline/Information Line

- Ideally the Helpline should not be isolated from the main hub of the organisation. Staff need to be able to access others to seek advice while the Helpline is operational. However, it does need to allow confidential conversations to take place and requires a dedicated space.
- Cabling to allow sufficient telephones is required. Once the media report on the issue is in the public domain then there is likely to be an influx of calls.
- Free phone telephone numbers need to be agreed with Telephone Exchange staff or relevant department.
- It is advisable to have a failsafe system to capture additional calls if the telephone lines become blocked with calls. This may involve agreeing with the Telephone Exchange staff to take details from those callers who are unable to get through quickly and ensure one of the Helpline staff return the call within an acceptable timeframe.

- Once the number of Helpline stations are agreed, personal computers are required for each to facilitate easy access to service user information. IT staff will assist in accessing the necessary cabling and hardware.

Briefing Paper for Helpline Staff

- It is important that those manning the Helpline should be trained and briefed. They should be provided with training and background information on the circumstances surrounding the Look Back exercise.
- Files should be prepared and updated daily with the initial press release and briefing notes on the subject (see Key Messages below).

Production of Algorithms

- Staff manning the Helpline will find it useful to have simple algorithms which assist in giving accurate information to callers. It may be that the caller has no reason to be alarmed when they are informed they are not within the affected group of service users.

Production of Key Messages

- Helpline staff need to be confident in the messages they are giving to callers. To assist this “key messages” should be agreed with the clinical teams and these are read to callers in response to specific questions. Helpline staff must not deviate from these messages.
- Some anxious callers will ring on many occasions and it is vital that if they speak to different Helpline staff they are being given a consistent message.
- Key messages will change as the review progresses. These then require to be updated in the individual files for Helpline staff.

Production of Proforma

- As each call is received it is important to maintain a record. A proforma should be designed to capture the relevant information. It should not be so detailed that the caller feels annoyed, however there needs to be sufficient to ascertain if follow up action is required.
- If the Helpline staff believe that follow up is required then a system needs to be agreed to segregate proformas, perhaps by identifying follow up calls with a red

dot. By the following day these need to have been actively followed up, probably by clinical staff in the speciality being reviewed.

- For completeness and post Look Back audit purposes a database of Helpline calls might be helpful.

Production of Rotas

- The Helpline opening times need to be agreed at the outset so that rotas can be produced. However as stated earlier the extent to which the matter is covered in the media will largely dictate when the calls might be made and some flexibility might be required. There is a strong correlation between media reports and number of calls made.
- In the early stages it will be essential to have staff with good communication skills. Staff will need to be released very quickly from their "normal" duties to assist with this work. There may need to be back filling of these posts to release these staff to assist.
- While staff should not be asked to work more than 6 hours at any one time on the Helpline, it is recognised that in the first few days resources may be stretched. On occasion some normal hospital business may need to be suspended temporarily. Overtime and out-of-hours arrangements should be considered and agreed through the Human Resources Department prior to the commencement of the Helpline.
- Ideally if new staff are coming onto the rota there should always be one member of staff who is familiar with the system and can advise others and co-ordinate overall. As far as possible the help lines should be staffed by experienced people with an understanding of the governance and duty of care responsibilities. Briefing on this area is helpful to understand the corporate responsibility.

Staff Briefing

- Briefing of staff, particularly in the early stages of the exercise is vital. A leader needs to be identified to take this role. This would normally be an Executive Director.

- Staff need to feel they are being listened to during the exercise. If they believe that the system could be improved they should have that opportunity to discuss their views at a daily staff briefing session.
- Catering arrangements should be in place for staff who assist in this work. Regular coffee breaks should be accommodated.

Appendix 5 Lookback Review Process Guideline – Process Checklist Template

	Look-back Review Process **The purpose of the check-list is to act as an aide memoir to managers and staff to assist them to ensure compliance with the HSE Look-back Review Process Guidelines.** **The check-list must always be used in conjunction with the Lookback Review Process Guidelines. References to the relevant sections of the Guideline have been included in the check-list.**	**You should refer to the relevant Guideline Section(s) for guidance on each stage of the process.**	**Tick as appropriate**		
1	**Stage 1: Scoping the extent, nature and complexity of the Lookback Review**	**Section**	**Yes**	**No**	**N/A**
1.1	Chief Executive notified that a Lookback Review Process may be required	**2.1**			
1.2	Chief Executive or nominated Director has established a Steering Group and Terms of Reference were agreed	**2.2 – 2.4**			
1.3	The Risk Assessment was commissioned by the Steering Group	**2.7**			
1.4	Using the information obtained from the Risk Assessment, the Steering Group made a decision to progress to the Service Review/ Audit and Recall stages of the Lookback Review Process	**2.7 – 2.8**			
1.5	The Chair of the Steering Group has notified the relevant bodies (DoH, HSCB, PHA) of the decision to progress with the Lookback Review Process	**2.9 – 2.10**			
2	**Stage 2: Identifying and Tracing Service Users at Risk**	**Section**	**Yes**	**No**	**N/A**
2.1	The Steering Group agreed the Scope and the Terms of Reference of the Service Review/ Audit and Recall stages of the Lookback Review Process	**3.1**			
2.2	The Steering Group developed a Lookback Review Action/Work Plan to inform the Audit and Recall Stages of the Lookback Review Process	**3 .1 – 3.2**			
2.3	A database was established to collate and track the information gathered by the Lookback Review Process	**3.2 – 3.3**			
2.4	The Service Review/ Audit was undertaken by nominated team or experts commissioned by the Steering Group	**3.4**			
2.5	The Service Review/Audit identified persons affected to be included in the Recall stage	**3.4**			
2.6	The Helpline/ Information Line was established by the Steering Group	**4.2 , 4.5 & Appendix 4**			

3	Stage 3: Recall Stage	Section	Yes	No	N/A
3.1	The Recall stage was announced by the relevant Director	**4.3 – 4.4**			
3.2	The Recall stage was announced after persons affected had been informed of their inclusion in the Recall stage of the Lookback Review Process	**4.4**			
3.3	The Recall Team(s) implemented the Recall stage as per the Steering Group Action Plan	**4.1**			
3.4	The Recall Team identified actions to be taken to address any deviations from required standards of care	**4.1**			
3.5	The Recall Team implemented actions and/ or communicated required actions to the Steering Group	**4.1**			
3.6	The Steering Group undertook an evaluation of the Lookback Review Process and developed an anonymised report with recommendations and learning	**5**			
3.7	The Chair of the Steering Group submitted the anonymised report to Chief Executive and relevant external bodies	**5**			

Policy for Implementing a Lookback Review Process

Final draft

Contents

This policy should be read in conjunction with the Regional Guidance for Implementing a Lookback Review Process.

This policy, and the accompanying Regional Guidance, replaces HSS (SQSD) 18/2007 issued by the Office of the Chief Medical Officer on 8 March 2007.

Lookback Review Policy

1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have potentially been exposed to a specific hazard, in order to identify if any of those exposed have been harmed and to identify the necessary steps to ameliorate the harm as well as to prevent further potential occurrences of harm.[1]

A Lookback Review is a process consisting of four stages;

- immediate action including a preliminary investigation and risk assessment to establish the extent, nature and complexity of the issue(s),
- the identification of the service user cohort to identify those potentially affected,
- the recall of affected service users and finally
- closing and evaluating the Lookback Review Process and the provision of a report including any recommendations for improvement.

The decision that a Lookback Review is required, often occurs after a service user, staff member or third party such as a supplier has reported concerns about the death or harm to a service user, or the potential for death or harm, the performance or health of healthcare staff, the systems and processes applied, or the equipment used.

The triggers for consideration of a Lookback Review may include, but are not limited to the following:

- Equipment found to be faulty or contaminated and there is the potential that people may have been placed at risk of harm;
- Concern about missed, delayed or incorrect diagnoses related to diagnostic services such as screening, radiology or pathology services;
- Concerns about incorrect procedures being followed or evidence of non-compliance with extant guidance;
- Concerns raised regarding the competence of practitioner(s) or outdated practices;

[1] Health Service Executive (HSE) 'Guideline for the Implementation of a Look-back Review Process in the HSE', HSE National Incident Management and Learning Team, 2015. Section 1 page 4.

- A service review or audit of practice shows that the results delivered by either a service or an individual were not in line with best practice standards and there is a concern that there was potential harm caused to a cohort of service users as a result;
- Identification of a staff member who carries a transmissible infection such as Hepatitis B and who has been involved in exposure-prone procedures which have placed service user at risk; or as
- A result of the findings from a preceding Serious Adverse Incident review, or thematic review by the Regulation Quality and Improvement Authority.

This Policy, should be read in conjunction with the 'Regional Guidance for the Implementation of a Lookback Review Process' which documents the steps, including the service user and staff support and communication plans that are to be undertaken by Health and Social Care (HSC) organisations when a Lookback Review Process is initiated. HSC organisations should develop their own local policies and procedures, consistent with this Regional Policy and related Guidance, to address any potential Lookback Review Processes.

As the triggers for considering a Lookback Review process may also constitute a Serious Adverse Incident (SAI) and/or an Early Alert, the Policy should also be read in conjunction with the Health and Social Care Board (HSCB) SAI Regional Guidance [2] and Department of Health (DoH) Early Alert Guidance.[3]

The circumstances may also require the HSC organisation to notify other statutory bodies such as the Coroners Service for Northern Ireland, the Police Service for Northern Ireland and/or the Health and Safety Executive for Northern Ireland. In that regard, all existing statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Policy.

2.0 Purpose

The purpose of this policy and regional guidance is to ensure a consistent, coordinated and timely approach for the notification and management of

[2] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incident'. November 2016.
[3] DoH 'Early Alert System' Reference HSC (SQSD) 5/19.

potentially/affected service users carried out in line with the principles of openness and candour, [4] [5] [6] whilst taking account of the requirements of service user confidentiality and Data Protection. [7] [8]

3.0 Objectives

The objectives of this policy are to:

1. Assist HSC organisations adopt a risk-based approach and ensure the timely management of appropriate and relevant care for affected groups of service users.

2. Establish a standard approach to notification of service users, families/carers, healthcare managers and the public of adverse incidents involving potential injury, loss or other harm to groups of service users.

3. Ensure that communication with, and support for, all affected and potentially affected service users, their families and/or carers and also staff occurs as soon as reasonably practicable, and in as open a manner as possible.

4. Ensure that the HSC organisation adopts appropriate support mechanisms for the health and well-being of staff involved.

5. Ensure that communication with the Department of Health (DoH), the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and the public occurs in a consistent and timely manner.

6. Ensure that HSC organisations' services have established and consistent processes in place when a Lookback Review is undertaken, that also maintain the business continuity of existing services and public confidence;[9]

[4] In his Inquiry into Hyponatraemia Related Deaths (IHRD), Judge O'Hara made recommendations concerning openness and candour. This included a recommendation for the legal duty of candour for HSC organisations and staff, as well as support and protections to enable staff to fulfil that duty. Work is underway to introduce the necessary legislation and policies to implement these recommendations.
[5] DoH 'Being Open – Saying sorry when things go wrong'. January 2020.
[6] National Patient Safety Agency (NPSA) 'Being open – communicating patient safety incidents with patients and their carers'. September 2005. Archived on 18 February 2009 at webarchive.nationalarchives.gov.uk.
[7] European Union (EU) 'General Data Protection Regulations (GDPR)'. 25 May 2018 at https://eugdpr.org.
[8] Data Protection Act 2018 at www.legislation.gov.uk
[9] South Australia Health ' Lookback Review Policy Directive', Safety & Quality, System Performance & Service Delivery, July 2016. Section 1 page 4.

7. Ensure that HSC organisations appropriately reflect upon the issues which prompted the Review and any learning from the outcomes of a Lookback Review within their systems of governance.

4.0 Scope

This policy and related guidance applies to all HSC organisations. The purpose of the policy and guidance is to provide a person-centred risk-based approach to the management of a Lookback Review and support to any service users and their families/carers who may have been exposed to harm, and to identify the necessary steps to ameliorate that harm. The scope of the policy and related guidance also includes providing information and support to those not directly exposed to the harm in question i.e. concerned members of the public.

Whilst the outcomes of a Lookback Review may inform other processes e.g. Serious Adverse Incident reviews or a Coroner's Inquest, this is not the primary purpose of a Lookback Review Process.

Section 1 identifies some typical examples of the concerns which may lead to a Lookback Review Process being initiated. Where those concerns relate to the health, capacity or performance of practitioner(s) this may trigger a parallel process of investigation and/or performance management. This lies outside the scope of this guidance.

5.0 Roles and Responsibilities

5.1 The Chief Executive is responsible for:

- Commissioning the Lookback Review Process and establishing a Steering Group to oversee the implementation of the Lookback Review in line with extant policy, procedure and guidelines. This will usually be delegated to an Executive Director/Service Director who will act as Chair of the Steering Group (see below);
- Ensuring that effective Lookback Review Processes are implemented, when required, in line with extant policies, procedures and guidelines and that adequate resources are allocated to facilitate effective Lookback Review Processes;

- Reporting the rationale for the implementation of a Lookback Review Process to the DoH, HSCB and PHA as appropriate and as per extant guidance; [10] [11]
- Ensuring that the Lookback Review process is conducted with openness and transparency; and
- Providing service users, families and/or carers with a meaningful apology, where appropriate;
- Communicating the findings of the Lookback Review Process to the HSC organisation's Board and to the DoH, HSCB and PHA as appropriate and as per extant guidance. [12] [13]

5.2 The Oversight Group/Steering Group is responsible for:

- Overseeing the service review/ risk assessment process to identify the scope of the issue and inform the decision to progress to the service review/audit and recall stages of the Lookback Review Process as required;
- Deciding on the requirement for progression to Stage 2 Identifying and Tracing the Service User's at risk and Stage 3 Service User Recall;
- Communicating the need for the service review/audit and recall stages of the Lookback Review Process through the organisation's governance structures/Assurance Framework to the Board of Directors and external stakeholders (including DoH);[14]
- Developing the Scope and Terms of Reference for each element of the Lookback Review Process;
- Overseeing operational management of all aspects of the Lookback Review Process;
- Developing a Lookback Review Action/ Work Plan which outlines the methodologies to be implemented in relation to the Audit and the Recall stages of the Lookback Review Process;
- Ensuring that arrangements are in place to capture and report information on the outcome of the Lookback Review Process;

[10] DoH. (SQSD) 5/19. *Op.cit.*
[11] HSCB. November 2016. *Op.cit.*
[12] DoH. *Op.cit.*
[13] HSCB *Op.cit*
[14] DoH. HSCB. *Loc. Cit.*

- Ensuring that the impact on ‘business as usual’ for all service users is assessed and reported on;
- Ensuring that service managers implement contingency plans for service continuity where necessary, including providing for additional health care demands which may arise as a consequence of the Lookback Review Process, this should include service users not included in the ‘at risk’ cohort who also may be affected by the impact on services as a result of the Lookback Review Process;
- Ensuring that arrangements are in place to provide support to both service users and staff e.g. counselling and welfare services;
- Ensuring that service managers allocate the necessary resources to implement the Lookback Review Process and to meet associated demands;
- Ensuring communication at the appropriate time and implementation of recommended actions arising from the Lookback Review Process.

5.3 The Operational Group/Lookback Review Management Team are responsible for:

- Supporting the Steering Group in the implementation of the Steering Group Lookback Review Action/Work plan (see above);
- Putting in place arrangements to capture and report information on the progress of the Lookback Review Process;
- Implementing contingency plans for service continuity including implementing plans for referral pathways, rapid access clinics, diagnostic or pathology services;
- Providing support to both service users and staff e.g. counselling and welfare services;
- Providing the operational arrangements to support the communication plan, at the appropriate time with the implementation of actions arising from the Steering Group’s Action plan to meet Stage 2 and Stage 3 of the Lookback Review Process.

5.4 The HSC Organisation Board of Directors is responsible for:

- Ensuring appropriate oversight of the Lookback Review and that this is reflected within the organisation's system of governance e.g. risk register;
- Satisfying itself that the Lookback Review Process is being undertaken in line with extant policy;
- Satisfying itself that the Lookback Review Process has been appropriately resourced in terms of funding, people with relevant expertise, access to expert advice and support, IT and any other infrastructure required;
- Satisfying itself that the impact of the Lookback review process on 'Business as Usual' is assessed, monitored and reported on with mitigating measures in place where possible;
- Satisfy itself that required actions identified by the Lookback Review Process are implemented;
- Providing challenge, management advice/guidance and support to the Lookback Review Commissioning Director and the Lookback Review Steering Group as required.

5.5 The Public Health Agency is responsible for;

- Providing advice/guidance and support to the Lookback Review Steering Group as required;
- Dissemination of information and notification to the wider health services of the adverse incident or concern as required;
- Assisting the HSC organisation with the Lookback Review Process Action Plan and Communication Plan as required.

5.6 The Health and Social Care Board is responsible for;

- Providing advice/guidance and support to the Lookback Review Steering Group as required;
- Dissemination of information and notification to the wider health services of the adverse incident or concern as required;
- Assisting the HSC organisation with the Lookback Review Process Action Plan and Communication Plan as required;

- Monitoring compliance with the HSCB ‘Procedure for the Reporting and Follow-up of Serious Adverse Incidents’;
- Assisting with the dissemination of learning from the Lookback Review Process.

5.7 The Department of Health is responsible for;

- Ensuring that the HSC reporting organisation complies with the Policy Directive;
- Providing advice and information to the Minister.
- Assisting the HSC organisation with the development and management of communication strategies to the wider health service.

6.0 Legislative and Regional Guidelines

- Health and Safety at Work (NI) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Freedom of Information Act 2000;
- EU Data Protection Regulation (GDPR) 25 May 2018;
- Data Protection Act 2018;
- Department of Health ‘Code of Practice for protecting the confidentiality of service user information’ 31 January 2012;
- HSCB Procedure for the Reporting and Follow-up of Serious Adverse Incidents 2016;
- Department of Health Early Alert System HSC (SQSD) 5/19;
- Department of Health ‘Being Open – Saying sorry when things go wrong’. January 2020.

Southern Health and Social Care Trust

Quality Care - for you, with you

Our ref:

Date: 27th April 2021

Seán Holland
Deputy Secretary, Social Services Policy Group/ Chief Social Work Officer
Department of Health
Castle Buildings
Belfast

Dear Seán

MENTAL CAPACITY ACT (NI) 2016 LEGISLATION

On the 12th November 2020 you wrote formally to each of the regional Health and Social Care Trusts requesting an extension of the implementation period for the Mental Capacity Act (2016) and the protection from liability. The extension to the implementation period was made based on the recognition of pressures faced by Health and Social Care Trusts relating to the COVID-19 pandemic. The original date for the criminal offence of unlawful detention was due to commence 2nd December 2020, the extended implementation period revised this date until 31st May 2021.

In January 2021, all Trusts wrote to you to alert to the continuing impact of the COVID-19 pandemic on regional Health and Social Care Trusts' ability to comply with the Mental Capacity Act (NI) 2016 legislation.

Commented [A1]: Was this individual or collective response

Each of the Health and Social Care Trusts has endeavoured to meet this deadline by engaging a range of options which have included offering additional hours and shifts and identifying additional staff to conduct this work. Specifically, to mitigate the impact of COVID-19, each regional Trust initiated a local contingency action plan to support the completion legacy cases which requires a Deprivation of Liberty Safeguards (DoLS) assessment. However despite these concerted efforts, prioritisation of critical

Trust Headquarters, Craigavon Area Hospital site, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information Email:

service needs did not allow for these tasks to be completed within the designated timescales.

It is important to recognise the legislative changes associated with the introduction of the Mental Health Act (2016) are comparable both in scope and scale to those introduced by the Children's Order (1995) which introduced important legislation for protection of children including those relating to emergency protection. It is of note the introduction of this previous legislation was accompanied by a range of training and organisational supports to ensure that health and social care organisations met their legal requirements. In particular there was no attempt to introduce individual criminal offences for non-compliance with the statutory framework.

The section below sets out the challenges faced by the Trusts in meeting the 31st May 2021 implementation deadline.

Absence of a Code of Practice
It is of concern given the significant implications of the legislation for service users and staff that a designated code of practice to complement the legislation has not been developed. A code of practice that would provide detailed practical guidance on how to comply with both organisational and individual legal obligations we believe is essential for successful implementation.

Engagement of General Practitioners (GPs)
While there are particular implications for work in respect of legacy cases, the continued absence of involvement from GP colleagues presents additional challenges to the longer-term work requirements. The Trusts are of the view that renewed efforts to enable GP meaningful engagement, particularly in relation to community cases where their extensive and developed patient knowledge brings particular value, would be very beneficial. It is noted that with the ongoing requirement for COVID-19 centres and the regional vaccination programme, significant GP input will be difficult to obtain in the short term.

Trust Medical and Non- Medical Staffing Capacity
The implementation of the Act places a heavy reliance on medical staff. Each of the Trusts has made significant efforts to ensure the availability of key medical personnel to support this work. However recruiting all staff with the requisite skills and

experience has proven challenging despite the introduction of numerous and varied recruitment strategies.

DoLS Documentation
The process for completing DoLS documentation is detailed and is more extensive than the provision of a clinical summary by the attending practitioner. This has led to Attorney General's office not accepting documentation that is deemed not to have met a 'gold standard', which has resulted in delays in process. Delays are also occurring regarding the requirement to complete Rule 6 Statements for Review Tribunals and 1st and 2nd extensions are being prioritised to avoid DoLS lapsing. This is reducing teams' capacity to progress new and legacy DoLS.

Department of Legal Services (DLS) Advice
Trusts have collectively sought legal advice on the impact of the Act given the likelihood that all Trusts will be non-compliant by the time of the current deadline.
DLS have considered the legislation which has the potential for making numerous deprivations of liberty where Trusts and individual staff are acting in the best interests of individuals to keep them safe will become criminal offences. DLS have noted that the new offences of unlawful detention will be unique to Northern Ireland and that no such similar offences currently exist in England and Wales, Scotland or the Republic of Ireland.

COVID-19 Related Challenges
COVID-19 pressures have significantly impacted on the Trust's ability to meet the deadline. This includes Surge 3 which particularly impacted access to facilities and to key nursing staff. Also Trusts have been unable to redeploy staff in sufficient numbers to undertake work relating to the implementation of the Act.

Despite these challenges each Trust is continuing to operationalise, manage and monitor contingency plans to meet the requirements of the Act in full.

As referenced in your 12th November 2020 correspondence we remain cognisant of the importance of deprivation of liberty safeguards and the role they play to protect some of the most vulnerable people in our community and to ensure that people's autonomy is protected.

As a result of the continuing impact of the COVID-19 pandemic on the delivery of Trust services we are formally asking as a collective group for the Department of Health to provide a further extension of this implementation phase to allow for the full operational delivery of the requirements of the Act and consider additional supports as set out above to ensure its successful implementation.

As Chief Executives we believe that providing a further extension on the implementation period and delaying the commencement of the criminal offence of unlawful detention will continue to provide a lower risk and safer option for service users and staff moving forward.

Yours sincerely

Southern Health and Social Care Trust

Nosocomial COVID-19 Deaths Mortality Review Process

Version 1

Date: 23rd March 2021

Southern Health and Social Care Trust

Background

1. COVID-19 has been extensively documented as a particularly potent and virulent nosocomial infection that can spread easily in health care settings in part due to the increased susceptibility to infection among patients with co-morbidities and those who are immunocompromised.

2. As a result of the COVID-19 pandemic the Trust has experienced to date (23rd March 2021) 392 patient deaths where COVID-19 was recorded on either Part 1 or 2 of their death certificate.

3. As part a key element of Patient Safety, the Trust operates a Morbidity and Mortality review process that as part of its function reviews and quality assures the care we provided to our patients who die while resident under our care.

4. Given the scale and spread of COVID-19 and the subsequent number of deaths that record COVID-19 as a factor the Trust has developed a stratified review approach that utilises the Public Health Agency algorithm for assigning probability of COVID-19 resulting from nosocomial source, the Royal College of Physicians Structured Judgement Review and the regional Serious Adverse Incident review processes.

Mechanism of Review

The stages of the review process are as follows, a flow chart of actions is attached below

Identification of Patients with COVID-19 as a Cause of Death

5. Patients with COVID-19 recorded on their death certificate are held in electronic form by the MDO Patient Safety team. The Trust COVID-19 'App' allows for the automatic identification of patients according to the Public Health Agency definitions of Indeterminate, Probable and Define hospital onset of COVID-19.

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Information Collation

6. The Post Infection Review form will be initially pre-populated with patient information from electronic records by the MDO support team (Medical Technicians). The IPC team will review the content of the forms for completeness.
7. A Structured Judgement Review will be conducted by one of the Trust trained Medical reviewers, pending the outcome score a second, verification will be required if concerns in care are identified by the first reviewer.

Serious Adverse Incident Process

8. For those cases where the Structured Judgement review outcome indicates potential issues with care, the case will be considered for adverse incident screening and if required enter in to the Serious Adverse Incident review process.

Sharing of Learning from Nosocomial COVID-19 Mortality Reviews

9. Where learning has been identified from either post infection review, Structured Judgement Review or Serious Adverse Incident process this will be shared with Trust Morbidity and Mortality meetings and via other relevant Trust shared learning mechanisms.

Mortality Sign Off by M&M Chairs

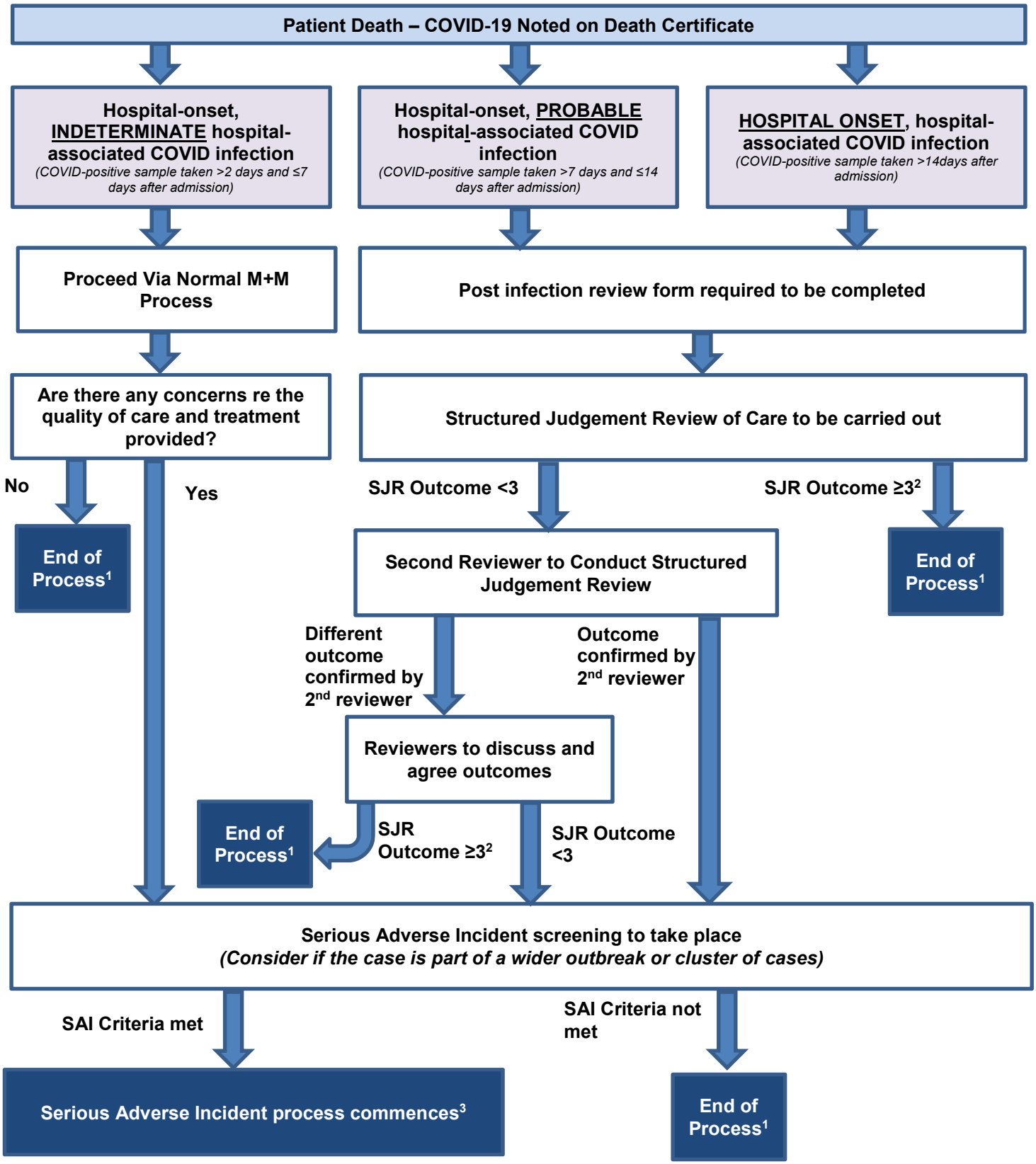
10. M&M Chairs will be asked to suspend full sign off of cases either found to be a result of probable or define nosocomial transmission pending completion of the Nosocomial mortality review process.

Timescales for Delivery

11. It is anticipated that based on the number of cases requiring review this process will take approximately 3 months to complete.

Southern Health and Social Care Trust

Appendix 1 - Nosocomial COVID-19 Deaths Mortality Review Process



[1]A Generic theme analysis will be conducted for all cases. Any relevant learning shared including via M+M. This will include areas of good practice and any assessment of problems identified.
[2] If there are there any concerns re the quality of care and treatment provided consideration should still given as to whether this reaches the threshold for an SAI?
[3]Any relevant learning shared including via M+M.

Southern Health and Social Care Trust

Appendix 2 – Post Infection Review Form

Addressograph	**Confidential** (When completed) **COVID-19 MORTALITY Information (SHSCT)**

Name		**Gender**	**F/M**
HSC			
D.O.B		**AGE**	
Address			
Consultant			
Speciality			
GP			
Hospital of 1st Admission			
ED Admission	**Yes/ No**		
Planned Admission	**Yes/ No**		

DIAGNOSIS

Presenting complaint	

Patient outcome (at point of completing this form) tick appropriate

Fatal		**Non-Fatal**	

Frailty Score (if known)

Charlson co-morbidity score	

CURRENT ADMISSION

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Date of Admission	
Date of death	
No of days between death/ discharge and admission	

If admitted from a long term care facility, name of facility	
Was the facility known to have a COVID-19 outbreak at that time?	

PREVIOUS ADMISSION within 14 days prior to positive test: **YES/NO**
If YES, please give detail test

Place (please note location if known)	Date of Admission	Date of Discharge	Length of stay

MOVEMENT OF PATIENT DURING CURRENT ADMISSION Ward(s): Please list all the wards and bed moves with dates where the patient have been during this admission (including bed spaces)

Hospital and Ward	Bed location (BAY and BED NO)	Single room YES/ NO	Dates	Duration of stay

Total number of bed moves during episode, EXCLUDING ED:	**0**

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How long after covid positive test was patient isolated? (hours)	0

RISK FACTORS

Older age ≥ 70 years			
Cardiovascular Disease			
Chronic Respiratory Disease			
Renal Disease			
Diabetes			
Hypertension			
Cancer			
Chemotherapy or immunosuppressive agents and/or steroid			
Obesity: BMI: ≥ 30			
Smoker			
BAEM			
Other			

TESTING

Covid Type Result: Circle as appropriate	Group 1	Group 2	Other

	Yes	No	N/A

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Was a repeat of negative screen completed within 5-7 days?			
Repeat PCR Test prior to discharge to Care Home (if relevant)			

EXPOSURE HISTORY *before* patient's positive test within 14 days of positive COVID test

Hospital setting

	Yes	No	Not available
Patient admitted via Respiratory ED			
Please note time spent in ED if appropriate			
Did patient have any contacts in previous 14 days prior to positive test with a patient who subsequently tested positive?			

COVID 19 INFORMATION OF DEATH CERTIFICATE

Death Certificate information:	
Place of Death: Please tick out as appropriate	☐ Hospital ☐ in the community within 28 days
Part 1a	
Part 1b	
Part 1c	
Part 2	

Communication with Patient	YES/ NO
Communication with Patient's relative	YES/ NO

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M&M Summary Attached (if appropriate)	Yes

Additional Information and Comments

Root Cause Analysis

Root Cause Analysis			
Contributory Factors		Tick relevant boxes	
1. Communications and team working		6. Policy and protocol	
2. Training, skills and knowledge includes use of appropriate PPE		7. Care pathway: includes failure of appropriate testing	
3. Workload and staffing resources		8. Patient-derived risk factors	
4. Environmental conditions; includes cleaning		9. Treatment-derived risk factors	
5. Equipment and utilisable resources: includes re-use of equipment		10. Failure of isolation	
		11. Visitor factors (e.g. potentially contaminated items brought in by family members).	

Issues identified (provide and explanation of the contributory factors – enter under corresponding section number)	
1	
2	
3	
4	
5	
6	
7	
8	

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9	
10	
11	

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Lessons Learnt / Lapses in care

Action Plans / Changes in practice to prevent further cases

Further comments / Recommendation

Completed by			
Name: (print)		Job Title:	
Signature:		Date:	
Updated			
		Date :	

Additional information:-

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

MEDICAL REVALIDATION OVERSIGHT GROUP

TERMS OF REFERENCE (20th April 2021)

Purpose

Medical revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice. A cornerstone of the revalidation process is that doctors participate in annual medical appraisal. On the basis of this and other information available to the Trust Responsible Officer (RO) from local clinical governance systems and additional feedback mechanisms, the RO makes a recommendation to the GMC, normally once every five years, about the doctor's revalidation.

The purpose of the Trust Medical Revalidation Group (the Group) is to provide a forum for Trust Medical Senior Management Team members to consider and inform decision regarding medical revalidation of Trust licensed doctors.

Aim and Objectives

The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership will:

- Provide assurance that opportunities for reflection, learning and development e.g. significant events and complaints have been adequately discussed and reflected on appropriately at appraisal
- Ensure there is has been a formative approach taken to the doctors appraisal process and there has been an appropriate level of engagement by the doctor
- Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the RO's decision prior to the revalidation recommendation date
- Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the responsible officer allowing for an informed decision to be made regarding a recommendation for revalidation

- Bring to the attention of the RO any additional information that has not been captured in other sources that require the consideration of the RO prior to making a revalidation recommendation.

Membership

Members of the group shall be made up of:

- Medical Director (Chair)
- Deputy Medical Directors
- All operational Associate Medical Directors / Divisional Medical Directors
- Assistant Director – Medical Directors Office

Others may be invited by the Chair to attend all or part of any meeting as and when appropriate and necessary.

Quorum

The quorum necessary for the meeting will be each AMD / DMD or nominated deputy for each operational area.

Members should aim to attend all meetings.

Frequency of Meetings

The Group shall meet via Zoom on a monthly basis.

Group members will receive agenda and papers confidential to their area no less than five working days in advance of the meeting.

Stinson, Emma M

From: OKane, Maria
Sent: 09 December 2020 11:01
To: Wallace, Stephen
Subject: FW: IPR's

Can we discuss???

From: Gibson, Simon
Sent: 09 December 2020 08:44
To: Reid, Trudy; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

See below

Individual Performance Review

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: Reid, Trudy
Sent: 09 December 2020 08:44
To: Gibson, Simon; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

Simon I have a mental block, what is it?
Trudy

From: Gibson, Simon
Sent: 09 December 2020 08:28
To: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: IPR's

P>S – If you don't have one, I'm sure we could all help you put one together as a baseline document

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: OKane, Maria
Sent: 09 December 2020 08:26
To: Wallace, Stephen; Reid, Trudy; Gibson, Simon
Subject: FW: IPR's

What are iprs?

From: Devlin, Shane
Sent: 08 December 2020 11:07
To: Beattie, Brian; Magwood, Aldrina; McClements, Melanie; McNeany, Barney; OKane, Maria; O'Neill, Helen; Morgan, Paul; Toal, Vivienne; Trouton, Heather
Cc: Alexander, Ruth; Campbell, Emma; Stinson, Emma M; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Livingston, Laura; PADirectorofP&RSHSCT; Willis, Lisa
Subject: IPR's

Dear All

At our next 1:1 meetings we will be discussing IPR's for 2019/20 and 2020/21. Can I ask that you do two things in advance of the meeting.

1. Please review your 2019/20 IPR noting achievements (up until 31st March 2020) and forward to me.
2. Based on 2019/20 IPR produce for 2020/21 a roll forward of those items not achieved in 2019/20. I would then suggest a general statement, which I will prepare, to go into all IPR's with regards to managing the organisation through the COVID-19 pandemic

Given the year of COVID we have had, I think this is a fair approach to IPRs for 2020/21.

We will for 2021/22 have a modified approach and I will discuss this further.

Many thanks, Shane

Southern Health and Social Care Trust
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Version 5 – 11th February 2021

Principles for the Management of Surgical Paediatric Patients up to their 16th Birthday

1) Introduction

These principles have been developed to provide clear guidance with regards to the admission and management of children and young people up to their 16th birthday with surgical presentations.

Children and young people before their 16th birthday will be admitted to the Blossom Children's and Young People's Unit, Craigavon or Daisy Children's and Young People's Ward Daisy Hill Hospital.

2) Exclusions

Young People excluded from these admission arrangements are those with specific specialist needs where they will be admitted to the specialist areas with support from Paediatric teams if requested:

- Trauma & Orthopaedics (T&O)
- Obstetrics & Gynaecology (OG)
- Emergency Department (ED)

Children and Young People up to their 16th Birthday with Diabetic Ketoacidosis (DKA) will be admitted to the CYP wards. Young adolescents 16 -18 years in DKA will be admitted to adult wards under the care of General Physicians with support and advice as requested from Paediatric Consultants; the paediatric DKA Pathway will be used in the management of these young people.

3) Purpose and Scope

a. This guidance is aligned with the following documents:

- the Royal College of Surgeons documents "Working together to improve the local delivery of the *General Surgery of Childhood - Statement of Intent (2018)*[1] and *Standards for Non Specialist Emergency Surgical Care of Children (2015)*[2]

- The recommendations from Inquiry into Hyponatraemia-related Deaths (IHRD) Clinical Workstream 4

a. The Southern Health and Social Care Trust is committed to providing safe, appropriate local surgical care to paediatric patients presenting to the Trust in both elective and non-elective settings. Each paediatric surgical patient will be in the care of a named Surgeon. Where specialist Paediatric input is required the 'Paediatrician of the Week' (and their Paediatric medical team) will be available to discuss the case and provide guidance.

b. Where Paediatric input has been sought from the 'Paediatrician of the Week' the Paediatricians name will be recorded in the child's notes. Equally, children who are under the care of a Paediatrician who require discussion or advice is the Surgical Team will have the Consultant Surgeon name recorded in the notes.

c. Paediatric patients are defined as all patients up to their 16th birthday.

d. The working practices outlined in this paper relate to children (<16yrs) admitted under the care of any surgical specialities within Southern Health and Social care trust, including to General Surgery, Urology, ENT, Trauma and Orthopaedics and Gynaecology. References in this document to surgery / surgical patients refer to children & young people under the age of 16 admitted under the care of any / all of these specialities. This excludes admissions requiring the admission to be into maternity services units'

e. The IHRD report highlighted some risks of current, established care pathways in the management of children, in particular with regards fluid management in the sick child.

f. Regional working group (clinical workstream 4) established to examine the recommendations of the O'Hara report have highlighted that some recommendations

[1] Working together to improve the local delivery of the General Surgery of Childhood, Royal College of Surgeons (2018) https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/final_workingtogethertoimprovethelocaldeliveryofthegeneralsurgeryofchildhood_110618.pdf

[2] Standards for Non Specialist Emergency Surgical Care of Children, Royal College of Surgeons (2015) https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/standards-and-policy/service-standards/childrens-surgery/service-standards-for-csf-final-published-101215.pdf

(e.g. recommendation 12 'Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients) would not provide the care required by children and young people requiring surgical intervention/management'. The trust is committed to establishing working patterns and care arrangements which intend to mitigate the deficiencies in care highlighted in the findings of the O'Hara report.

1) Southern Trust recognises that current surgical training programmes in Northern Ireland provide limited exposure to surgery in childhood and in particular limited exposure to the recognition and management of the deteriorating / sick paediatric patient.

2) Southern Trust also recognises that established surgical consultants manage small numbers of children during their ongoing practice, and in particular manage very small numbers of sick children or those requiring IV fluid replacement or those with long term medical conditions (eg diabetes). In recognising this, Southern Trust recognises that surgical consultants are not able to provide adequate clinical supervision of junior surgical care of trainees in these aspects of care.

3) Southern Trust recognises that Paediatric teams have limited exposure and training in the management of surgical conditions.

4) While patients can only be admitted under the care of a single consultant, Southern Trust recognises that different individuals may provide inputs into specific aspects of a patients care. In such collaborative working, responsibilities for different aspects of a patients care are shared by the clinical teams. For example a patient with diabetes may be admitted with appendicitis and cared for during the admission by the surgical team and paediatric team. The surgical team would be responsible for the surgical aspects of care while the paediatric team would be responsible for management of the child's diabetes with the consultant surgeon as the named consultant. The Southern Trust recognises that clinicians providing input and advice on patients under the care of another clinician are responsible for this aspect of the patients care.

4) Southern Trust Inpatient / Day Case Paediatric Surgical Services

a. Paediatric surgical services are provided to children on the Craigavon Area Hospital and Daisy Hill Hospital sites (?and south Tyrone for children aged 14-16 eg T&O??).

b. Elective orthopaedic inpatient / day case treatments are only provided to children aged 14-16 in Southern Trust as per current commissioning arrangements.

c. Unscheduled care for paediatric surgical patients is provided in Daisy Hill Hospital (General Surgery and Gynaecology) and Craigavon Area Hospital (General Surgery, ENT, Urology, Gynaecology). Unscheduled orthopaedic services (Fracture services) are provided to children aged 14-16 in Craigavon Area Hospital.

d. Assessing and treating the very young presents specific surgical challenges which necessitate specialist skills. The trust guideline (Guideline Policy as to who should Operate on and Anaesthetise Children for Elective and Emergency Paediatric Surgery in Southern Health & Social Care Trust) recognises this and children under the age of 5 should be transferred for specialist care in the Royal Belfast Hospital for Sick Children (RBHSC) unless their treatment is time critical and can be safely assessed and treated by the available anaesthetic and surgical team in Southern Trust. Similarly assessing children with special educational needs can on occasion present specific diagnostic challenges which may necessitate a skill set outside of those possessed by the available Southern Trust surgical team.

e. Unscheduled care provided to children in Southern Trust includes the management of;

i. Minor injuries (DHH and CAH)

ii. Appendicectomy (DHH and CAH)

iii. Testicular torsion / acute scrotum (DHH and CAH)

iv. Abscesses (DHH and CAH)

v. Lifesaving surgery, including trauma, this includes the initial management and stabilisation of paediatric trauma patients in the Emergency Department (DHH and CAH)

vi. Outpatient only fracture services (<14) (DHH and CAH)

vii. Inpatient fracture services (14-16) (CAH)

viii. Isolated Head injuries; below the age of 5 should be managed by the paediatric teams. Children over the age of 5, with minor head injuries, can be admitted for observation under the general surgical team. However, if the mechanism of injury is significant, or the child has multiple trauma, or a CT scan indicates ANY traumatic intracranial /head pathology the child should be referred to and transferred to RBHSC.

ix. ENT conditions refer to ENT protocol

x. Gynaecology refer to Gynaecology protocol

Management of conditions outside of this scope of practice may be carried out in Southern Trust where it lies within the competencies and expertise of individual consultants. However, where the locally available team do not have the required surgical expertise to treat conditions outside of these conditions it is expected that the child will be referred to the specialist paediatric surgical team in RBHSC.

5) Principles for Unscheduled Care Of Children

a. Most children admitted acutely in Southern Trust have uncomplicated inpatient stays and can be primarily managed by the admitting surgical team.

b. Small numbers of children have a more complex inpatient stay including, requirement for intravenous fluid resuscitation /maintenance, management of long term co-existent medical conditions or show deterioration in their paediatric early warning scores.

c. Some children may be admitted surgically with ongoing symptoms but without a surgical diagnosis. Similarly children may be admitted under the paediatric team with ongoing symptoms that may be explained by a surgical diagnosis.

d. Expertise for managing some specialist paediatric surgical conditions does not exist within either the surgical or paediatric teams in Southern Trust.

e. Paediatric and Surgical teams are committed to collaborative working within a shared care principle, with the teams agreeing responsibilities in patients requiring input from both teams.

f. Surgical trainees will have undertaken their BMJ hyponatraemia module and have completed in house training on prescribing IVF in children with the paediatric team. Prescriptions for short term (<24hrs), peri-procedural maintenance IVF will be prescribed by the surgical and / or anaesthetic team and the paediatric medical team will be available for assistance to support at all times.

g. Simple prescriptions, such as those for simple analgesia (eg ibuprofen and paracetamol) and oral antibiotics require dose calculations according to the patients weight and such prescriptions can and should be safely managed by the surgical team. Any concerns regarding dose should be raised with the appropriate team. Nurses and Pharmacists have a responsibility to ensure medications are prescribed in accordance with

professional standards and concerns raised by these members of staff should also be addressed appropriately.

h. More complex prescribing including prescription of IV antibiotics and IV fluid prescriptions, except short term peri-procedural maintenance IVF (as per 'f'), should be discussed with the paediatric team by the surgical juniors and this consultation detail and outcome clearly recorded in the notes including the name of the doctor giving the advice. IV fluid prescriptions should comply with Trust's IV fluid prescribing guidelines / hyponatraemia monitoring. Any advice provided should/must be recorded in the patient's notes in accordance with good clinical practice.

i. All children admitted under the care of the surgical team with long term conditions requiring medical treatment (eg diabetes) should have daily paediatric review specifically with regards the management of these medical conditions during their inpatient stay.

j. All children (under paediatric and surgical care) receiving IV fluids are discussed at the Paediatric safety huddle/ handover. The surgical team are welcome to attend the safety huddle. All surgical patients on IVF will be discussed with the surgical team at handover safety brief by paediatric team (9:00am and 4:45pm) to enquire re any concerns.

k. Foundation doctors in surgery form part of the clinical team and will be involved in the inpatient management of surgical paediatric inpatients. When assessing paediatric surgical inpatients, all input and decision making will be supervised by more senior surgical trainees (core trainee and above). Foundation doctors in surgery should always seek assistance from a doctor who is competent in prescribing IVF (Post foundation) when prescribing IV fluids and the IVF prescription will be co-signed by the paediatric doctor who provides input at the earliest opportunity. This support is available for all surgical trainees as required.

l. For children in whom there is no surgical diagnosis and ongoing symptoms should be referred to the paediatricians for review and joint discussion on ongoing care / management including consideration of seeking a specialist paediatric surgical opinion and agreement on responsibility for ongoing inpatient care. The reverse principle applies to children under the care of the paediatric team who have symptoms which may be attributable to a surgical diagnosis ie they should be referred to the surgical teams for review and joint discussion on ongoing care / management including consideration of seeking a specialist paediatric surgical opinion and agreement on responsibility for ongoing inpatient care.

m. All children admitted under the care of the surgical team, who are deteriorating on their Paediatric early warning score should be assessed by both the surgical team and paediatric team and a joint discussion regarding ongoing management should occur.

n. Children requiring surgical treatment outside of the expertise of the local surgical team should be referred to and transferred urgently to the specialist paediatric surgeons at RBHSC, and receive appropriate resuscitation / stabilisation with the input of surgical, anaesthetic and paediatric teams as required.

o. A clear unambiguous pathway for transfer of paediatric surgical patients to Belfast needs to be established. This is appropriate when experienced surgical staff feel that the resources (technical and physical) required by the patient have been exceeded in their present location (DHH or CAH), and ongoing care requires superior resources and expertise elsewhere.

p. Any child judged to require laparotomy should be transferred to Belfast EXCEPT in cases of emergency (no other option). DHH and CAH lack the resources and expertise for post-operative management of these cases.

q. In the spirit of shared care for the child, the surgical team may require assistance from the paediatric medical team with fluid or medicine prescriptions for a child under their care if they are unavailable in theatre, to enable timely care. Similarly, if imaging results are made available to the surgical team, and show significant non surgical pathology, the paediatric medical team are expected to provide input, and take over care where appropriate, upon request By surgical team

r. Nursing staff, using professional and objective criteria eg PEWS, must contact medical teams, surgeon or paediatrician as appropriate if there are concerns with a patient's condition.

DR MARK HAYNES
ASSOCIATE MEDICAL DIRECTOR
SURGERY AND ELECTIVE CARE

DR AHMED KHAN
ASSOICATE MEDICAL DIRECTOR
CHILDREN AND YOUNG PEOPLES SERVICES

Stinson, Emma M

From: Wallace, Stephen
Sent: 05 May 2021 09:02
To: Reid, Trudy; OKane, Maria
Subject: RE: Letter re SAI Procedures

Thanks Trudy,

Further to this I doubt the Trust would have the legal authority to access the required details for a full outbreak review, access to non-Trust residents and staff would make a full review all but impossible.

A much more pragmatic and sensible approach would be for the PHA to develop a pandemic outbreak review template (potential SJR based) for completion by the PHA and care home collectively. Its not a dissimilar solution to what we are doing for COVID mortality

---

From: Reid, Trudy
Sent: 04 May 2021 23:13
To: OKane, Maria; Wallace, Stephen
Subject: RE: Letter re SAI Procedures

Maria reviewing the guidance, I don't think it's as straight forward as 'overseeing the SAI in line with the regional SAI procedure' the here are some of the elements I thing guide us . The guidance would not have been written in the context of a pandemic where the PHA have responsibility for the management of COVID outbreaks as noted in the Draft Regional Infection Prevention and Control Framework for Northern Ireland. The HSC Trusts have been asked to provide IPC input/support to the homes, however, it is my understanding the PHA still get regular/daily updates from homes, give advice and formally close the outbreaks).
Some of the sections of note are
3.3 In*cidents that occur within the Independent /Community and Voluntary Sectors (ICVS) SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be* ***reported and reviewed by the HSC organisation who has****: - referred the service user (this includes Extra Contractual Referrals) to the ICVS; or, if this cannot be determined; - the HSC organisation who holds the contract with the IVCS. HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified. All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA….*

3.6 Reporting of SAIs to RQIA- ***RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure****. In order to* ***avoid duplication of incident notification and review****, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB: -*

- *All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986. –*
- *Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.*

It is acknowledged these incidents should already have been reported to RQIA as a 'notifiable event' by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service. –
The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

Can also be considered under MOU as it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations)…..

Appendix 13 notes
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.***

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.*

Happy to discuss

Regards,

Trudy

From: OKane, Maria
Sent: 01 May 2021 19:13
To: Reid, Trudy; Wallace, Stephen
Subject: FW: Letter re SAI Procedures
Importance: High

What does this mean exactly?

From: Reid, Trudy
Sent: 30 April 2021 22:21
To: OKane, Maria; Wallace, Stephen; Gormley, Damian; Diamond, Aisling; Doyle, Caroline; Beattie, Brian; Devlin, Shane
Subject: FW: Letter re SAI Procedures
Importance: High

Dear all please see attached letter received today from Rodney Morton and Brendan Whittle in relation to lead responsibility for SAI's in care homes.

Regards,
Trudy

Trudy Reid

Interim Assistant Director Corporate Clinical & Social Care Governance and Infection Prevention & Control
Craigavon Area Hospital
SHSCT
Mobile Personal Information redacted by the USI

From: OHara, Annette
Sent: 30 April 2021 11:10
To: Reid, Trudy; Wellwood, Gemma; Hedderwick, Sara; Boulos, Angel; McKeating, Cara; Donnelly, Claire Mary; Lewis, Kevin; Kelly, Kate; Rennie, Elizabeth; Lynch, Dymphna; Clarke, Colin; McClughan, Naomi; Soye, Barbara
Subject: FW: Letter re SAI Procedures
Importance: High

FYI

Kind regards
Annette

From: Hannah Gamble Personal Information redacted by the USI
Sent: 30 April 2021 10:44
To: Bob Brown (WHSCT); Beattie, Brian; Gillian Traub (BHSCT); Nicki Patterson (SEHSCT); Roy Hamill (NHSCT); Brenda Creaney (BHSCT); Catherine McDonnell; Lynne Charlton; OKane, Maria; Nicki Patterson (SEHSCT); Suzanne Pullins (NHSCT); sinead.okane Personal Information redacted by the USI ; Adverse Incidents North (HSCB); 'caroline.doyle Personal Information redacted by the USI '; Corporate.Governance; 'martine.mcnallly Personal Information redacted by the USI '; 'SeriousAdverse.Incidents Personal Information redacted by the USI '; 'therese.brown Personal Information redacted by the USI '; 'adverse.incidents Personal Information redacted by the USI '; 'claire.cairns Personal Information redacted by the USI '; 'SeriousAdverseIncident Personal Information redacted by the USI '
Cc: Rodney Morton; Ruth Lockhart; Brendan Whittle; Margaret Blakley; Denise Boulter; Caroline McGeary; serious incidents; OHara, Annette; Caroline McGeary; Claire Fitzsimons; Clare Robertson; McDonagh, Denise; Emily Roberts; Fiona Hughes; Gillian Clarke; Grace Doherty; Hannah Gamble; Isobel.king Personal Information redacted by the USI ; Janeen McKeown; Jean Gilmour; Jonathan Montgomery; Karen Scarlett; Karen Devenney (BHSCT); Maxine Gibson; Naomi Baldwin (NHSCT); Pauline McMullan; Philip Boyle; Rodney Morton; Ruth Donaldson; Ruth Finn; Ruth Robb; Shaunagh Small; Siobhan Donald; Thomas Hughes; Wendy Cross
Subject: Letter re SAI Procedures
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Dear all

Please see attached letter from Rodney Morton, Executive Director of Nursing, Midwifery and Allied Health Professionals PHA and Brendan Whittle, Director of Social Care and Children & Executive Director of Social Work HSCB in relation to SAI Procedures.

Many thanks

Hannah

Hannah Gamble
Project Manager for Infection, Prevention and Control Cell

Public Health Agency | Nursing and AHP Directorate |
12- 22 Linenhall Street | Belfast | BT2 8BS |
M: Personal Information redacted by the USI

E: Personal Information redacted by the USI | Web: www.publichealth.hscni.net |

Public Health Agency

Via email

Office of the Director of Nursing,
Midwifery and Allied Health
Professionals
Public Health Agency
4th Floor South
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: Personal Information redacted by the USI
Website: www.publichealth.hscni.net
Email: Personal Information redacted by the USI

30th April 2021

Dear Colleagues

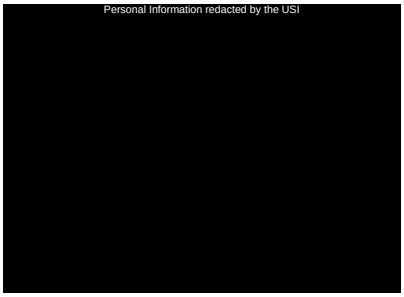
Serious Adverse Incident (SAI) Procedure

We are writing to you following a query raised at the Regional Infection, Prevention and Control Cell on Wednesday 21st April 2021 seeking clarity with regards to who has lead responsibility for SAI related outbreaks in Care Homes, in light of the PHA Health Protection role in supporting Care Homes during an outbreak.

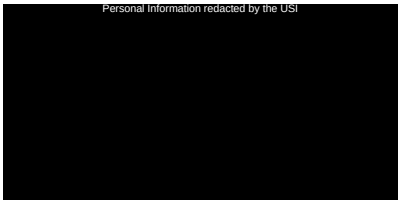
We can confirm that, as with any other Serious Adverse Incidents (SAI's) occurring within a Care Home, the commissioning Trust retains responsibility for overseeing the SAI in line with the regional SAI Procedure. (http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf)

The HSCB Governance Team and PHA Safety and Quality Nursing Teams can provide guidance with regarding the SAI procedure if required. For any queries please email Irrelevant information redacted by the USI and your query will be disseminated to the relevant team/person.

Yours sincerely



Mr Rodney Morton
Executive Director of Nursing, Midwifery and Allied Health Professionals
PHA



Mr Brendan Whittle
Director of Social Care & Children & Executive Director of Social Work
HSCB

DOI: 10.1111/j.1744-4667.2011.00081.x
The Obstetrician & Gynaecologist
http://onlinetog.org
2012;14:50–53

Views and counterviews

What have maternity networks ever done for us?

Simon Jenkinson FRCOG

Consultant Obstetrician and Gynaecologist; and Lead Clinician, Staffordshire, Shropshire and Black Country Maternity Network, Department of Obstetrics and Gynaecology, Royal Wolverhampton Hospitals NHS Trust, New Cross Hospital, Wednesfield Road, Wolverhampton WV10 0QP, UK
Correspondence: Simon Jenkinson. Email: simon.jenkinson@nhs.net

Key content
- Maternity networks are the key to the future of successful maternity services.
- Funding issues are putting their future at risk.

Learning objectives
- To be aware of the range of maternity networks that exist/have existed.
- To be aware of the outputs of maternity networks.
- To recognise the potential of maternity networks and their importance to the future of maternity services.

Ethical issues
- How can we ensure that maternity services meet the demands of women and families?

Keywords care pathways / Department of Health / European Working Time Directive / funding / neonatal services

Please cite this paper as: Jenkinson S. What have maternity networks ever done for us? *The Obstetrician & Gynaecologist* 2012;14:50–53.

Introduction

The question, 'What have maternity networks ever done for us?' anticipates an impressive list of effective contributions to the world of obstetrics attributable to managed, collaborative working. While maternity networks are a feasible solution to the challenges faced by present and future maternity services, their full potential has not yet been realised. An expectation that maternity services will naturally join forces across localities without commissioning input or regional strategic planning has discouraged their use and limited the extent of their work. High-quality, collaborative maternity services need commissioned, managed maternity networks to ensure that women receive the right treatment in the right place at the right time.

How did we get here?

The UK model of maternity care has undergone significant change over the last 20 years. While individual hospitals have in the past provided all the care needed by women throughout pregnancy and by their newborn babies, maternity units are now differentiated by the level of care they are able to provide and women are transferred accordingly.

The report of the Department of Health expert group into the provision of neonatal services in 2003[1] made two main recommendations:

- Care should be provided across managed clinical newborn networks.
- Within each network units should have a level of care designation ranging from routine care up to neonatal intensive care (level 3 units). When extreme prematurity is anticipated, mothers should be transferred, with their babies in utero if possible, to an appropriate unit within the network.

This new model is supported by evidence suggesting a significant improvement in outcome for preterm infants transferred in utero to larger centres focusing on low-volume, high-technology care.[2–4] At the same time, advances in fetal and maternal medicine have been concentrated in larger units or perinatal centres. Smaller units often refer maternity cases to these centres for diagnostic or therapeutic services.

Minimum training standards and shorter, more structured training times[5] have been introduced for doctors in training, together with a reduction in working hours (the New deal[6]/European Working Time Directive). These changes have meant that some smaller units which have relied in the past on long working hours and extensive service provision from a small junior doctor establishment have had to scale down or cease obstetric services altogether.

All this has led to a need for more collaboration between units over wide geographical areas and there are implications for staffing, skill mix and training for individual maternity units collaborating within such a network of units.

What are we trying to achieve?

In 2004 the National Service Framework for Children, Young People and Maternity Services[7] set out a vision for maternity networks as linked groups of professionals working together to ensure equitable provision of high-quality, clinically effective care.

> Knowing which path to follow, and who is responsible for providing what, will help to reduce clinical variation, eliminate duplication of services, maintain quality of care and adherence to clinical or other guidelines and give professionals agreed control over the care of the delivery process.

In 2007, in the *Maternity Matters* report[8] it was stated that women and families should be offered a choice of antenatal care and type and place of birth, depending on their circumstances (Figure 1).

> Development of maternity, neonatal and perinatal mental health networks will ensure that all women and their babies have equitable access to the whole range of more specialist services where necessary and can be readily transferred via ambulance should any possible complications or emergencies arise.

In 2007, the Royal College of Obstetricians and Gynaecologists, in conjunction with the Royal College of Midwives, the Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health, published *Safer Childbirth*,[9] an updated set of standards for obstetric care. This fresh look at the organisation of care in labour introduced minimum staffing levels for consultant and middle grades on labour wards and made recommendations that would make it difficult in the future for smaller units to continue to provide a full range of services safely. Maternity networks were presented as key in helping maternity services to achieve these standards.

A maternity network, which includes births at home, in midwifery units and in obstetric units, should have a common governance structure, including robust systems and clear guidelines for monitoring the safety, quality and performance of the maternity services and transfer arrangements within the network should problems arise.[9]

How did maternity networks begin?

Maternity services were faced with government objectives of greater clinical effectiveness, improved quality and increased choice for women and families, plus a demand for higher standards in maternity care, and presented with local alliances of maternity health professionals as the solution. Thus, maternity networks were developed. Without the support of a strategic framework, however, their development has been somewhat restricted. There is no single maternity network model, but somewhat isolated groups of collaborating clinicians with objectives derived from sometimes limited local perspectives, with little opportunity to share their successes on a national stage. Maternity networks were developed in a variety of circumstances but, in many cases, are now struggling for survival.

What do maternity networks do?

The nhsnetworks website (see Websites) lists 22 networks with an interest in maternity care. In some cases, this interest has a specialist focus. Fetal medicine research, smoking cessation, maternity risk management, midwifery standards and HIV in pregnancy are among those topics that have networks devoted to them. Twelve of those listed are networks of local maternity services aimed at facilitating collaborative solutions to the challenges of modern day maternity care.

The common themes of work for all of these local networks are:

- obstetric collaboration with neonatal services
- common agreement on care pathways
- shared learning and training.

The Staffordshire, Shropshire and Black Country (SSBC) Maternity Network sits within the SSBC Newborn Network. It covers one-third of the West Midlands, a large region with the highest perinatal mortality rates in the UK. Across the six units that constitute the SSBC Network there are approximately 26 000 births annually. The network was proposed in 2005 following a series of stakeholder consultation events. In 2006, European Working Time Directive money funded a project team which was given the task of scoping the impact of the European Working Time Directive and facilitating the development of clinical care pathways across local maternity services. The project team established working groups which focused on in utero transfer protocol and the patient experience, workforce planning and collaborative work on clinical guidelines and audit.

How are they funded?

Unlike their neonatal counterparts, maternity networks are funded in a somewhat ad hoc way. Newborn networks were established following recommendations from the Department of Health's 2003 National Strategy for Improvement. As the way forward for neonatal care, they were allocated funding through specialist commissioning using national resources. The national recognition that maternity networks are a vital part of perinatal service planning has never been accompanied by allocated resources. When available, funding has, therefore, happened locally, from a variety of sources with a range of interests. There is no standard model of maternity networks and no guarantee that any of the existing networks will continue.

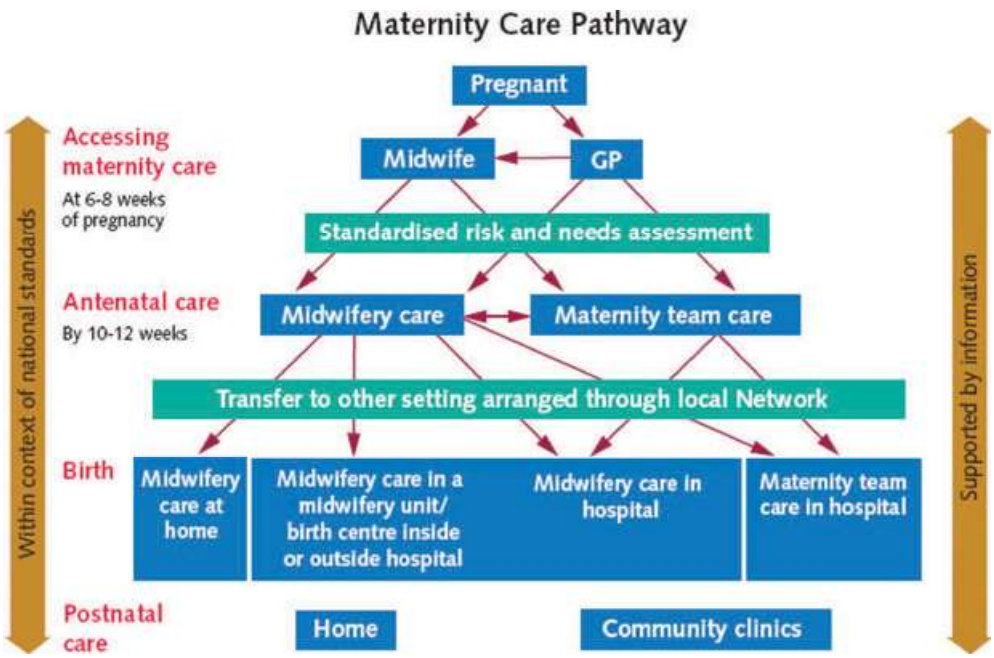


Figure 1. Maternity care pathway. Reproduced from *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service*.[8] ©Crown copyright (reproduced under the Open Government Licence)

Since 2007, the SSBC Maternity Network has been funded through the SSBC Newborn Network. This has been a temporary arrangement which has enabled the development of the already established network. Future funding, however, is uncertain.

How should they be funded?

The concept of a managed clinical network implies a funded clinical network established to meet local maternity needs. This needs to be a locally commissioned service with a service level agreement setting out the expected outcomes and collaborative activities in alignment with the strategic planning of the local strategic health authority. *Maternity Matters*[8] advocates a responsibility to develop high-quality maternity services. The role of primary care trusts (PCTs) is to 'commission high-quality, equitable, integrated maternity services as part of local networks according to local need'.[8] It falls to strategic health authorities to 'provide strategic leadership to assist PCTs in the development of the local vision for local maternity services, the development of networks and of user involvement'.[8]

What could they do?

Managed clinical care entails the provision of all maternity services within a network area according to a locally agreed care pathway. In the Staffordshire, Shropshire and Black Country area, for example, this could mean, perhaps, there being one network for directing or managing the care pathways of 26 000 women. A maternity network would be designed according to the needs of the local population. This would, typically, include a number of small units providing local care to most women, with one or two larger units for high-risk cases. Maternity services would be planned according to clear care pathways, ensuring the capability and capacity for high-quality care. Such collaborative work opens up a range of possibilities for workforce planning and solutions to the training of junior doctors. There is also a clear potential for comprehensive data collection and collaborative audit.

Websites

nhsnetworks [www.networks.nhs.uk]

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Cervical Cytology Service – Position paper - Feb 2021

Background

The Trust's Cervical Cytology Service is delivered through Craigavon Area Hospital (CAH) Cellular Pathology Laboratory. The service typically supports primary screening for 24,000 smears per year. 6000 of these smears also require further verification by a senior Biomedical Scientists (BMS) in the lab.

In the last three years, the service required additional sessions to keep up with demand, supported by waiting list funding from Health & Social Care Board. In recent months the service has lost three WTE BMS to other Trusts and backlogs are now accruing. In addition to the imbalance between service demand and capacity, additional NI Cervical Cancer Audit Framework requirements have been introduced which are putting additional pressure on the service.The current position is not sustainable and this position paper sets out a proposed more viable way forward for the service in the context of Pathology modernisation.

Pathology Modernisation

The Pathology Modernisation program is progressing through the regional Pathology Network chaired by Jennifer Welsh (Chief Executive – Northern Trust). It is recognised that in future there will be some changes to how laboratory services are delivered across Northern Ireland as a region. Whilst most cellular pathology services will remain unchanged and continue to be delivered on their current locations, a small number of service areas will be delivered by either one or two laboratories. Cervical Cytology Screening is one of those service areas.

Primary HPV testing will eventually replace Cervical Cytology screening as a primary screening tool and this policy change will consequently mean a smaller number of locations are needed to deliver the future service. The Southern Trust Laboratory Team accepts that change is inevitable and that Cervical Cytology will not be delivered here in the future. Therefore we are seeking to proactively manage this change whilst supporting staff through the process and focusing on a robust and sustainable SHSCT Cellular Pathology service model.

Target areas for CAH Cellular Pathology service development include:

- Support and expand Radiology in Rapid Onsite Evaluation Diagnostics.
- Increase capacity in biopsy reporting for elective and unscheduled care.
- Digital Pathology and Advanced Roles for Biomedical Scientists to support Consultant workforce shortages.
- Develop and deliver training programme for advanced BMS roles.

Primary HPV Testing

NI is the only region of the UK not to have rolled out primary HPV testing within cervical screening. Primary HPV testing is more sensitive than cytology which means it is less likely to miss pre-cancer compared to cytology. Cytology is a suboptimal test relative to what is available and a policy decision to move to primary HPV testing has been awaited in the region for several years.

As we deliver the screening programme by cytology rather than HPV testing, Quality Assuring the service is difficult as no national benchmarking will be available in the future. There is added risk at present and until a policy decision is made to introduce primary HPV testing this risk continues. To mitigate this risk co-testing could be considered and adopted (where all smears have both cytology and HPV testing done) however, the PHA does not currently support this move. Co-testing would mean little change to patient pathways as the colposcopy referral rate in SHSCT is high already. There would be a small additional financial cost of a HPV test.

Demand and Capacity

There is currently insufficient capacity available in the cellular pathology service to meet demand. Despite a significant amount of additional screening having been done, backlogs can accrue thus introducing clinical risk. The current staffing model for Cervical Screening is as follows:

Table 1:

Staffing	Sessions / WTE	Role
Consultant Sessions	3	Consultant Pathologist reporting / MDT
Band 8A BMS	0.5	CSPL
Band 7 BMS	2.5	Primary screening and checking
Band 7 BMS	0.5	Primary screening

This current staffing model in **Table 1** provides capacity for 12000 smears to be screened and reported by the Cervical Cytology Service at SHSCT. The demand currently however is, based on 2019 cervical cytology workload, around 24,000. The additional numbers were supported at financial risk through overtime.

The current deficit in capacity is resulting in backlogs and delays in reporting resulting in reduced turnaround times. Currently the training of cervical screeners is paused and recruitment of staff to support our service here is not an option. As a short to medium term solution, through the regional cellular pathology escalation process, it is proposed that 12,000 cervical cytology specimens are sent to Cellular Pathology in the WHSCT for primary screening and reporting through an SLA / contract. This proposal will ensure the safe delivery of the Cervical Cytology Service at the proposed reduction of the current workload. The WHSCT are agreeable to this proposal.

Cervical Cancer Audit Review

New Framework

The Northern Ireland Framework for the Audit of Invasive Cervical Cancers and Disclosure of Findings was published in 2019 and applies to all new cervical cancer diagnoses from the start of 2019 onwards.

This requires the Trust to carry out a review of the cervical screening history in all women diagnosed with cervical cancer. This involves a review of any previous screening test (cervical cytology), diagnostic test (biopsy) and any clinical treatment or management (colposcopy).

In most cases there is either no adverse review finding or minor review findings within the limitations of screening, classified as Category 1 and 2 outcomes respectively. In all these cases the patient is written to and advised that the audit review is complete and the outcome disclosed to patients where they require this, including invitations to meet with the Trust to discuss if necessary.

However, sometimes a more serious error is found (Category 3 outcome) and if such an error is found it is usually within the screening test, where a patient has received a false negative result – this is when the test result says you don't have a condition, but you actually do.

In the specific circumstances of this audit review of cervical cancer patients we will identify some women who were previously told they had a negative or normal smear test when in fact pre-cancer changes were present. These changes could have been treated and prevented cancer from developing.

The Framework asks for a specific standard to be applied when defining the audit outcome – *'Did staff carrying out the screening or diagnostic test do so to a standard that most staff could be expected to achieve?'* Applying this means for the Southern Trust around 3 women per year diagnosed with cervical cancer will have a previous false negative result. These are then required to be investigated as a SAI.

Every year in which cytology has been used as the primary screening test will have this outcome. Since it usually takes around 10 years for cervical cancer to develop the Trust will have to continue to undertake this audit until at least 2030 adding an additional year for each year that passes where HPV is not introduced to replace cytology as the primary test.

SHSCT New Framework outcomes 2019 and 2020

The Trust has completed the new framework approach for the 2019 patient cohort. There are three category 3 outcomes for 2019 and these are being investigated as Level I SAI. The review team has been established and the process to engage with patients has begun. This new framework approach has a significant additional administrative time commitment, acknowledged in other Trusts also, which is unfunded. So far there are no Category 3 outcomes for 2020.

Cervical Cancer patients 2009 – 2018

Prior to the Framework above Trusts had been asked to carry out a review of the cervical screening history in all women diagnosed with cervical cancer. The Medical Director of the Public Health Agency wrote to Trust Chief Executives to ask that this be done for all cases diagnosed from 2009 onwards and that the NHS cervical Screening Programme guidance (*'Disclosure of Audit results in Cancer Screening, Advice on Best Practice')* was to be followed. In 2014 a laboratory specific protocol was introduced but largely resulted in little change to the audit review.

Whilst this audit review has been done in the Southern Trust 2009 – 2018 but there is no evidence of patients having been told it was happening and subsequently very few instances of disclosure of outcomes.

This issue has been put to the Directorate of Legal Services (DLS) as questions below:

Questions to DLS

1. Considering the *'Disclosure of Audit results in Cancer Screening, Advice on Best Practice'* guidance drawn to the attention of Trusts in 2009:

Between 2009 and 2014 did the Trust have a duty of care or any obligation to patients in respect of this audit of invasive cervical cancers?

(a) To ensure patients knew the audit was being undertaken *and*

(b) To disclose the results of audit reviews for those who asked to know the outcome?

2. Considering the *'NI Protocol'* Trusts was asked to follow in December 2014:

From then onwards did the Trust have a duty of care or any obligation to patients in respect of this audit of invasive cervical cancers?

(a) To ensure patients knew the audit was being undertaken *and*

(b) To disclose the results of audit reviews for those who asked to know the outcome?

3. Does the Trust have a duty of care or obligation to now retrospectively disclose the results of all audit reviews were a patient consents to know the outcome?

Response from DLS:

The Trust owes a duty to the patients from 2009 onwards to advise that an audit of their screenings has taken place and disclose same where the patient consents.

Governance and Patient Safety

The current service model for cellular pathology is not sustainable and will inevitably change as the pathology modernisation work progresses. The new NI Cervical Cancer Audit Framework will add pressure to the team, which they are not currently able to deliver. It is in this context that now is the time to change the service model – committing to cellular pathology activity that is deliverable and safe, as well as refocussing on the development of different parts of the service in the context of the pathology modernisation programme.

In conclusion

We need a sustainable service model for Cellular Pathology which takes cognisance of regional pathology modernisation and focuses on the parts of the service that will be delivered from SHSCT Cellular Pathology Laboratory.

It is acknowledged that cervical cytology as a service area will not be delivered from the SHSCT in the long term. We are seeking to proactively manage this change whilst supporting staff through the process and focusing on the development of development of other services in the context of pathology modernisation.

In the short to medium term it is proposed that the following actions are progressed to address the issues / risks highlight in this report:

- **An SLA is established with the WHSCT to support delivery of the SHSCT cervical cytology service** pending regional progress on a policy decision. Our current staffing model provides the capacity for 12000 cervical cytology specimens to be reported by the SHSCT cellular pathology laboratory. We propose sending 12000 cervical cytology specimens to the WHSCT for screening and reporting through the establishment of an SLA. This SLA would also free up time to allow us to deliver the Cervical Cancer Audit Review Framework. *The cost of this arrangement will be c£115K*. The SLA can commence on 15 March 2021.Previously this need would have been met through a combination of additionality, support from other Trusts or through high cost locums screeners, therefore this plan would be broadly in line with costs from previous years.

- Primary HPV testing is a more sensitive test and will eventually replace cervical cytology as a primary screening tool. NI is the only region of the UK not to have rolled out primary HPV testing. It will be difficult to quality assure our service as no national benchmarking will be available. We acknowledge the false negative risk of a cytology based test screening programme and that NI is currently at variance with UK and ROI. **Until a policy decision is made to introduce primary HPV testing in Northern Ireland It is proposed that we commence co-testing from 15 March 2021. The cost of this arrangement per year is estimated to be up to £100K**

- **The team are requesting that the Trust formally raises the issue of disclosure for the patients during the period 2009-2018 with the PHA** - this could equate to approximately 30 patients. The Trust should indicate to the PHA that we plan to make contact with these patients; however it would be preferable if this was coordinated regionally.