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

Southern Health and Social Care Trust

Quality care – for you, with you

GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	13th May 2021	
Agenda item	Learning from Experience Update	
Accountable Director	Dr Maria O'Kane, Medical Director	
Report Author	Name	Caroline Doyle
	Contact details	Personal Information redacted by the USI

This paper is presented for: **Information**

Links to Trust Corporate Objectives		
	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	√	Improving our services
	√	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

This report cover sheet has been prepared by the Accountable Director.

Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.

It details how it impacts on the people we serve.

1. Detailed summary of paper contents:
This paper is a Clinical and Social Care Governance proposal paper to update Trust Governance Commitee on Trust Learning from Experience ongoing progress and identified challenges. This paper should be considered as supplementary to the Trust Clinical and Social Care Governance Review. The key elements that are addressed are listed below: • Challenges of Learning from Experience • Developing a Culture of Learning from Experience • Pathways for Sharing Learning from Experience • Implementing Change as A Result of Learning • Learning from Experience Objectives 2021/22
2. Areas of improvement/achievement:
The following learning from experience objectives have been set for year 2021/22 • To reissue the Trust Safety Culture Survey first launched 2017 • To develop templates and standardised processes for identifying and sharing Organisational level learning • To develop an accessible Organisational repository of learning allowing staff to access learning across departments and time periods • Conduct activities to further promote a learning culture within the Trust • To fully map the network of formal and informal learning functions and forums throughout the Trust • To develop a 'lessons learned log' to track progress on acting on learning
3. **Areas of concern/risk/challenge:**
What should be included here:

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	Not Applicable
Board Assurance Framework	Not Applicable
Equality and Human Rights	Not Applicable

Learning from Experience Update 13th May 2021

Introduction

Purpose of Paper:

This paper is a Clinical and Social Care Governance proposal paper to update Trust Governance Committee on Trust Learning from Experience ongoing progress and identified challenges. This paper should be considered as supplementary to the Trust Clinical and Social Care Governance Review. The key elements that are addressed are listed below,

- Challenges of Learning from Experience
- Developing a Culture of Learning from Experience
- Pathways for Sharing Learning from Experience
- Implementing Change as A Result of Learning
- Learning from Experience Objectives 2021/22

1. Healthcare will never be risk free, but we can minimise these risks in order to provide high quality care for service users. Learning from experience is crucial to continually improve person-centred, safe and effective delivery of care.

2. A learning culture is promoted within the trust and any review is not intended to blame individuals but to seek the causal factors and share the lessons learned to prevent a reoccurrence of an incident or other negative event.

3. Learning from experience will contribute to the supporting the Trust health and wellbeing outcome that people who use health and social care services are safe from harm. *"The best way to reduce harm ... is to embrace wholeheartedly a culture of learning."*

4. The Trust has made a number of improvements to our processes for managing and learning from adverse events including strengthening our responses to Serious Adverse Incidents (see Trust Serious Adverse Incident Framework). However, achieving cultural change regarding learning from experience is challenging and will take time. There are increasing the opportunities to actively learn from experience and put improvements into practice.

5. The Trust recognises that learning can come from a variety of other sources and so it is useful to routinely review all types of learning to ensure that this is embedded into local practice and to prevent recurrence of events that led to the learning in the first place, these include:
    - Service User Complaints / Complaints Ombudsman Reviews
    - Morbidity and Mortality Reviews
    - Litigation Outcomes
    - Coronial Outcomes
    - Patient Safety Alerts (local, regional and national)

6. Learning can also be shared from events that have taken place in other organisations and to that end the Trust is committed to working effectively with other bodies, whether external agencies who undertake assessments and reviews or other Trusts, to learn from these experiences. Best practice can also be obtained from other organisations.

7. This Learning from Experience Framework outlines how the Trust aims to strengthen our systematic approach to learning from all types of events and ensure that this is disseminated through appropriate mechanisms.

8. To support improvement in sharing learning from experience, the Trust operates a Lessons Learned Forum, chaired by the Medical Director which will oversee the management and sharing of learning from experience (Terms of Reference Appendix 1). The Forum was rebranded as the 'Learning from Experience Forum' in 2020.

Challenges of Learning from Experience

9. The Southern Trust as with other healthcare providers has identified a variety of challenges with the management, monitoring and sharing of learning from experience. Some of the more common challenges are listed below under identified themes of capacity, stakeholder engagement, sharing learning, governance and overview and quality improvement. The term 'event' is used throughout this document to signify any potential learning event (adverse event, complaint, litigation etc)

    - Creating the capacity and capability to carry out effective event reviews
    - Providing support to those involved in an event (patients, family, carers and staff)
    - Ensuring review recommendations are translated into practical actions that lead to improvements
    - Identifying and sharing key learning points widely,
    - Working across directorate and Trust boundaries to move towards a more consistent approach.

10. Several of these challenges were identified as part of the Trust Staff Cultural Survey conducted in 2016. This is not to say that progress has not been made, but rather emphasises the complexity and long-term nature of the task to transform the culture to an open learning one. The Trust paper on Strengthening Our Response to Adverse Incidents addresses several of the areas of challenge.

Area of Challenge	Elements
Capacity	• Having capacity to undertake event reviews. Due to clinical or other commitments, event reviews can become person dependent, can result in delays and can lead to a focus on the process rather than on identifying the key learning points and improvement required. • Meeting event review timescales outlined within regional guidance can be difficult, particularly for events which are inter-organisational. • Having sufficiently trained staff in critical review and analysis, interview techniques and human factors, and maintaining review skills for those staff who only occasionally take part in adverse event reviews.
Stakeholder Engagement	• Providing meaningful and timely support to patients, family and carers. • Providing support to staff involved in adverse events; involving all staff in adverse event processes and encouraging local ownership. • Staff feeling confident to have conversations with patients, family and carers about adverse events.
Sharing Learning	• Understanding and reflecting relevant background information and situational context in thematic event reviews, review reports and learning summaries to ensure the information supports improvement. • Understanding and sharing lessons learned and promoting a systematic approach to sharing learning.
Governance and Overview	• Capacity to monitor actions arising from event reviews and ensuring actions are taken. • Capacity to evaluate if actions taken following event reviews result in changes that are improvements. • Prioritising which areas to focus on when there are a number of identified themes and issues around events. • Ensuring that external review recommendations (e.g. Inquiry into Hyponatraemia Related Deaths) are implemented in a way that builds on existing adverse event processes and does not create a system that is built around solely quantitative measurement
Consistency	• Ensuring consistency in the quality of event reviews and reports, and developing expertise in operational units to support a standardised approach. • Supporting an open culture around adverse events

11. Much regional work has taken place in recent years to foster an open learning culture, and ongoing work from the regional IHRD programme has contributed to this. However, a number of barriers to moving to an open learning culture still exist.

12. Additionally, the ever-increasing interest from the media and wider public for identifying who is to blame fuels a defensive, blame culture where individuals working within the service are afraid of being open about failures to protect their careers. It has been well reported that only by combating the blame culture in health and social care will transparency and meaningful change take place. Learning from adverse events is one contributor to changing that culture.

Developing a Culture of Learning from Experience

13. To make our care safer we are required to improve our learning about how day-to-day care is delivered, how it feels to work for frontline staff, and ways in which they need to adapt and adjust what they do to keep patients safe.

14. This means learning how care is delivered, not how we imagine it is delivered, but exactly how it is done on a day-to-day basis. It requires us to improve our learning about what is working well and what doesn't go as planned or expected.

15. Underpinning this learning is a culture which is kind, respectful and which enables people to speak out openly, and to share issues, concerns and ideas without judgement, Dekker 2013, describes this as:

    - A learning organisation is where everyone facilitates a culture that helps to continually transform and improve that organisation.
    - A learning organisation that has safety at its heart studies all aspects of care. This, in turn, uses that knowledge to help people redesign the workplace

16. To achieve this there is a growing body of evidence that demonstrates that a way forward is for organisations to embed a just and learning culture. Healthcare providers therefore, have the responsibility for role modelling the right behaviours to create and maintain a safe and supportive environment for both the patients and staff that is fair, open and able to learn.

17. To gain an insight into the Trust's safety culture in 2017 a Trustwide survey was undertaken to assess the safety culture level in the organisation. The survey provided direction on how we should target resources to further develop our safety culture.

18. In order to further support our learning agenda there is a requirement for the Trust to support and promote a culture that seeks to understand the actions and choices made by our staff before they are judged, our staff should be primarily supported to learn from them. Furthermore, they should be asked for their advice and help to design the systems that could help change things for the better.

Pathways for Sharing Learning from Experience

19. The following table lists existing reports that provide data on the trends and themes relating to incidents, complaints, litigation and clinical audit projects separately or for specific areas of the organisation.

Report Name	Frequency	Content	Receiving Group
Clinical and Social Care Governance Report	Quarterly	Trend information on complaints, adverse incidents and Serious adverse Incidents	• Trust SMT • Directorate Governance Coordinators • Trust Governance Committee
Annual Quality Report	Annual	Information on Trust quality indicators including summary lessons learned information	• Trust SMT • Directorate Governance Coordinators • Trust Board / Governance Committee
Trust Mortality Report	Quarterly	Information on both quantitative and qualitative mortality measures including analysis of trends among specific mortality indicators	• Medical and Nursing Leaders • Trust SMT • Directorate Governance Coordinators • Trust Governance Committee
Service User Experience Annual Report	Annual	Information on service user feedback and potential improvements in service provision	• Trust SMT • Directorate Governance Coordinators • Trust Governance Committee
Litigation Governance Report	Quarterly	Information on trends in litigation and coronial activity within the Trust	• Trust SMT • Directorate Governance Coordinators • Trust Governance Committee
Clinical Audit Report	Annual	Summary of implementation of clinical audit both local and national recommendation implementation	• Medical and Nursing Leaders • Trust SMT • Directorate Governance Coordinators

Annual Complaints Report	Annual	Detailed information on complaints received	• Trust SMT • Directorate Governance Coordinators • Trust Governance Committee
*Learning/Good Practice Template**	*As required*	*Key learning from events*	• *Lessons Learned Forum* • *Directorate Governance Coordinators*
*Learning Bulletins**	*As required*	*Key learning from events*	• *Lessons Learned Forum* • *Dissemination in operational and professional groups as relevant*
*Learning Log**	*Monthly*	*List of learning and actions taken*	• *Lessons Learned Forum* • *Trust SMT* • *Trust Governance Committee*

**Under development via the Trust Lessons Learned Forum*

20. The following table lists high level meetings where lessons learned are discussed and shared with relevant staff and divisional groups.

Meeting	Frequency	Content /	Attendees
Morbidity and Mortality Meetings	Monthly	Discussion of inpatients who have died / suffered a serious harm or near miss event. Meetings held at a divisional level (e.g. surgery, medicine, pediatrics etc)	• Trust Medical Staff • Other Staff Groups Invited
Nursing and Midwifery Governance Forum	Monthly	Reserved section to discuss learning / service improvements that may require cross directorate / corporate support to implement learning	• Trust Nurse and Midwifery Senior Staff
Medical Forum	Quarterly	Reserved section to discuss learning / service improvements that may require cross directorate / corporate support to implement learning	• Trust Associate Medical and Clinical Directors
Directorate Operational Governance Meetings	Monthly	Discussion of adverse incident / complaints and litigation cases that occurred within the directorate	• Directorate senior management • Directorate senior medical. Nursing and social work staff

21. It is acknowledged that the above list of meetings is non-exhaustive and local level learning will take place at various levels within each operational directorate. The information shared via each will be tailored to the specifics of the audience group.

22. The Trust Lessons Learned Forum seeks to further standardise and identify new pathways for sharing of learning from experience.

Organisational Process for Implementing Change as a Result of Learning

23. The Trust is committed to learning lessons and promoting improvements and making changes in practice using all of the information and experience available. Learning from experience is derived from three main sources as listed in the table below.

Learning Source	Details	Responsibility for Sharing
Learning from Trust level events and experiences	Analysing individual and aggregated information relating to incidents (including, Serious Incidents), complaints, litigation etc which includes identifying trends, causes and impacts	The directorate where the learning is identified are responsible for sharing the lessons; directly with other directorate governance fora where the similar services are provided and with the Trust Lessons Learned Forum
External assessments, reviews, national enquiries and recognised best practice;	Reviewing and understanding best practice standards and requirements, this includes: • Allocating responsibilities for implementation • Developing and implementing actions plans to address identified	Directorate governance forums are responsible for implementing and providing assurance on the adoption and implementation of learning from experience from external bodies.
Cross Organisational learning	Reviewing and understanding learning that may be regional or from another HSC Trust. • Liaising with regional organisations to develop action plans for implementation • Developing organisational action plans and informing directorate governance teams of learning	Trust corporate clinical and social care governance team work with directorate governance teams to share learning from experience

Department Level Learning

24. Each operational governance team is responsible for reviewing all event information relevant to their service areas and are responsible for owning issues that arise and feeding back the results of these reviews to staff.

25. A variety of systems for embedding learning are considered which include simulation-based learning, reflective practice sessions, and reviewing how changes can be made and implemented in practice. The system used for embedding individual learning is dependent on the issue that is being addressed. Each directorate has its own mechanism for disseminating and communicating learning which can be in the form of a bulletin or newsletter.

26. All department learning is captured and discussed as part of individual departmental team meetings and this in turn is fed into the governance reporting structure within individual directorates.

27. Each directorate discusses learning within its governance structure, reporting any wider issues to the appropriate Board level committee/group. These governance groups act as the link to facilitate the dissemination of learning from Trust SMT down to staff and from staff to Trust SMT.

28. Any learning which impacts on the care of service users is considered for dissemination centrally from the Corporate Clinical and Social Care Governance office.

Learning from Experience Objectives 2021/22

29. The following objectives have been set for learning from experience for f2021/22

	Objective	Purpose
1	To reissue the Trust Safety Culture Survey first launched 2017	To gauge the current level of Safety Culture within the organisation against the 2017 baseline.
2	To develop templates and standardised processes for identifying and sharing Organisational level learning	To ensure that significant Organisational level learning is captured an d shared in a consistent manner
3	To develop an accessible Organisational repository of learning allowing staff to access learning across departments and time periods	To ensure an Organisational memory of lessons learned is maintained
4	Conduct activities to further promote a learning culture within the Trust	To engage staff and leaders at a variety of levels to support the development of an

		open and learning culture (such as Being Open)
5	To fully map the network of formal and informal learning functions and forums throughout the Trust	To ensure a comprehensive map of learning functions is available to help assist learning dissemination and embedding
6	To develop a 'lessons learned log' to track progress on acting on learning	To allow the organisation to track progress on actions that were outcomes of lessons learned

Appendix 1 - Lessons Learned Forum – Terms of Reference

Learning from Experience Forum – Terms of Reference

Date: 2nd December 2020

Background

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses, and know that if this is done effectively it can help to minimise future risk and strengthen the quality of the services we provide.

The Trust is committed to quality improvement, and will continue its strong focus on delivering high quality, safe and effective services. The Trust Learning from Experience forum will assist in the identification, sharing and appropriate risk mitigation of areas of concern by highlighting areas of learning and sharing these messages.

Purpose / Role of the Group

- To provide a formal corporate cross directorate interface for the identification and sharing lessons learned from adverse incidents, complaints, morbidity and mortality, litigation cases learning through patient experience , nursing and other quality indicators and areas of good practice for service improvements, internal to the Trust, regional and national.
    - To support the presentation and discussion of sharing learning from experience
    - To provide input to corporate level communications in the form of emails, newsletters, staff education and briefings to support the embedding of learning from experience
    - To oversee and review a learning from experience learning log to track actions
    - To identify Learning from Experience projects that have potential as Quality Improvement projects
    - To provide assurance and updates in the form of 6 monthly reports to Trust Governance Committee on the work of the forum

Membership

- Medical Director (Chair)
- Trust Operational Directors
- Non-Executive Director
- Deputy Medical Director Safety and Quality

- Associate Medical Directors (or nominees)
- Operational Assistant Directors (as nominated by Directors)
- Assistant Director Clinical and Social Care Governance
- Directorate Governance Coordinators
- Director of Pharmacy
- Executive Director of Nursing
- Assistant Director Professional Lead Social Work and Care
- Assistant Director Professional Lead Nursing Governance
- Assistant Director AHPs
- Assistant Director Quality Improvement
- Operational Assistant Directors as nominated by Directors
- Project Manager Clinical and Social Care Governance
- Governance Officer, Clinical and Social Care Governance
- Trust Simulation Lead
- Lead Medicines Governance Pharmacist
- Head of Patient Safety Data and Improvement
- Trust Litigation Manager
- Deputy Director HROD
- Trust Board Secretary

Meeting Format

- Meetings held on a quarterly basis (4 meetings per year)
- Chaired by Medical Director
- Papers will be circulated 5 working days prior to meeting date via email
- Additional members or presenters will be invited as dictated by the Forum Chair

Review

- Terms of reference for the group will be reviewed at least annually

Confidentiality

- Lessons Learned will be anonymised and confidential information removed.

Reporting

- The Forum will provide quarterly updates to the Trust Quality Improvement Steering Group
- The Forum will report twice yearly to the Trust Governance Committee

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 4th May 2021
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:

- Ongoing SAIs 84
- 5 SAI Notifications being prepared for O&G
- Trust introduced weekly governance reporting in relation to Granville Care Home
- Introduction of a summary table of Adult Safeguarding Activity
- One additional Urology claim received
- Exploring the use of Student Lawyers to assist in Subject Access Requests.
- Preliminary Hearings held in the last week details can be found in section 22.

-Outcome of SMT Discussion:

Summary of Weekly Governance Activity 19.04.2021 - 25.04.2021

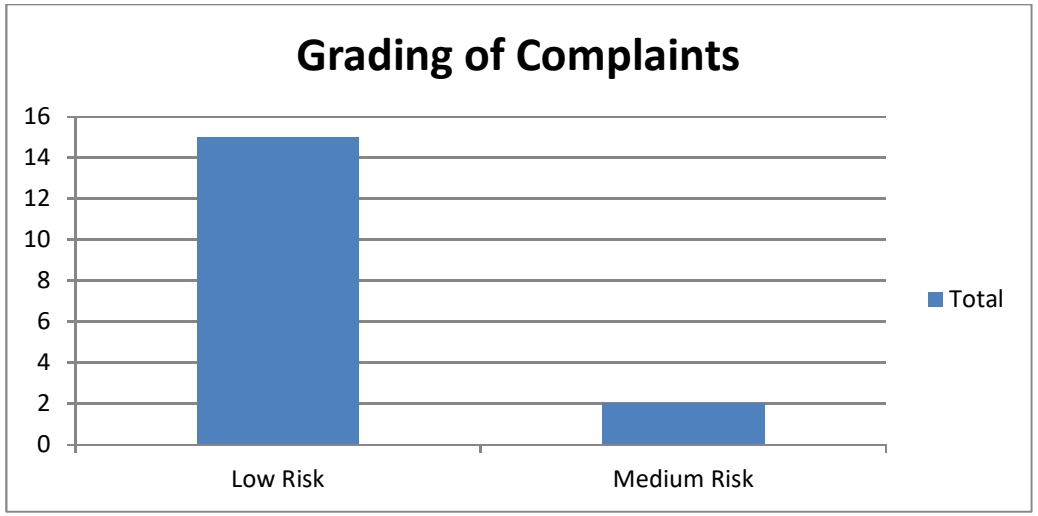
	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAI's Notification's	0	0	0	0	0
SAI Reports submitted to HSCB	0	0	0	0	0
Ongoing SAI's*	26	46	8	4	84[1]
High Risk Complaints	0	0	0	0	0
NIPSO Case Accepted for Investigation	0	0	0	0	0
NIPSO Draft/Final Reports Received	0	0	0	0	0
Early Alerts	0	0	1	2	3

*Below highlights the change in ongoing SAI figures from 83 last week to 83 this week:

Ongoing SAIs reported last week – 18/04/2021	83
Add New SAI notifications:	0
	83
Less SAI reports submitted:	0
Ongoing SAIs reported week ended 25/04/2021	83

[1] Includes one notification reported w/b 26th April 2021.

Grading of Formal Complaints Received 19.04.2021 – 25.04.2021



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 19.04.2021 - 25.04.2021

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	Total
6	12	8	26

Discussion at meeting	Action
Another 5 SAIs will be reported in the coming week in relation to O&G.	Meeting taken place to review at 2pm 29/04/2021

2. **Catastrophic Incidents**

Datix ID	Incident Date	Description
Personal Information	27/04/2021	Readmission with Hospital Aquired Pneumonia, >6 weeks post acetabular fracture. Covid +ve during previous admission (Ramone ward).
Personal Information	29/03/2021	Death of patient post surgery. This incident has been screened and notes requested.

Discussion at meeting	Action
Dr Gormley confirmed that the SJR model being used for the review of Covid deaths does not replace any existing Governance arrangements.	n/a

3. **Never Events**

None

4. **Issues escalated by Corporate or Directorate office at meeting**

Discussion at meeting	Action
Incident: Personal Information **Description:** Personal Information old covid positive patient admitted to 2 north. Suicidal, had taken an overdose. Not clerked in prior to coming to ward, no 1:1 staff available and no medical plan in place. Patient then clerked in on 2 north but later had respiratory arrestand transferred to ICU.	Screening process commenced.
Incident: Personal Information **Description:** Patient attended DHH following RTC diagnosed with unstable cervical spine injury, BHSCT initially advised transfer to them in them in the morning. Ortho team in CAH refused patent. Patient admitted to general surgery.	Patricia to forward details to Dr O'Kane for sharing with the Medical Director of the BHSCT.
Incident: Personal Information Patricia escalated SAI Personal Information to Dr O'Kane, difficulties obtaining input from SET regarding plastics.	Patricia to forward details to Dr O'Kane for sharing with South Eastern Trust.

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)

5. Status of SAI's

Summary of the status of SAI's between 19.04.2021 - 25.04.2021

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
25	12	7	2	46

Discussion at meeting	Action
Tony confirmed there are a number of SAI reports nearly ready for submission to the HSCB. Tony raised a case within Physical Disability that will potentially require a cross directorate case review to identify learning.	Tony will link with Dr O'Kane to discuss this in more detail and resend her draft SAI reports.

6. Catastrophic Incidents

Datix ID	Incident Date	Description
Personal Information	17/04/2021	"The Trust were notified via the SD1 process of the suspected suicide of a service user in the community. The service user was known to Primary Mental Health Care Team"

7. Never Events

None

8. Issues escalated by Corporate or Directorate office at meeting

Discussion at meeting	Action
Tony informed the group of the Trust attending a Serious Concerns meeting with the RQIA regarding Granville. The Trust has started Weekly Governance reporting in relation to this with a steering group set up for 30/04/2021, there will also be a Directors oversight meeting to monitor progress of the concerns raised at the meeting.	n/a

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)

9. Status of SAI's

Summary of the status of SAI's between 19.04.2021 - 25.04.2021

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	Total
5	2	1	8

10. Early Alerts

19/04/2021 – Missing child

Discussion at meeting	Action
Marita has sought an update in relation to this Early Alert but no response received.	n/a

28/04/2021 – Overdose, will be reported on next week's paper

Discussion at meeting	Action
Dr O'Kane has arranged for Clinical staff to meet the patient to offer additional support.	n/a

11. Never Events

None

12. Issues escalated by Corporate or Directorate office at meeting.

None

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)

13. Status of SAI's

Summary of the status of SAI's between 19.04.2021 - 25.04.2021

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
4	0	0	4

14. Early Alert

19/04/2021 – GP OOH

23/04/2021 – GP OOH

15. Never Events

None

16. Issues escalated by Corporate or Directorate office

17. Actions from Previous Week

Discussion at meeting	Action
Misidentification of end of life patient in PNH	SAI to be raised, HSCB notification pending Update 29/04/2021 Notification pending, work progressing to ensure appropriate action has been taken.
Incident involving a care worker assaulting a patient. Care worker is to be prosecuted.	Early Alert submitted. . Update 29/04/2021 Notification pending.
Review of Covid deaths in Care Homes. Connie advised that at the Regional Governance meeting held this week, the Trust was advised there had been a letter sent to confirm if the Incident meets the criteria of SAI then an SAI is to be raised. Ambiguity remains in realton to the Governance Framework around all of these incidents.	Connie to locate this letter and forward to Dr O'Kane who will write to Rodney for clarification of the Governance Framework for Care Homes.

LITIGATION

18. New Clinical negligence

New clinical negligence claims: 19.04.2021 – 23.04.2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
Personal Information redacted by the USI	ACUTE	MUC	Failure / Delay in diagnosis	11/01/2016	15/04/2021	19/04/2021	It is alleged that there was a failure to diagnose a fracture to the wrist (MIU, STH)
Personal Information redacted by the USI	ACUTE	SEC	Failure / Delay in treatment	01/03/2018	15/04/2021	19/04/2021	It is alleged that there was a failure to provide appropriate treatment in Urology, CAH (case added to Section 4)
MNS	OPPC	OPS	Moving/Handling	23/09/2020	22/04/2021	22/04/2021	It is alleged that staff failure to set up moving and handling equipment correctly (in the community) resulted in a service-user's fall
MNS	OPPC	OPS	Failure / Delay in treatment	01/05/2007	19/04/2021	23/04/2021	It is alleged that there was a failure by District Nursing services to adequately assess and provide appropriate treatment for wound care.

19. Clinical Negligence Claims Listed for Hearing in May 2021

The following clinical negligence cases are listed for hearing in May 2021.

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
Personal Information redacted by the USI	ACUTE	IMWH	Lack of Assistance/Care	08/06/2015	10/08/2015	28/05/2015	Alleged failure to provide assistance to a patient with mobility issues, resulting in a fall and injuries sustained **Trial is listed for 11 May 2021 (for 3 days)**
Personal Information redacted by the USI	ACUTE	MUC	Failure / delay in diagnosis	13/09/2010	16/02/2011	31/01/2011	Alleged failure to diagnose an ankle fracture **Trial is listed for 11 May 2021 (for 1 day)**

Personal Information redacted by the USI	ACUTE	SEC	Failure to Monitor/Failure to Treat	22/12/2012	31/03/2016	06/04/2016	Alleged failure to monitor patient following an ERCP procedure, and treat for cholangitis and sepsis **Trial is listed for 17 May 2021 (no of days still to be confirmed)**
Personal Information redacted by the USI	CYP	Corporate	Failure to Monitor/Assess	16/10/2009	01/10/2012	08/10/2012	Alleged failure of the Trust to ensure foster care placement appropriate/alleged failure to safeguard and promote welfare of the Plaintiff **Trial is listed for 23 May 2021 (3-4 days)**

Discussion at meeting	Action
Dr O'Kane asked for an additional column for the Litigation cases to identify the Trust process the incident has been through eg M&M/SAI.	Lynne to consider for future papers.

20. Vaginal Mesh Cases

The Trust has 17 open cases where the allegations relate to vaginal mesh. The case that was originally scheduled to take place in May 2021 is now rescheduled for 6 December 2021 (for 4 days).

Stage	Number of Mesh Cases
Letter of Claim	0
Discovery	5
Investigation	8
Proceedings Issued	3
Trial date Set	1

21. 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 in the Trust, it is anticipated that there will be an increase in related medico-legal requests and litigation cases. There has been one further urology claim that was received (as outlined in Section 1). Whilst this Letter of Claim does not specifically refer to the Consultant in question, it has been established that there was involvement of the above Urology Consultant in this patient's care This claim has therefore been added into the figures below:-

Medico-Legal Requests	Litigation Claims
0	2 (at early stage)

Discussion at meeting	Action
In addition to the 9 SAIs submitted for Urology there are a number which are being investigated via the SJR. Patricia raised a point regarding notifiying the families of this process. Heather Trouton is leading on this piece of work with input from Melanie McClements and Dr O'Kane. The Royal College has appointed a number of External retired urologists. Subsequent updates will be notified at this meeting.	Connie to speak with Stephen regarding liaison framework for Urology. Patricia to speak with Martina Corrigan about notifying the families of SJR. Patricia and Connie to speak regarding leaflets for the families involved in SJR.

22. Coroner's Inquiries and Inquests

There were no Coroners Inquiries received 19.04.2021 – 23.04.2021

The following Inquest Hearings were heard during April 2021. There are no Inquest Hearings scheduled for May 2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description
Personal Information redacted by the USI	ACUTE	SEC	Unexpected death	Personal Information redacted by the USI	09/01/2019	16 April 2021	A post-mortem was not directed in this case. Coroner agreed cause of death 1A – small bowel perforation 1B – Strangulated hernia II - Diabetes Mellitus II; Hypertension; Chronic Obstructive Airways Disease; Congestive Heart Failure **Written findings have been received and communicated to relevant senior management.**
Personal Information	ACUTE	SEC	Unexpected death	Personal Information redacted by the USI	02/05/2017	19-23 April 2021	Coroner directed a post mortem in this case and the preliminary finding is multi-organ failure, probable peritonitis and intra-abdominal haemorrhage following laparoscopic cholecystectomy. **Currently await written findings from the Coroner's Office.**

The following preliminary Inquest Hearings are scheduled in April 2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description
Personal Information	ACUTE	IMWH	Maternal Death	Personal Information redacted by the USI	09/03/2018	28/04/2021	PM Report records cause of death as post-partum haemorrhage following emergency c-section in association with lacerations of uterus, uterine atony, breech position of the foetus and premature rupture of membranes
Personal Information redacted by the USI	MHD	MHS	Self-harm	Personal Information redacted by the USI	08/02/2018	29/04/2021	The deceased died of suspected suicide on following discharge from CAH
Personal Information redacted by the USI	CYP	SOCIAL	Self-harm	Personal Information redacted by the USI	04/07/2019	29/04/2021	The deceased was known to the Trust's Gateway Service and died of suspected suicide.

Discussion at meeting	Action
MHD discussed the double Homicide incident. Litigation confirmed there is Preliminary Hearing on 22nd June.	MHD Governance to follow up on the action plan and send to Dr O'Kane. Update 15/04/2021 – Tony Black confirmed that Acute are following up with Paul Smith regarding the first Action Plan. Tony to link with Stephen Wallace to establish if the second action plan was submitted to HSCB prior to Christmas 2020.

23. 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. Approval has since been provided and the recruitment process is under-way. The Team however are also faced with unexpected absences in respect of current funded staff, which is impacting on the ability to deal with requests.

There is currently a back-log of 318 requests that are in excess of 90 days across the following areas:-

Directorate	Acute Services	C&YP	MH&D	OPPC	HROD	TOTAL
Number of Outstanding Requests	253	29	28	8	0	318
New requests opened 19.04.2021 – 23.04.2021	52	1	2	0	1	56

The back-log has Increased 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.

Discussion at meeting	Action
Dr O'Kane confirmed the team will need additional resource for the number of outstanding SARs and the Public Inquiry. Lynne confirmed that the numbers above don't reflect the positive activity performed by her team in relation to the completion of Medico Legal Claims. The team average 246 per month.	Dr Diamond and Lynne Hainey to discuss the possibility of using student lawyers to assist with this process.

MEDICATION INCIDENTS

24. Medication Incidents between 19.04.2021 - 25.04.2021

- Personal Information – Patient on methadone attended and advised could take own supply of methadone during admission. Own supply taken for two days before transfer to ward where this was noted. No duplicate doses received.

SAFEGUARDING

25. 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

New adult safeguarding activity week beginning 19.4.2021 – 25.04.2021 by Directorate

Adult Safeguarding Activity 19.04.2021 - 25.04.2021	Trustwide	MHD	OPPC	Acute
No of new adult safeguarding referrals	23	17	2	4
No of new adult safeguarding referrals meeting threshold for Adult Protection Gateway team	13	10	1	2
No of new referral assessed as Adult in Need of Protection (APGT)	7	6	1	0
No of new referrals managed as adult at risk of harm	7	7	0	0
No of new referrals with NFA under Adult Safeguarding	6	2	0	4
Referrals by category of allegation				
▪ Physical	9	6	0	3
▪ Psychological	4	3	1	0
▪ Sexual	7	6	0	1
▪ Financial	3	2	1	0
▪ Neglect				
▪ Institutional				

	0 0	0 0	0 0	0 0
No of open adult protection cases	177	103	59	11

3 referrals pending outcome of assessment and decision making (2 OPPC & 1 MHD)

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

2 Ongoing SAI in MHD where adult protection investigation was undertaken. 1 API ongoing.
1 SAI on hold OPPC - Ongoing Joint Protocol – awaiting PPS decision – Personal Information care Home
1 SAI OPPC – relates to JP case common assault in Personal Information care home. Proceeding to court hearing.
1 ongoing complaint in OPPC where adult protection investigation has been closed. Final meeting with medics to confirm info to close case outstanding. Coroner involved.
2 adult protection investigations in Acute where there has also been a complaint.
1 adult protection investigation ongoing in Acute related to pressure care.
Personal Information redacted by the USI Care Home – ongoing support being provided by SHSCT to address wider care and governance issues. Review due mid April. Individual adult protection JP case is ongoing. Next court date Mid May – date to be set.
1 complaint regarding Adult Protection Process – MHD case

INFORMATION GOVERNANCE

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

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	7	-	8	17	-	-	-	-

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.

27. Data Breaches reported to the ICO

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

There have been no data breaches reported to the ICO in this period. In this period one complaint (from the ICO) has been closed and we have received another complaint in relation to the time taken to respond to a SAR.

NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED

28. Responses Sent.

Title of Correspondence	Full Implementation Date for S&G	Directorates applicability	Assurance Response
Potential Risk of Towel Dispensers Being Used as a Ligature Point	Response sent 23/04/2021	Acute, CYPS, OPPC, MHD **SHSCT Point of Ligature MDT working group**	20210423_SHSCT

29. Responses that are due to be submitted to an external agency within the next 4 weeks (up until 1 June 2021)

Title of Correspondence	Category	Full Implementation Date for S&G	Directorates applicability	Clinical Lead
Steroid Emergency Card to Support Early Recognition and Treatment of Adrenal Crisis in Adults	Patient Safety Alert	12/05/2021	**Acute, OPPC**	**Short life MDT Working group**
Implementation of guidance on Group B Streptococcus in Pregnancy	CMO Correspondence	19/05/2021	**Acute, CYPS**	**Dr Kamath**
Assurance Required in relation to HSC (SQSD) Deterioration Due to Rapid Offload of Pleural Effusion Fluid from Chest Drains	DOH Correspondence	01/06/2021	**Acute,**	**Dr Alexander John**
Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation	Patient Safety Alert	01/06/2021	**Acute,**	**TBC**

30. Responses that are overdue for submission

Title of Correspondence	Full Implementation Date for S&G	Directorates applicability
OPS and AS - Care Home Admission and Initial Review	18/09/2020	**OPPC, Acute, MHD**
Refusal of Treatment	15/04/2021	**Acute, OPPC**
Investigation and Management of Pulmonary Nodules	15/04/2021	**Acute,**
Incidents Relating To Significant or Unexpected Radiological Findings	15/04/2021	**Acute,**

31. Newly Issued S&G received by SHSCT from date of last Corporate Governance meeting

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
End of the 2020/21 Flu season and related issues	23/04/2021	HSS (MD) 31/2021	CMO Correspondence	n/a	n/a
Implementation of guidance on Group B Streptococcus in Pregnancy	23/04/2021	HSS (MD) 19/2017 HSS (MD) 29/2019	CMO Correspondence	n/a	19/05/2021
COVID-19 vaccine (Astrazeneca) and thromboembolic events with concurrent low platelet counts	20/04/2021	n/a	PHA Correspondence	n/a	n/a

32. Regional PIVFAIT Audits

CAH CYP	2 /3 = 50%. •Non-compliant for indicator 4 (Cumulative input and output totalling and fluid balance)  PIFVAIT action plan 18.4.21.docx
DHH CYP	1/3 = 33%. Both cases Non-compliant for indicator 4 (Cumulative input and output totalling and fluid balance)
ACUTE	1 case this week, returns awaited- 6 from previous to be reviewed – Total = 7 to review

Discussion at meeting	Action
Joanne advised a potential theme has been identified in relation to indicator 4.	Joanne is going to review audits over the last few weeks to identify any areas for improvement and create an action plan.

33.PPE Report

Discussion at meeting	Action
Trudy informed the panel there has been a number of incident reported, whereby staff are experiencing reactions to the masks. These incidents are being reported through Datix.	n/a

AOB

Attendees: Connie Connolly, Rebecca Murray, Caroline Beattie, Joanne McConville, Lynne Hainey, Nicole O'Neill, Damian Gormley, Marita Maginness, Jillian Redpath, Patricia Kingsnorth, Christopher Warr, Caroline Doyle, Catherine Weaver, Tony Black, Aisling Diamond, Claire McNally, Deborah Hanlon, Dr O'Kane, Heather Trouton, Trudy Reid, Mark McKeever, Lauren Weir

Apologies:

Southern Health and Social Care Trust

Chief Executive – Medical Director
1-1 Meeting
8th June 2021

	Item	Attachment
1	**Urology Update SAIs** • GMC have requested copy of 9 sets of patient notes from most recent SAI. A review meeting for AOB suspension is due this month, it is expected that the exclusion will be extended. • Dermot Hughes has confirmed that the 11 overarching SAI report recommendations meet the requirements found in the 9 individual reports, this makes for a total of 11 recommendations for the Trust to complete. • Apology letters drafted, pending finalisation – dates to be finalised • DoH Considering legislative powers to ask RQIA to intervene re private patients and AOB	20210527_LtrApology2.doc 20210521_LtrApology1.doc Summary of Patients under the care of AO
2	**ED SAI** • ED SAI is concluding, communications with staff member and family to progress	
3	**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. HSCB meeting to take place this week to discuss further. Lookback guidance due to be launched end of June. **Resourcing** • Fiona Davidson (8B) will be working 2 days per week overseeing work to deliver on the recommendations. This may increase to 3 days from July.	Regional Guidance for Implementing a Lc Policy for Implementing a Lookb
4	**Mental Health and Learning Disability** • Mental Capacity Act update from Tomas Adell • Update on regional MHLD challenges	DoLs circular - Oct 2010.pdf MCA DoLS - emergency provisions MCA DoLS - policy paper deprivation of l
5	**Infection Prevention and Control** • Role of the DIPC – potential for this to be a nurse lead. Consideration of banding of this post	Director of Infection Prevention and Contr

6	**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. DoH sign off expected on process in next few weeks	Nosocomial COVID-19 Deaths Mo
7	**Structured Judgement Reviews / SAI Chairs** • Meeting proposed with Mark Lee DoH to discuss SJR for MHLD SAI • Meeting took place with Andrew Dawson to discuss SJR approach, DoH to consider further • Fourth SAI Chair available, 2 Pas required • RQIA review suggests Suicide removed from automatically being in SAI process	Memo - Structured Judgement Review -
8	**HCAT Model** • Meeting with Andrew Dawson agreed a regional pilot of HCAT with a view to using HCAT in place of CH8 coding. Regional group to be established in coming weeks	
9	**Medical Leadership Proposal** • Phase 1 posts have been circulated: CYPS, Older Persons, IMWH, Surgery and Emergency Medicine closing 18th June • Phase 2 posts, Medicine, Cancer Clinical MHLD and Anaesthetics to progress in coming weeks following 1-1 conversations • Identification of 3rd Deputy Medical Director post – Professional Governance / Appraisal and Revalidation	
10	**Appraisal, Revalidation and Annual Management Reviews for Doctors** • Update on monthly DMD Revalidation Oversight Group has been established to inform revalidation recommendations. • Update on the discussion with UHB further meeting planned for April – PowerPoint of UHB model attached. • Appraisal Private Practice Structured Reflective Template developed – Trust to pilot for the region Appraisal Structured Reflective Template regarding Private Practice based on the principles agreed by the Academy of Medical Royal Colleges document (April 2020). The template covers a range of private practice areas including: ○ Job Planning ○ Medical Protection / Indemnity Arrangements ○ Scope of Practice Volume of Work ○ Experience ○ Duration of working in this way / future plans ○ Record Keeping ○ Overlap with other roles ○ Benchmarking, integration and support ○ Personal approach to risk and governance	Annual professional review for consultant Medical Revalidation Oversight Group ToR Private Practice Structured Reflective

	around your private practice ○ Continuous Professional Development (CPD) Consideration of requiring a proportionate amount of patient feedback should come from private practice sources.	
11	**Trust Paying Patients Guidance** Trust is conducting a review of paying patient policy and guidance. Change of status forms will be electronic and all relevant information required must be filled out to submit. This removes the manual keying in for all involved, and allows a variety of reports to be run. As part of QA, a report will be run quarterly and a sampling of Change of Status forms sent to medical records to check waiting lists to ensure that patients are entering at the correct point. Reports will be consultant specific and highlight issues and patterns such as patients frequently changing status within a short time frame. Division reports will be possible to see the pattern in each area. Undertaking to pay will be generated automatically. Plan to remove the MD as approver for change of status forms in place of Clinical Director / AMD DivMD	
12	**Individual Performance Review** • Shane to discuss what will be required for IPR re Medical Director	FW IPR's.msg
13	**Hyponatraemia** • Hyponatraemia 8B commenced last week – updated workplan attached	IHRD Rec. Database 07.06.21.xlsx Memo to IHRD Programme Members
14	**Crowe SAI** • Update - meeting this week. PPT being prepared for discussion with HSCB on approval times for ToR and discussion of communications re SAI discussions	20210603 Letter to [redacted]
15	**Compliance re Surgical Rota**	
16	**MDO Risk Register**	
17	**COVID-19 Level 3 SAI Update** • SAI on course for 30 June completion	
18	**Obs and Gynae** • Weekly meeting continuing, next meeting now 4 weeks. Progress being made on safety indicators. SAI for never events being progressed. Chair Aidan Armstrong approached to lead SAI. Further calls with O&G experts being progressed to develop increased safety measures. Request for regional	

	Maternity network drafted	
19	**CSCG Staffing Proposal Update** • AD CSCG post – extension / permanent • 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
20	**Unscheduled Care Centre Governance** • Clinical Governance for the UCC will sit with ED.	
21	**Weekly Governance Report** • 24.05.2021 Report	Weekly Governance Report 24.05.2021 -

Southern Health and Social Care Trust

Quality Care - for you, with you

27th May 2021 Ref:

XXXXXXX
XXXXXXX
XXXXXXX
XXXXXXX

Dear XXXXXX,

RE: CARE PROVIDED TO XXXXXXXX

My name is XXXXXXXX and I am XXXXXXXXX for Southern Health and Social Care Trust. I am writing to you, to offer my apologies regarding the shortfall in care you received whilst being treated within the Southern Health and Social Care Trust.

At the Southern Health and Social Care Trust, we aim to provide a quality service to all of our patients, service users and families and we would like to acknowledge on this occasion the care delivered has fallen short of these standards.

Commented [WS1]: Is this appropriate wording

As you are aware, to determine what happened a review of your care was conducted by Dr Dermot Hughes. Dr Hughes produced a report which has been shared with you that contains lessons to be learned and recommendations for the Trust to prevent any reoccurrence. I personally want to assure you that we will be enacting this learning and recommendations promptly.

As a Trust, we are committed to being open when events such as this happen and we want to ensure as well as sharing the review findings we would like to keep you informed of the progress towards implementing the lessons learned and recommendations. To deliver on

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

this commitment we will write to update you in regular intervals of our progress ensuring you are fully informed at all stages.

- First Update by 27th August 2021
- Second Update by 26th November 2021
- Third Update by 25th February 2021

You have a right to expect the very best care every time you use our services. However, if things do go wrong, it is the role of the Trust and our staff to learn from any failings, so that we can provide answers to families and patients and improve our care now and in the future.

Commented [MR2]: Added paragraph

We will do everything we can to support you and your family during this process. In the meantime, I would like to reassure you that that we are working hard to deliver the high quality Urology Services that the people in our communities rightly deserve.

If you would like to meet or speak with me or have any questions then please contact me as follows: INSERT NUMBER/EMAIL. The Trust also has a designated Family Liaison Officer, Fiona Sloan who has been in contact with you. Fiona is independent of the service and can support you at this time.

Once again I offer my sincerest apologies to you and our assurance that we will continue to work openly and honestly to learn from this event.

Yours sincerely

_____

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

25th May 2021 Ref:

XXXXXXX
XXXXXXX
XXXXXXX
XXXXXXX

Dear XXXXXX,

RE: CARE PROVIDED TO XXXXXXXX

My name is XXXXXXXX and I am XXXXXXXXX for Southern Health and Social Care Trust. I am writing to you, to offer my deepest condolences, following the death of your RELATIONSHIP TO DECEASED. Please also accept my sincere apology that this happened, while XXXXXXXX was in our care. At the Southern Health and Social Care Trust, we aim to provide a quality service to all of our patients, service users and families and we would like to acknowledge on this occasion the care delivered has fallen short of these standards.

Commented [WS1]: Is this appropriate wording

As you are aware to determine what happened a review of XXXXXXX's care was conducted by Dr Dermot Hughes. Dr Hughes produced a report which has been shared with you that contains lessons to be learned and recommendations for the Trust to prevent any reoccurrence. I personally want to assure you that we will be enacting this learning and recommendations promptly.

As a Trust, we are committed to being open when events such as this happen and we want to ensure as well as sharing the review findings we would like to keep you informed of the progress towards implementing the lessons learned and recommendations. To deliver on

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You have a right to expect the very best care every time you use our services. However, if things do go wrong, it is the role of the Trust and our staff to learn from any failings, so that we can provide answers to families and patients and improve our care now and in the future.

Commented [MR2]: Added paragraph

We will do everything we can to support you and your family during this process. Please be assured that it is not our intention to intrude upon you, or your family at this difficult time, however, we would like to keep you informed.

If you would like to meet or speak with me or have any questions then please contact me as follows: INSERT NUMBER/EMAIL. The Trust also has a designated Family Liaison Officer, Fiona Sloan who has been in contact with you. Fiona is independent of the service and can support you at this time.

Once again I offer my sincerest apologies and condolences to you and our assurance that we will continue to work openly and honestly to learn from this event.

Yours sincerely

_____

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

Patients under the care of Mr O'Brien and currently in process of being reviewed
7 June 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)	911 (Result Review)	CNS/ Professor Sethia	625	Professor Sethia	July 2021	No	Update from last report: **No change**
	Pathology Results	150 Patients (168 Episodes)	168 (Result Review)	M Haynes/D Mitchell	0	N/A	N/A	Yes	Update from last report: **No change**
	Oncology Reviews (IS)	236 Patients	200 (Face to Face ISP)	P Keane	36	M Haynes	June 2021	No	Update from last report: **No change**

		187 Patients (271 Episodes)	271 (SME Record Review)	Prof Sethia	52 (need second opinion)	M Haynes	July 2021	No	Update from last report: **No Change**
		511 Patients	111 (Virtual Clinics)	M Haynes	400	M Haynes/T Glackin	March 2022	No	Update from last report: **9 patients reviewed**
		155 Patients	10(reviewed at clinic)	M Haynes	145	Prof Sethia	Sept 2021	No	Update from last report: **No Change**
		933 Patients	747 (Record Review, 26 Face to Face Reviews)	M Haynes	186	M Haynes	March 2022	No	Update from last report: **No change**
		143 patients	0	TBA	143	Clinical Team	Dec 2021	No	Update from last report: **No change**
	Total	**4465**	**2930**		**1587**				

- 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

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?

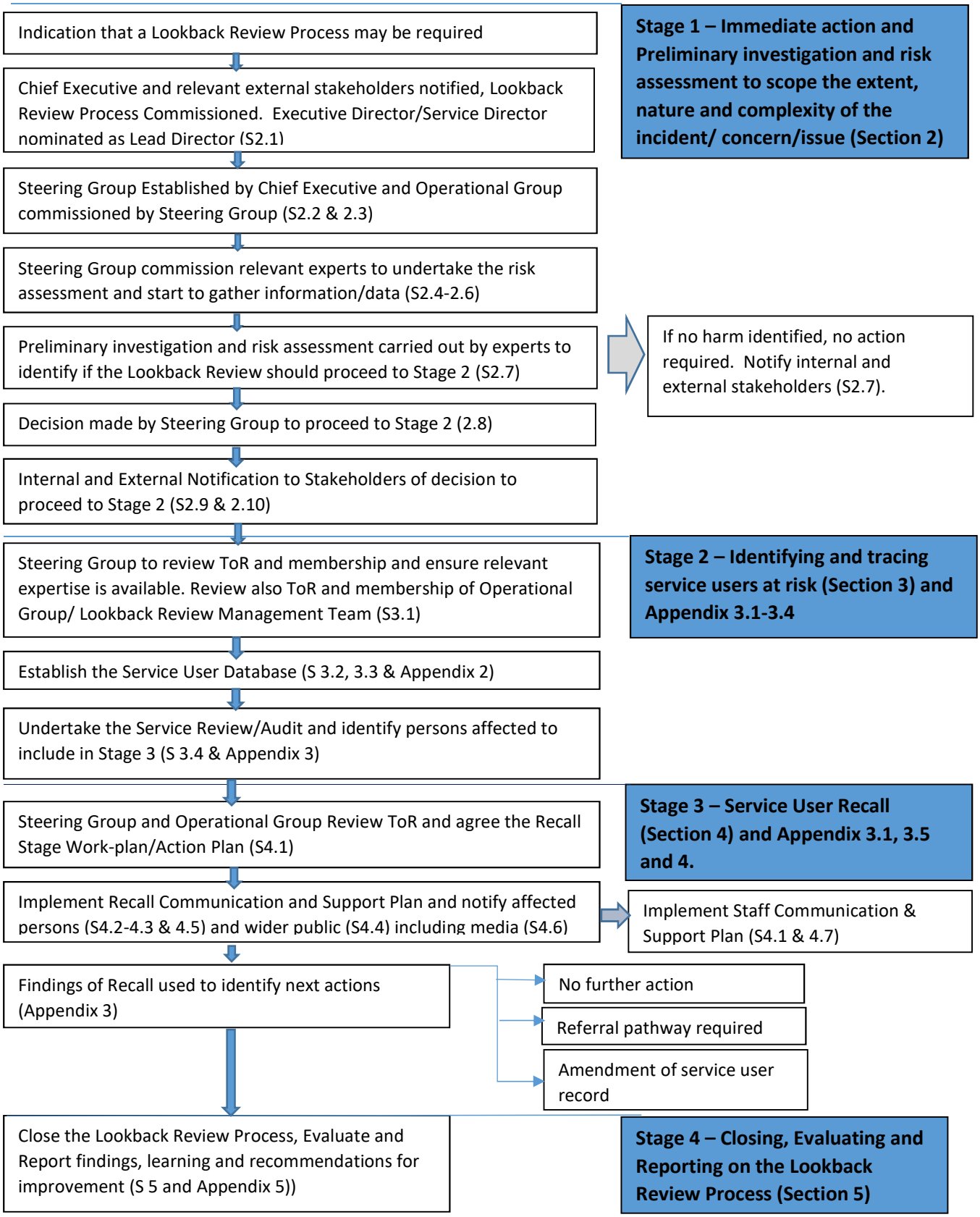
The Lookback Review Process involves:

- 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.

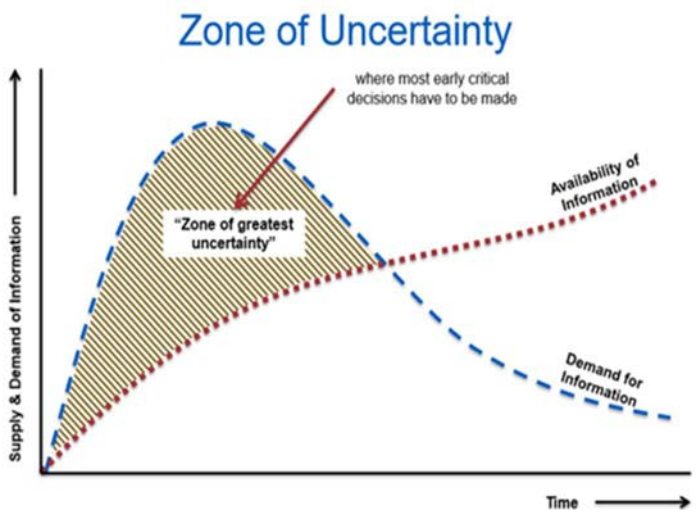
[13] New South Wales 'Lookback Policy Directive', Clinical Excellence Commission Safety & Quality, System Performance & Service Delivery, September 2007. Section 4 Page 5.

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.

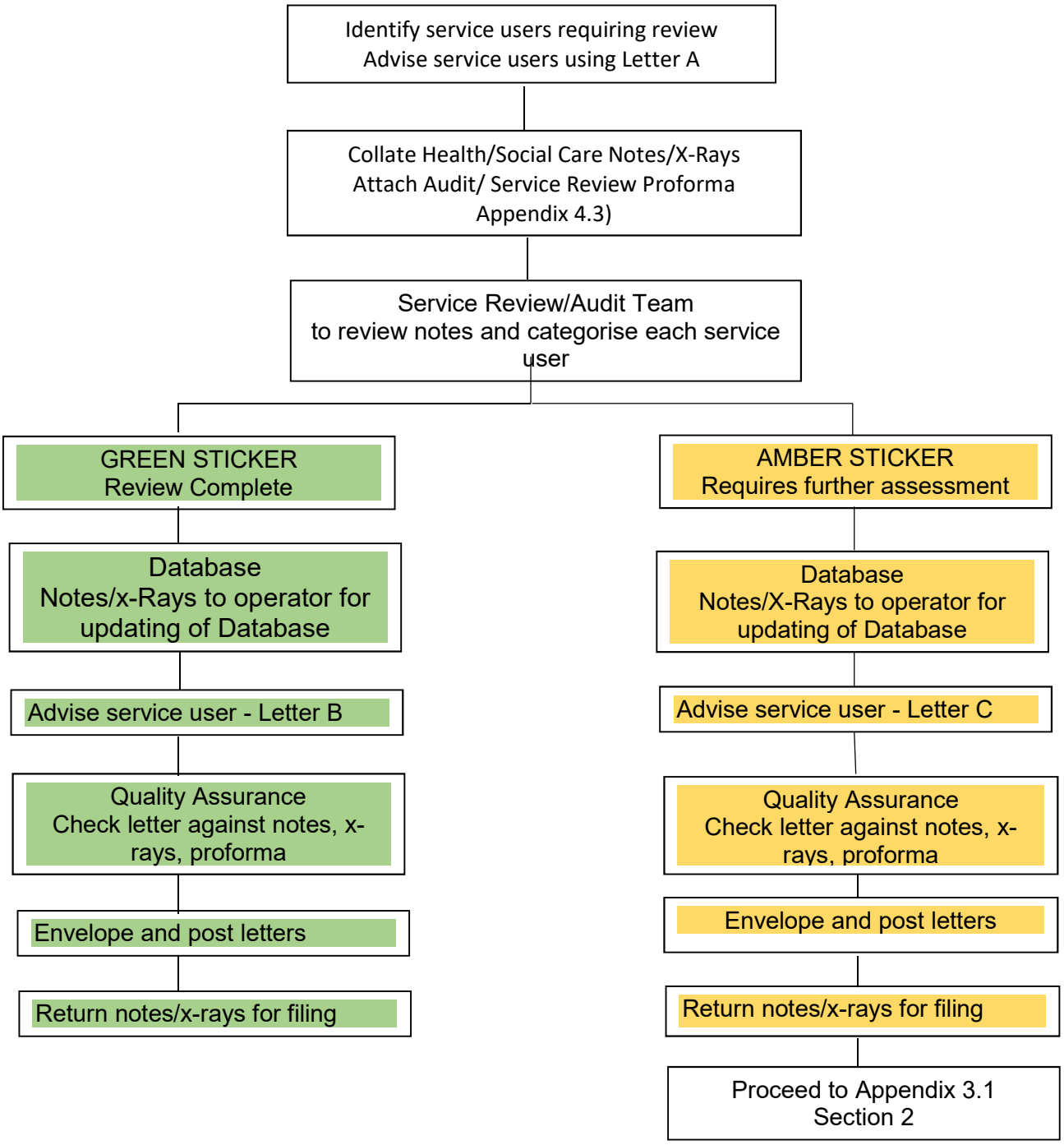
The service user database needs to be updated after completion of this proforma.

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.

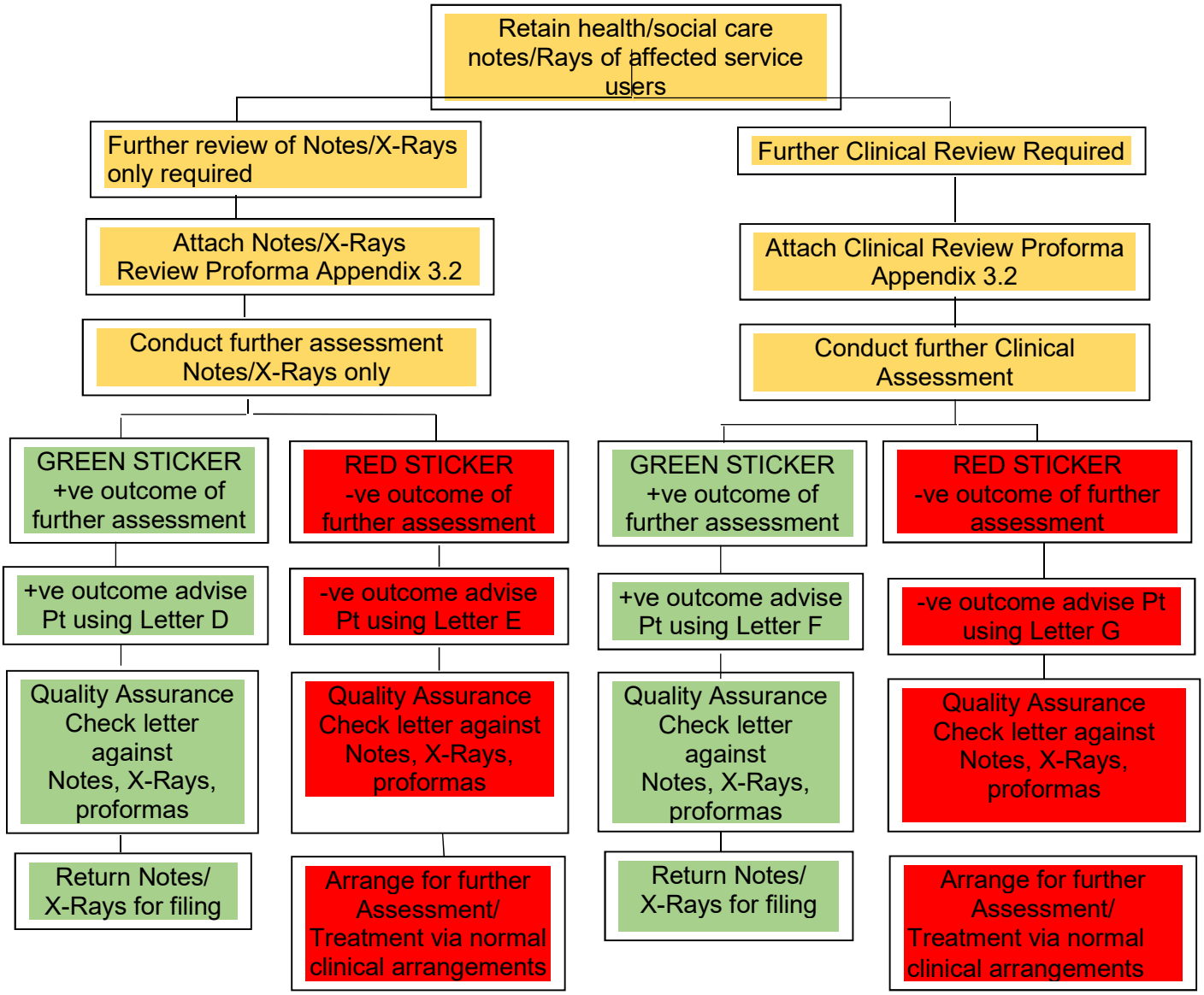
- If it has a **green** sticker attached: file into service user notes.
- If it has a **red** sticker attached: return service user notes and pro forma to admin support for processing within normal clinical arrangements.

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	OUTCOME -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.

Dr Maura Briscoe
Director Mental Health & Disability Policy

Department of
Health, Social Ser
and Public Safety
www.dhsspsni.gov.uk
AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poibl
MÄNNYSTRIE O
Poustie, Resydènter Heisi
an Fowk Siccar

To:
Chief Executive of HSC Trusts
Chief Executive of HSC Board (for cascade to GPs and other relevant practitioners)
Chief Executive of PHA
Chief Executive of RQIA (for cascade to private hospitals, clinics and other relevant establishments and agencies)
Chief Executive of PCC
British Medical Association (NI)
Royal College of Nursing (NI)
Royal College of Psychiatry (NI)
British Association of Social Workers (NI)
College of Occupational Therapists (NI)

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Your Ref:

Our Ref: HSC/MHDP – MHU 1 /10 - **revised**

Date: 14 October 2010

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance

Purpose

1. The purpose of this circular is to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty. The guidance is issued pursuant to the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case (see Annexe 1) and is therefore an important element in the protection of Human Rights of patients as required under the European Convention of Human Rights. The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 (the Order) and best practice, pending the introduction of new mental capacity legislation in Northern Ireland.

2. The guidance is intended for use by staff working in hospital and/or community care settings across all HSC organisations and relevant independent sector organisations where an individual may be subject to deprivation of their liberty.

A copy of this circular has been placed on the Department's website (www.dhsspsni.gov.uk).

3. This guidance revokes and replaces Circular Letter HSC/MHDP – MHU 1/10: DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance, issued by the Department on 1 March 2010.

The Case

4. Attached (annexe 1) is a summary of the Bournewood judgement which involved HL, a man who had autism and learning disabilities who was admitted to Bournewood Hospital for treatment. HL eventually took proceedings to the ECHR against the UK government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirement of Article 5(4) of the ECHR. The summary conclusions of the ECHR are important and are attached.

Deprivation of Liberty

5. The European Court found that HL had been deprived of his liberty within the meaning of Article 5(1) of the Convention. It is important to note that the judgement does not concern the treatment of incapacitated patients generally. It was only concerned with the question of deprivation of liberty of an incapacitated person.

6. The European Court's judgement does not, therefore, mean that incapacitated patients admitted to hospital or to care homes are automatically deprived of their liberty, even if staff would prevent them leaving unescorted for their own safety.

7. There must be particular factors which provide the "degree" and "intensity" to render the situation one of deprivation of liberty. The factors might relate for example, to the type of care being provided, its duration, its effects and the ways in which admission came about.

8. In this case, the European Court said that:

> "the key factor in this present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements".

and, noting that HL had been resident with his carers for over three years the Court went on to say that

> " the clear intention of Dr M and the other relevant health care professionals [was] to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from hospital to the care of Mr and Mrs E as and when professionals considered it appropriate (paragraph 91).

9. Accordingly the Court found that "the concrete situation was that the applicant was under continuous supervision and control and was not free to leave" (paragraph 91).

10. The Court attached particular importance to the fact that HL had a settled home with his paid carers to which he was prevented from returning and that his contact with those carers was (to some extent) restricted by the staff of the hospital. The court did not consider the issue of whether the ward was “locked” or “lockable” to be determinative.

Lack of Procedural Safeguards

11. The European Court did not find that HL’s rights had been breached simply because he was admitted to hospital on the basis of common law doctrine of necessity (i.e. in his “best interests”), rather than under specific statutory provisions (e.g. the Mental Health Order).

12. However, the Court did find that the absence of procedural safeguards surrounding his admission failed to protect him against “arbitrary deprivation of liberty on grounds of necessity and, consequently, (failed) to comply with the essential purpose of article 5(1) of the Conventions”.

13. In this latter respect, the European Court was clearly influenced by the “lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted” when contrasted with “the extensive network of safeguards applicable to psychiatric committals covered by the (Mental Health Act 1983). Paragraph 120 is of relevance.

14. The European Court also said:

> “the nomination of a representative of a patient who could make certain objections and applications on his/her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities” (paragraph 120)
>
> By which it presumably had in mind the role of the nearest relative under current mental health legislation.

15. Above all, although it did not question their good faith, the Court seems to have been concerned that the hospital’s health care professionals were able to assume “full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit” (paragraph 21).

16. The Court did not say that HL should have been formally detained under the Mental Health Act. Nor, in the Department’s view, does the judgement mean that procedural safeguards for people in HL’s position must be identical to those patients detained under the current mental health legislation. However, it is accepted that to avoid further violations of Article 5(1), new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in the best interests under common law doctrine.

Breach of Article 5(4)

17. The European Court also found a violation of his rights under Article 5(4) of the convention.

Next Steps

The following paragraphs outline the next steps to be taken by DHSSPS, HSC organisations and relevant independent sector organisations.

Proposals for new procedural safeguards

18. The Department will bring forward new safeguards in law via the proposed Mental Capacity (Health, Welfare and Finance) Bill.

Interim steps that might be taken by HSC bodies and relevant independent sector organisations.

19. Until these safeguards are established in law, the effect of the Bournewood Judgement is that it would be unlawful for an HSC body (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of Article 5 of the Convention unless the patient were detained under the Mental Health (NI) Order 1986.

20. Nonetheless, the HSC will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period, both for their good, and, it follows, the care and protection of other patients.

21. Pending the development of new safeguards described above, HSC bodies will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of successful legal challenges.

22. The Department suggests that HSC bodies and relevant independent sector organisations will want to ensure they have systems in place so that when making arrangements to provide care to an incapacitated person which involves a restriction on the liberty of that person, consideration is given as to whether what they are proposing amounts in practice to a deprivation of that person's liberty within the meaning of Article 5 of the Convention, taking into account the range of factors identified by the Court set as described above and also contained within (a) to (f) in the Bournewood Judgement attached. The same question will need to be asked when reviewing the circumstances of those people who they have already placed who may, in practice, be deprived of their liberty.

23. If patients are considered to be deprived of their liberty (or at risk of it), consideration should always be given to alternatives to ensure that they get adequate care but which falls short of deprivation of liberty. In particular, HSC bodies and independent sector organisations will want wherever possible, to avoid situations in which professionals may be said to take "full and effective control" over patients care and liberty.

24. Elements of good practice which are likely to assist in this, and in avoiding the risk of legal challenge, may include:

- ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. There should, for example, be a proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed, and that decisions should be taken on the basis of proper medical advice by a person properly qualified to make the judgement.

- effective, documented care planning and record keeping for such patients, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare and safety.

- ensuring that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case.

- ensuring appropriate information is given to patients themselves and to family, friends and carers. This would include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews and the way in which they can challenge decisions (e.g. through the relevant complaints procedure). The involvement of local advocacy services, where these are available, should be encouraged to support patients and their families, friends and carers.

- taking proper steps to help patients retain contact with family, friends and carers, with proper consideration given to the views of these people. If, exceptionally, there are good clinical reasons why that is not in the patient's best interests, those reasons should be properly documented and explained to the people they affect.

- ensuring both the assessment of capacity and the care plan are kept under review. It may be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the HSC Body/independent organisation, or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the organisation's decisions. But, even where there is no dispute, an organisation must ensure its decision making stands up to scrutiny.

25. If it is concluded that there is no way of providing appropriate care which does not amount to deprivation of liberty, then consideration will have to be given to using the formal powers of detention in the Mental Health (NI) Order 1986. However it is important to remember that:

- nothing in the judgement changes the requirements in the Mental Health Order which must be met before patients can be detained. It should not therefore be assumed that all patients who are to be subject to restrictions

which may amount to deprivation of liberty can be detained under the Order. (For example, it would be unlawful to detain patients under the Order if their mental disorder does not warrant detention in hospital, although reception into guardianship under the Order might be appropriate in some cases).

- there are dangers in using the Order simply to be "on the safe side". Although it provides procedural safeguards, the use of the Mental Health Order will not necessarily be welcomed by their family, friends or carers, given the stigma that is often (wrongly) perceived to attach to it. Moreover, a significant increase in the use of the Mental Health Order will inevitably put considerable further pressure on approved social workers, the availability of second opinion appointed doctors (SOADs) and on the operation of the Mental Health Review Tribunal (MHRT).

Action Required

26. I should be grateful if Trust Chief Executives would bring this guidance to the attention of all relevant personnel; ensure the principles it contains are embedded into Trust's procedures; and, confirm to me by **10 December 2010** that this has been done.

Yours sincerely

[SIGNED]

DR MAURA BRISCOE
Director of Mental Health and Disability Policy

Annex 1

The Bournewood Judgement

The Bournewood judgement refers to the European Court of Human Rights' decision in the case of "H.L. v the UK" (published on 5th October 2004).

The case involved H.L, a man who suffered from autism and learning disabilities, who was admitted to Bournewood hospital for treatment under the common law doctrine of necessity. H.L lacked the capacity to consent or object to being admitted and detained for treatment. Although H.L. did meet the criteria for detention under the Mental Health Act 1983 (the 1983 Act) he was not formally detained because he was compliant and did not resist admission and was, therefore, admitted as an "informal patient".

This approach was taken in compliance with the Code of Practice drawn up under the 1983 Act. Chapter 2 of that Code specifically provided that, "if at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal. The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common law doctrine of necessity".

H.L. applied, by his carers, to the High Court for leave to apply for judicial review of the hospital/Health Trust's decision to admit him, for a writ of habeas corpus and for damages for false imprisonment and assault. The Court held that, although the 1983 Act provided a comprehensive statutory regime for those formally admitted to psychiatric care, section 131(1) of that Act preserved the common law jurisdiction in respect of informal patients. It concluded that H.L. had not been "detained" but had been informally admitted and that the requirements of the common law principle of necessity had been satisfied. The application was therefore refused.

H.L appealed and the Court of Appeal held that he had been detained by the hospital/Trust and that the right to detain a patient for treatment for mental disorder was to be found only in the 1983 Act, which excluded the application of the common law doctrine of necessity. It considered that section 131(1), which preserved the right to admit a patient informally, applied only to a patient who had the capacity to and did consent to his/her admission. The Court of Appeal therefore held that, since H.L. had been admitted for treatment without his consent and without the other formalities required by the 1983 Act, his detention was unlawful.

The hospital/Trust then appealed to the House of Lords, which unanimously allowed the appeal.

H.L. then took proceedings to the ECtHR against the UK Government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that the procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirements of Article 5(4) of the ECHR.

The relevant parts of Article 5 are set out below.

Article 5 - Right to liberty and security

Article 5(1):
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty *save* in the following cases and in accordance with a procedure prescribed by law.

Article 5(1)(e):
The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants.

(The case of *Winterwerp v Netherlands* (1979) set out the criteria which must be satisfied in order to lawfully deprive a person of his/her liberty on the basis of unsoundness of mind, namely: the person concerned must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.)

Article 5(4):
Everyone who is deprived of his/her liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his/her detention shall be decided speedily by a court and his/her release ordered, if the detention is not lawful.

European Court of Human Rights considerations

The ECtHR had to consider whether H.L. had in fact been detained: and, if so, whether that detention was lawful (i.e. whether detaining H.L in his own best interests under the common law doctrine of "necessity" complied with Article 5(1)); and also whether sufficient safeguards existed to comply with Article 5(4).

The ECtHR concluded that:

- H.L. had in fact been detained and, therefore, the right to liberty in Article 5(1) had been engaged.

  The Court considered that the question as to whether there has been a deprivation of liberty or a restriction upon a person's liberty depends on the particular circumstances of the individual case and "account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question". It stated that "the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance". It considered the facts of HL's case and concluded that he had been detained because he was constantly under supervision, was not free to leave and because "the health care professionals treating and managing him exercised complete and effective control over his care and movements".

- HL's detention under the common law doctrine of necessity in his own best interests was unlawful under the ECHR, as it did not comply with Article 5(1): i.e. it lacked procedural safeguards which are required to protect against the risk of arbitrary deprivation of liberty.

The ECtHR considered the common law under which H.L was detained. It noted particularly "the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" in contrast with the extensive safeguards available to persons who are compulsorily detained under the Mental Health Act 1983. It also noted the lack of the following attributes which would be necessary to ensure compliance with Article 5(1):

a) Formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions;

b) A requirement to fix the exact purpose of admission (e.g. for assessment or for treatment);

c) Limits in terms of time, treatment or care which should attach to the person's admission;

d) Specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention;

e) A requirement to nominate or appoint a representative of a patient who could make certain objections and applications on his/her behalf; and

f) Arrangements to enable the person (or his/her representative) to have access to a court/body with judicial character to have the lawfulness of the detention and/or any decision relating to deprivation of liberty reviewed and dealt with within a reasonable period of time.

The Court concluded that "this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1)".

- HL's detention was also contrary to Article 5(4) because he was unable to take proceedings by which the lawfulness of his detention could have been challenged and decided quickly by a court.

  The ECtHR considered that HL's application for leave to apply for judicial review of the decision to admit and detain, including a writ of habeas corpus, did not provide H.L. with an adequate means to challenge his deprivation of liberty. Therefore, Article 5(4) of the ECHR was breached.

The ECtHR formally held that Articles 5(1) and 5(4) of the ECHR were violated by the UK Government.

Assumptions

- The person is in a place where care and treatment is available
- There has been no refusal by the Trust panel to an application for authorisation
- The Tribunal has not terminated the deprivation of liberty

SCENARIO 1: No application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- Staff take all reasonable steps to put in the additional safeguards of the MCA:
  - formal assessment of capacity; and
  - application to Trust panel.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 2: Application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- An Application has been made to the Trust for Trust panel authorisation.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

TIME LIMITS: There are no time limits to the use of emergency provisions
REQUIREMENTS: There must at all times be a reasonable belief of lack of capacity, best interests, that the DoL is to prevent serious harm and that the DoL is proportionate to the likelihood and seriousness of the harm.

SCENARIO 3: Decision has been made by Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.

authorisation by Trust panel

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 4: Trust panel has made decision to refuse DoL

A DoL cannot take place.

Staff are not protected from liability.

SCENARIO 5: No steps taken by staff to put in safeguards

Staff are not protected from liability.

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Policy position
Mental Capacity Act (Northern Ireland) 2016
Deprivation of Liberty Safeguards

By:
Mental Capacity Unit
Department of Health

Date: 2 June 2021

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Deprivation of liberty and liability
Protection from liability
Emergency provisions

Introduction

1. This is a policy position paper by Mental Capacity Act Unit in the Department of Health. This paper constitutes **official guidance** in respect of the implementation period of the Deprivation of Liberty Safeguards. This guidance must be read in conjunction with the Mental Capacity Act (Northern Ireland) 2016 (the Act), the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations 2019 (the Regulations) and the Code of Practice (the Code).

2. The first phase of the Act was commenced on 2 December 2019 for the purposes of deprivation of liberty (DoL), offences and money and valuables. Research provisions of the Act were commenced on 1 October 2019.

3. At commencement the Department noted that phase 1 of the Act would allow for a 12 month implementation period. Due to pressures relating to the Covid-19 pandemic it was decided to extend the implementation period until 31 May 2021.

4. This policy paper outlines the requirements for authorisation in respect of deprivation of liberty, safeguards and protection from liability and provides guidance in respect of the emergency provisions in the Act.

Deprivation of Liberty

5. European Convention on Human Rights (ECHR), Article 5 provides that:

   Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

6. This ensures that no one can be deprived of liberty unless it has taken place within a legal framework. In judgements from the European Court of Human Rights

(*Bournewood*[1]) and the UK Supreme Court (*Cheshire West*[2]) the Courts have refined the requirements for a deprivation of liberty to note that:

a. The common law defence of necessity is not sufficient to meet the requirement for a procedure prescribed by law.
b. All deprivation of liberty cases must be authorised prior to taking place.
c. The acid test for a deprivation of liberty is the two questions:
    i. Is the person free to leave?
    ii. Is the person under continuous control and supervision?
d. It does not matter if a deprivation of liberty is done for good reasons if it is not authorised; it would still be unlawful.

7. **The effects of the Courts' decisions are that a deprivation of liberty that is not authorised is unlawful**. If a person is carrying out an unlawful deprivation of liberty, that person carries potential civil and criminal liabilities and the corporate entity (such as the HSC Trust, care or nursing home or other) carries civil liabilities.

8. In Northern Ireland the criminal liability in relation to a deprivation of liberty pre-dates the Mental Capacity Act. The criminal offence of false imprisonment applies in circumstances where a person is preventing another person from leaving the place. A consequence from the ECtHR case of *Bournewood* is that the defence of necessity does not apply to false imprisonment where it is planned, pro-longed or part of a care plan. A person preventing someone from leaving in a health and social care setting therefore potentially carries criminal liabilities relating to false imprisonment, unless the deprivation of liberty has been authorised.

9. Prior to the commencement of the Mental Capacity Act the only methods of authorisation in the health and social care system in Northern Ireland were the Mental Health (Northern Ireland) Order 1986 for patients in hospital or a declaratory order in the High Court.

10. The first phase commencement of the Act, through the Deprivation of Liberty Safeguards (DoLS), provides a statutory framework to authorise a DoL in all settings where the Mental Health (Northern Ireland) Order 1986 does not apply. As such the Mental Capacity Act provides protection from the criminal liability of false imprisonment.

Legislative background

11. The functioning of the Act is based on the concept of **protection from liability**, as found in section 9 of the Act. This provides a protection from a liability in relation to a person who is over 16 who lacks capacity to consent to a specific act that would normally require that person's consent.

12. Many acts done in relation to a person that interfere with a person's body are done based on the person's consent. This includes most acts in a health and social care setting. For example:

    a. if a nurse provides the flu vaccination through an injection on a person the nurse requires consent to do so. If no consent is provided the nurse is

[1] *HL v UK* (2004).
[2] *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16.

potentially committing the criminal offence of assault and the tort of trespass to the person.

b. if a care assistant helps a person dress in the morning and touches the person, without consent potentially the criminal offence of assault has been committed and the tort of trespass to the person.
c. if a surgeon operates on a person, consent is required. If no consent is provided the surgeon potentially commits the offence of wounding and trespass to the person.
d. if a support worker prevents a service user from leaving a building the support worker potentially commits the offence and tort of false imprisonment.

13. Valid consent negates the liability, as the act is consented to. If a person lacks capacity to consent, the act can be carried out if it is deemed necessary, by relying on the common law defence of necessity. This defence allows an act to be carried out because it is necessary even though it would normally be unlawful.[3]

14. The Mental Capacity Act, through the protection from liability, codifies the common law defence of necessity. That means if a person (D) does an act in relation to a person who is 16 or over and lacks capacity (P), **D is protected from liability if the safeguards and additional safeguards of the Act are adhered to**.

15. The first phase commencement, with the go live date on 2 December 2019, relates to acts that amount to deprivation of liberty and research, with deprivation of liberty the focus on this policy paper. In relation to DoL the protection from liability relates to care arrangements amounting to deprivation of liberty.

Safeguards and additional safeguards

16. The protection from liability as found in the Act for the purpose of an act that is a detention amounting to a deprivation of liberty can be relied upon if two safeguards and four additional safeguards are met.[4]

17. The safeguards are:

a. Reasonable belief of lack of capacity; and
b. Reasonable belief of bests interests.

18. The additional safeguards are:

a. Formal assessment of capacity;
b. Prevention of serious harm condition (POSH);
c. Consultation with nominated person (NP); and
d. Authorisation[5].

[3] Please note as a result of jurisprudence in the European Court on Human Rights and the UK Supreme Court the common law defence of necessity cannot be relied upon when the act is a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights.
[4] In the case of an emergency the additional safeguards of formal assessment of capacity, Nominated Person and authorisation can be delayed to protect P from unnecessary harm.
[5] Short-term detention authorisation or trust panel authorisation.

19. All the safeguards and additional safeguards are of equal importance. If one of the safeguards or additional safeguards are not in place the protection from liability cannot be relied upon (unless the situation is an emergency – see footnote 4).

Power v protection

20. Traditionally statutory provisions in relation to detention and deprivation of liberty have provided powers to act. For example, the powers of detention in the Mental Health (Northern Ireland) Order 1986 provide explicit powers to detain a person. Those powers are vested in the statutory report and forms where the signing of the form provides a power to detain a person.

21. **The Act does not provide powers of detention but a protection from liability.** That means that there are no "traditional" powers of detention and a deprivation of liberty cannot take place simply because there is a form, papers, care plan or similar that notes that a person should be deprived of liberty. The person doing the act (D) must be satisfied that the safeguards and additional safeguards are met at all times (except in an emergency). If ***any*** of the safeguards are not met, or if there is no reasonable belief for D that the criteria for detention are met, a deprivation of liberty cannot occur.

22. When D is considering whether the criteria are met, D can rely on previous work and work of others. That means a formal assessment of capacity forms a good foundation for reasonable belief that P lacks capacity. However, it is important to note that D must have a reasonable belief. If the formal assessment of capacity is obviously incorrect D cannot rely on that information.

Liability

23. **The Act provides a protection from liability for D if the criteria for deprivation of liberty are met and the safeguards and additional safeguards of the Act are fulfilled.** This protection is enshrined in the law and is absolute – if the law is followed correctly.

24. The person needing protection is the person who carried a liability i.e. D. As there are no powers of detention the only person that requires the protection is the person who prevents P from leaving a place.

25. A deprivation of liberty normally carries liabilities as this could amount to a false imprisonment. That means a deprivation of liberty that is done without an authorisation or other approval could amount to criminal behaviour. This is not a consequence of the Mental Capacity Act, but of previous case law in the UK Supreme Court and the European Court of Human Rights, the European Convention on Human Rights and the Human Rights Act 1998. **In the Mental Capacity Act, D is protected against the personal liabilities (both civil and criminal)** that is included by falsely imprisoning a person as long as D has a reasonable belief that the criteria for DoL and the safeguards required under the Act are in place.

26. The safeguards include a reasonable belief of lack of capacity and best interests and the additional safeguards of a formal assessment of capacity, consultation

with the nominated person, prevention of serious harm condition and authorisation.

27. These additional safeguards, including the authorisation, do not provide powers to act or powers to detain a person. Rather it provides the safeguards that D requires to be protected from liability. Therefore carrying out the safeguards by, for example, making the formal assessment of capacity or sitting on a trust authorisation panel, does not constitute acts that create a liability (outside normal duties of care and professional responsibilities). It is part of normal assessments in the health and social care system that provides a basis for the reasonable belief required by D.

28. As noted, a person doing an assessment, writing a report or signing an authorisation has not carried out an act that would normally require P's consent. These people therefore have no liability and therefore have nothing to be protected from.

29. If the Act had been drafted to provide powers of detention, the person signing the authorisation could have been held liable for an unlawful deprivation of liberty based on their signing the authorisation or reports. However, as the Act **does not** provide such powers, and rather is **based on the concept of protection from liability** then there is **no liability** in relation to the assessors, report writers or authorisers. The **liability rests with the person who prevents P from leaving the place**.

30. There are, of course, general responsibilities to carry out professional functions in a professional manner and to act within professional standards. If a professional purposefully or wilfully provides a false assessment, statement, report or authorisation this could, and should, be dealt with in line with normal disciplinary manners. Such wilful acts may also constitute the offence of wilful ill-treatment or neglect of a person deprived of liberty.

Protection from liability of false imprisonment

31. The current position in Northern Ireland in relation to deprivation of liberty is that a lawful authorisation must be in place before a deprivation of liberty. The 2004 European Court of Human Rights case, *Bournewood*, ruled that deprivation of liberty cases needed procedural safeguards so as to ensure a person is not being deprived of their liberty unnecessarily. In 2014, the Supreme Court ruled in Cheshire West that a person was deprived of their liberty if they were under continuous control and supervision and not free to leave.

32. Therefore, if a person believed to lack capacity is unable to leave and under continuous control and supervision, their confinement **must** be authorised. The Mental Capacity Act contains the procedural mechanisms by which a DoL is authorised and provides protection from liability for those depriving a person of their liberty.

33. **The Act provides a statutory framework to protect from this liability**. As such the purpose of the Act is twofold. On the one hand it provides a statutory framework of protections for P; this ensures that P is only deprived of liberty when it is right and just to do so. On the other hand it also provides protection for those

depriving P of liberty (D); so that the health and social care worker who prevents P from leaving has a statutory protection for the act he or she is doing.

Emergency provisions

34. The Act provides that in some circumstances waiting until all the required safeguards are met would create an unacceptable risk of harm to P and thus would risk greater harm to P than the risk of doing the act without the safeguards. It may then be possible to rely on the emergency provisions under the Act. **Chapter 10 of the Code of Practice[6] outlines guidance on the emergency provisions.** The following paragraphs provide advice on how to interpret the emergency provisions during the implementation period.

35. For the protection of liability to apply in relation to DoL there must always be a reasonable belief of lack of capacity and that the care arrangements are in P's best interests, even if the situation is an emergency. If there is not a reasonable belief of lack of capacity and best interests the person doing the act (D) will never be protected from liability.

36. The prevention of serious harm (POSH) condition must also always be met when a DoL is carried out, even when the situation is an emergency.

Definition of emergency[7]

37. Emergency has a specific meaning for the purposes of the Act. For a situation to be an emergency there does not have to be a crisis and the place of the emergency is irrelevant; it may be in an Emergency Department, but it may also be in a care home, in a private house or anywhere else where an act must be done for P.

38. For a situation to be an emergency **two** conditions have to be met:
    a. that D knows that an additional safeguard is not met, or that D does not know whether the safeguard is met; and
    b. waiting until the safeguard is met, or waiting to establish if the safeguard is met, would create an unacceptable risk of harm to P.

Effects of the emergency provisions

39. Circumstances amounting to an emergency may allow one, or more, of the additional safeguards to be delayed to avoid creating an unacceptable risk of harm to P. It is important to note that just because it would create an unacceptable risk of harm to P to wait for one of the safeguards it does not mean that all safeguards can be delayed.

40. For example, DoL requires a formal assessment of capacity, nominated person and authorisation. It may be that not detaining P in circumstances amounting to a DoL while waiting for a trust panel authorisation (who have up to 7 working days to make a decision after receiving the application), would create an unacceptable risk of harm to P but waiting a number of hours while the other safeguards are met

[6] Much of the advice in this guidance is also available in Chapter 10 of the Code of Practice. However, the Code of Practice provides further guidance on emergencies.
[7] The emergency provisions can be found in sections 65 to 67 of the Act.

would not. In such a situation, if all the safeguards were ignored D would not be protected from liability, whereas he or she would be protected if the trust panel authorisation was not yet in place but the formal assessment of capacity and nominated person safeguards were met.

41. Another example of this may be where P is an in-patient in hospital, subject to a short-term detention and is due to be discharged into a care home. It has been determined that it is in P's best interests to be subject to a DoL in the care home. At the time of the discharge it has not been possible to make an application and get trust panel authorisation. If it would be best for P to be discharged from hospital and admitted into the care home it would normally cause an unacceptable risk of harm for P to remain in hospital. The emergency provisions can then be used to ensure that there is no delay in the discharge from hospital.

Reliance on emergency provisions

42. Staff can rely on the emergency provisions in the Act if D knows an additional safeguard is not in place, but waiting to put in place the safeguard would create an unacceptable risk of harm to P. **This provides a protection in law from liabilities, including from criminal sanctions.**

43. D must have reasonable belief of both lack of capacity and best interests, must be satisfied that the POSH condition is met and must take all reasonable steps to put in place:
    a. **a statement of incapacity;**
    b. **a nominated person; and**
    c. **an authorisation.**

44. As noted above the inability to do one or more additional safeguards is not a reason to not do any. It may therefore be possible to do one or two of the three additional safeguards above.

45. **Statement of incapacity in an emergency** – A wide range of professionals can make statements of incapacity. Such persons must also have received relevant training, have experience working with people who lack capacity and must be designated as a person to make capacity assessments by his or her employer. If a person does not meet the requirements he or she cannot do a statement of incapacity, and can rely on the emergency provisions to deprive P of liberty by informing others, including their line manager, that a statement of incapacity is needed, as this would be considered taking all reasonable steps to fulfil the additional safeguard. For further information on statements of capacity/capacity assessments see chapters 5 and 8 of the Code of Practice.

46. **Nominated person in an emergency** – A nominated person is a person either nominated by P (in writing and witnessed), a person on the default list or a person appointed by the Review Tribunal (see chapter 9 in the Code of Practice for further information). Anyone can ensure a nominated person is in place if nominated by P or taken off the default list, but only some people can apply to the Tribunal to have one appointed. If a person does not meet the requirement to apply to the Tribunal he or she can rely on the emergency provisions to deprive P of liberty by informing others, including their line manager, that an application to the Review Tribunal to appoint a nominated person is needed.

47. **Authorisation in an emergency** – An authorisation outside hospital includes an application to a Trust and a decision by a Trust Panel (see the Code of Practice for further information). If a person does not meet the requirement to make a Trust Panel application he or she can rely on the emergency provisions to deprive P of liberty by informing others, including their line manager, that an application for Trust Panel authorisation is needed.

48. There are no time limits for how long the emergency provisions can be relied upon. However, at all times D must take all reasonable steps to put the additional safeguards in place.

49. If D is an employee of another person (E), E can be held liable for any unreasonable delays in putting the additional safeguards in place. However, the liability of E does not affect the liability of D.

Summary of emergency provisions

50. Anyone can rely on the emergency provisions, and be protected from liability as below. **If a person relies on the emergency provisions and takes all necessary steps required, that person is protected from liability.**

51. A one page summary /process map of the emergency provisions is provided at the end.

Offences

52. Section 269 of the Act provides that it is an offence to unlawfully detain a person. From 31 May 2021, this is a new statutory offence under the Act. **However, it has always been an offence in common law to falsely imprison someone.** A similar offence is also currently in force under the Mental Health Order (NI) 1986. Therefore, the Act does not create a new criminal offence.

53. The staff member/carer, unlawfully detaining the person will be guilty of the offence. Senior managers will also be guilty of the offence if it was done with their consent, if they connived with it or if it can be attributed to neglect on their part.

54. However, if a person is relying on the emergency provisions in the Act, the person is protected from liability. That means the person carries no risk in relation to the statutory offences in the Mental Capacity Act or the Mental Health Order or the common law offence of false imprisonment.

55. Health and social care staff can be assured that where they act in compliance with the Act, and where they take the reasonable steps available to them to put in place all relevant safeguards they are **not** at risk of liability.

56. Only where health and social care staff are **intentionally** ignoring the requirements to have a legal authority for a deprivation of liberty; or where the staff member does not consider if the deprivation of liberty is in the best interests and are not attempting to put processes in place, may there be criminal liability. This is to protect patients, residents and others from arbitrary detention when the deprivation of liberty cannot be justified.

Assumptions

- The person is in a place where care and treatment is available
- There has been no refusal by the Trust panel to an application for authorisation
- The Tribunal has not terminated the deprivation of liberty

SCENARIO 1: No application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- Staff take all reasonable steps to put in the additional safeguards of the MCA:
  - formal assessment of capacity; and
  - application to Trust panel.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 2: Application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- An Application has been made to the Trust for Trust panel authorisation.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

TIME LIMITS: There are no time limits to the use of emergency provisions
REQUIREMENTS: There must at all times be a reasonable belief of lack of capacity, best interests, that the DoL is to prevent serious harm and that the DoL is proportionate to the likelihood and seriousness of the harm.

SCENARIO 3: Decision has been made by Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.

authorisation by Trust panel

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 4: Trust panel has made decision to refuse DoL

A DoL cannot take place.

Staff are not protected from liability.

SCENARIO 5: No steps taken by staff to put in safeguards

Staff are not protected from liability.

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

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.

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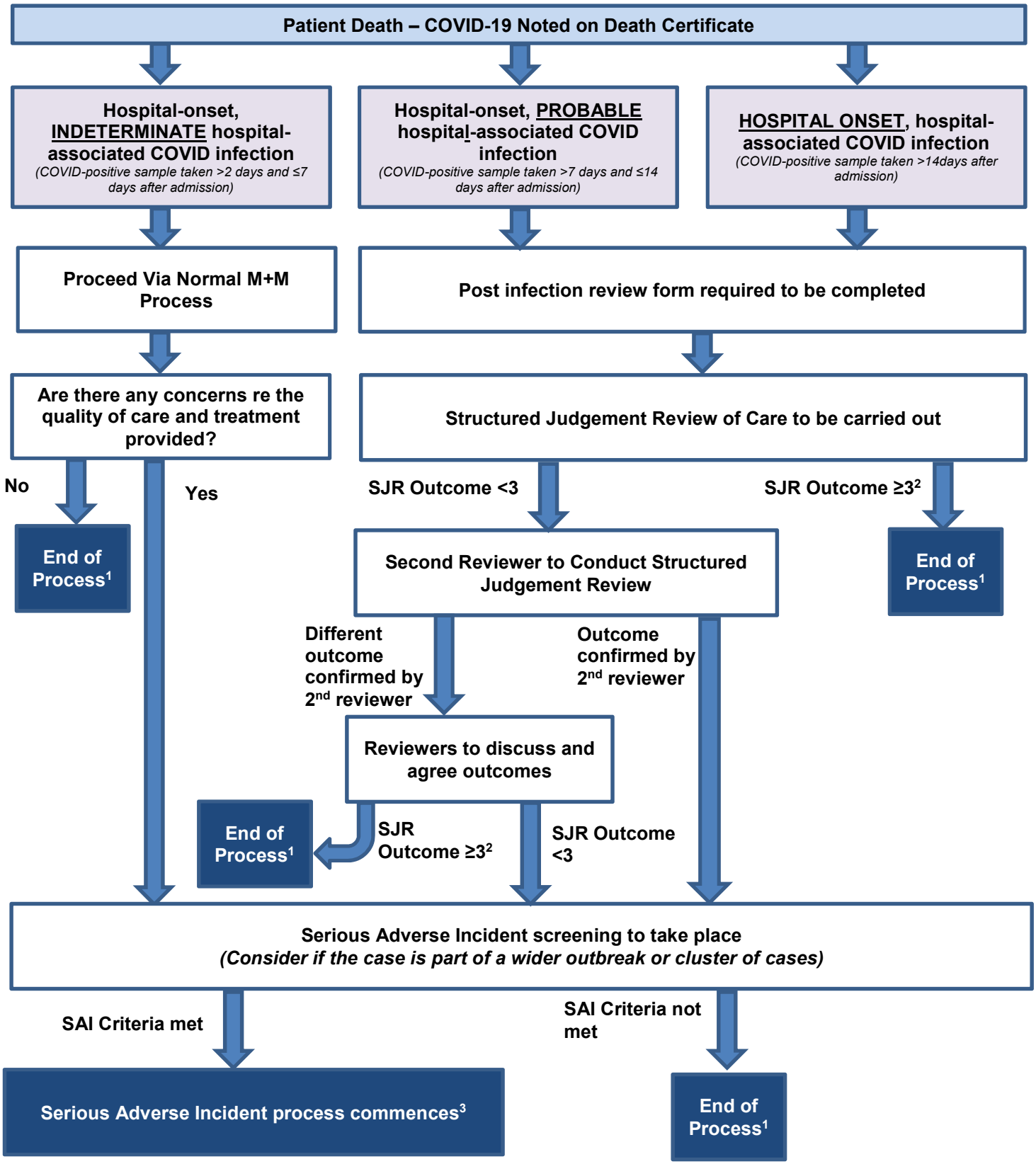
Appendix 1 - Nosocomial COVID-19 Deaths Mortality Review Process



[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.

Received from SHSCT on 27/09/2022. Annotated by the Urology Services Inquiry.

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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

Medical Directorate

Memorandum

To:	Mr Mark Lee, Director of Mental Health, Disability and Older People – Department of Health, Northern Ireland.
c.c.	
From:	Dr Maria O'Kane, Medical Director
Date:	17th May 2021
Subject:	**Royal College of Psychiatrists – Care Review Tool for Mortality Reviews**

Dear Mr Lee,

I am writing to detail work we are undertaking within the Southern Trust regarding the Royal College of Psychiatrists Care Review Tool for Mortality Reviews that is designed to review the care provided to patients and service users who have died by suicide. The review tool has the potential be used as an alternative review methodology to the existing Serious Adverse Incident process for deaths in mental health services.

As you may be aware, the Royal College of Psychiatrists developed the Care Review Tool through its centre for Quality Improvement. The tool is based on the Structured Judgement Review methodology (SJR), originally developed by the Royal College of Physicians. Please find attached the documentation regarding the Care Review Tool attached.

The SJR method asks reviewers to consider the strengths and weaknesses in the processes of the care and treatment provided to patients. It provides learning from care when it goes right, as well as identifying gaps, problems or difficulties for the patient when care goes wrong. The tool aims to allow Trusts to screen all deaths of patients who have been in contact with Mental Health services which would normally be subject to the SAI process, and help determine areas where good care can be recognised as well as recognise where care can be improved.

Following a RQIA/GAIN report, published in September 2019 entitled "*A Project Examining learning arising from Serious Adverse Incidents involving Suicide, Homicide and Serious*

Self Harm", some recommendations were made with regards to deaths from suicide namely:

Recommendation 3: "Incidents related to suicide should be taken out of the SAI reporting system. Trusts must continue to review suicides, using an appropriate level of review with discretion to escalate as an SAI when the trust deems it necessary to do so. Suicides that occur within an inpatient setting/trust facility must continue to be reported using the SAI reporting and learning system."

Recommendation 4: "A task and finish group should be established, with oversight provided by the Department of Health, to develop a standardised process for trusts to follow, for review of the suicide of an individual known to mental health services, that occurs outside an inpatient setting/trust facility and has not been escalated as an SAI."

With this in mind and in collaboration with the HSCB, the Trust has conducted a retrospective pilot review of 10 cases of deaths by suicides using the SJR method and detailed the outcomes. These cases had previously been subject to an SAI review. The SJR reviews were conducted by Dr John Simpson, Consultant Psychiatrist during March and April 2021.

Dr Simpson has provided a summary report on his findings from this pilot. I have enclosed these with this correspondence. Given the tangible benefits of this approach including the ability to identify learning themes in excess of the SAI process, I would be very interested in meeting to discuss this work in more detail including the potential for developing a further prospective pilot within the Southern Trust.

Yours sincerely

DR MARIA O'KANE
MEDICAL DIRECTOR / INTERIM DIRECTOR OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES

Encs

Annual Professional Review

Job planning & performance pay for consultants

Dr Nick Murphy
Assistant Medical Director – Consultant Workforce

Building healthier lives

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Context

- Changes to the consultant contract 2018
  - End of the LCEA system
  - Introduction of “performance pay”
- The merger of the Trusts
  - The development of single systems
- Development of Medic@Work 2

Consultant & employer

Appraisal

Job planning

Building healthier lives

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Appraisal

- GMC
  - Assurance not excellence
  - Meeting a benchmark
  - Personal development
    - objectives
  - Revalidation

What does appraisal assess?

Appraisal requires the production of evidence relevant to GMP to support continued practice

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Job Planning – reviewed annually

- Timetable
  - DCC / SPA
  - Pay
- Declarations
  - PP, conflicts of interests
- Trust objectives

The job plan - document

- Timetable of activities
- Summary of total number of PAs of each type in timetable
  - DCC & SPA
- On-call arrangements i.e. supplement category and rota
- List of agreed SMART objectives (both DCC & SPA)
- List of supporting resources necessary to achieve objectives
- Description of additional responsibilities to the wider NHS and profession (including external duties)
- Any arrangements for additional PAs
- Any details of regular private work
- Any agreed arrangements for carrying out regular fee-paying services
- Any special agreements or arrangements regarding the operation/ interpretation of the job plan
- Any agreed annualised activity

DCC PAs

- Work directly relating to the prevention, diagnosis, treatment and on-going management of illness
- Scheduled emergency work and on-call
- Theatre sessions, including pre and post-op follow-up/review
- Out-patient clinics
- Formal ward rounds
- Informal ward rounds (which will be typically less than the duration of a formal ward round)
- Clinical diagnostic work
- Preparation time for MDT
- Clinical admin (dictation, reviewing results/ requests/referrals), request investigations, etc.

SPA PAs

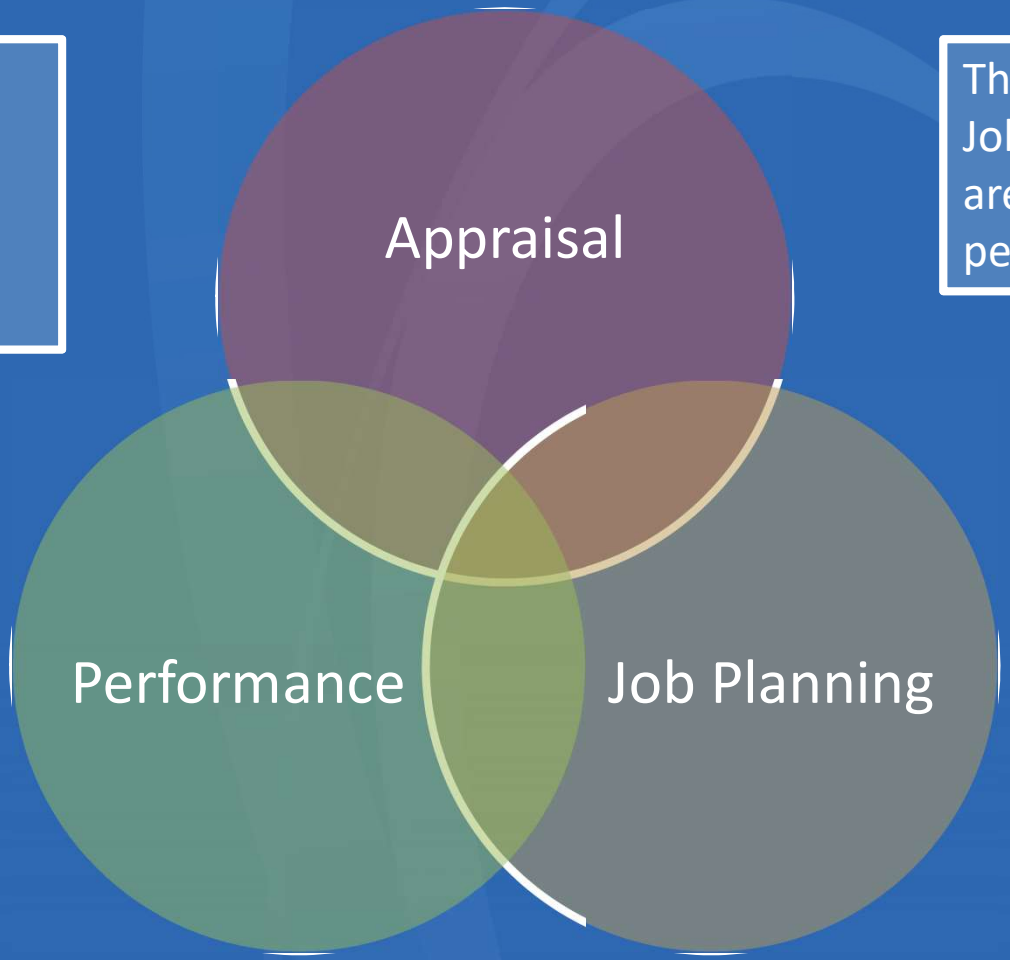
- Maximum of 2.5, unless agreed by DD or MD
- New starters get 2.0 in most specialties
- 1.0 SPA is minimum needed to meet CPD for revalidation
- Additional SPA time should be linked to organisational objectives, such as research, clinical management or medical education roles
- Based on SMART objectives and measurable outcomes
- Flexibility on location – how many hours “off site”?
- Should support the service

What is the annual professional review?

- Annual meeting with your clinical lead
  - Meeting with your employer
- Discuss contribution to Trust & how the consultant is performing & excels
  - How this might influence the job plan
- Combination of performance & job planning
- There is some overlap with appraisal

Appraisal, Job Planning & Performance

The collection of evidence for appraisal can be used to evidence performance



The completion of Job plan objectives are linked to performance

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Annual professional review

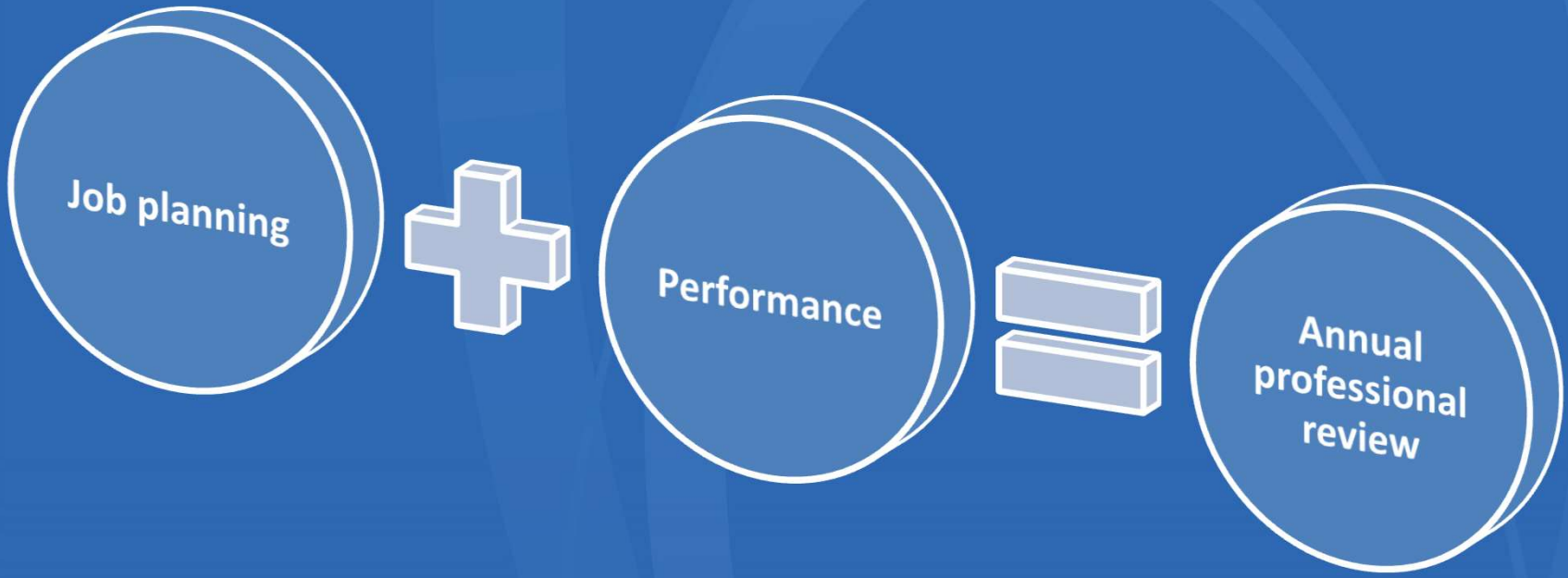

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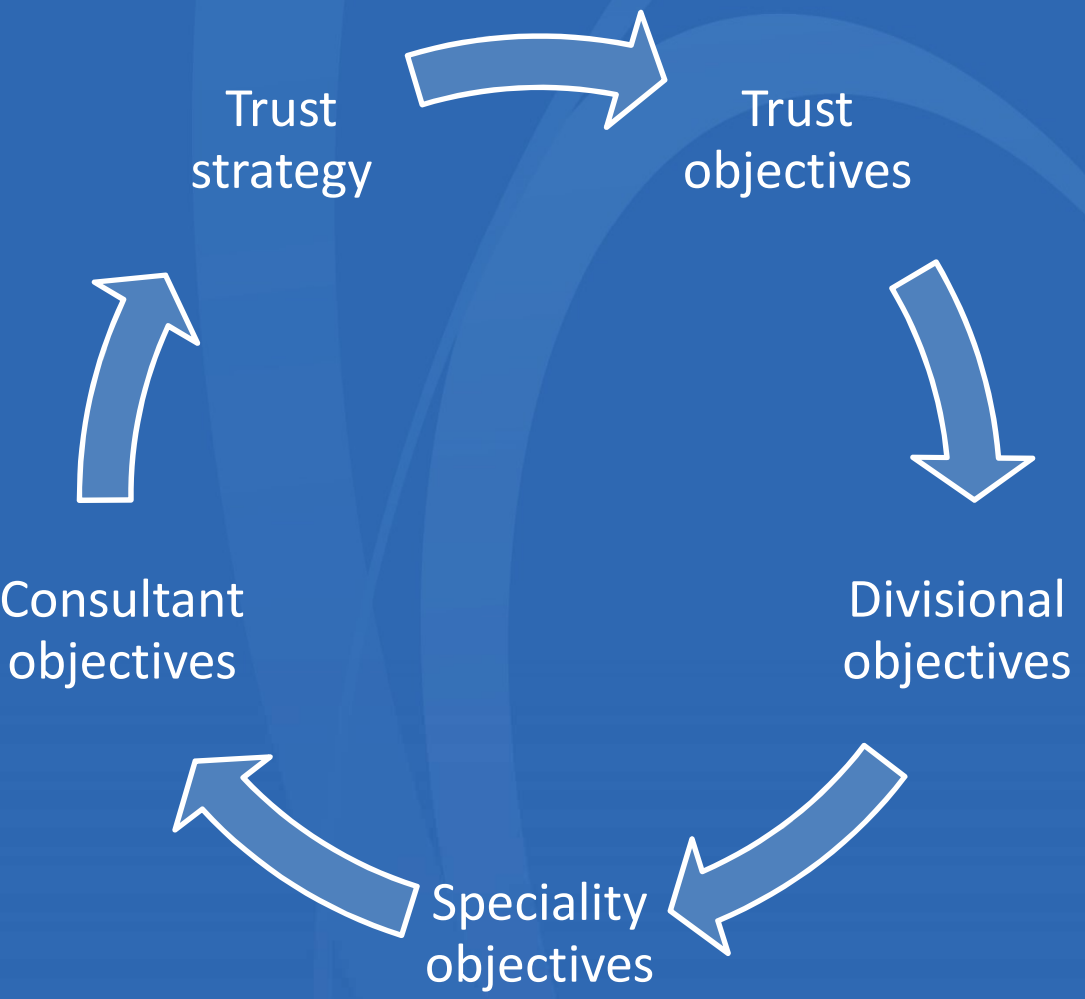
Figure 1: UHB's nine strategic themes from the multi-year strategy

Trust needs to be explicit in what it wants from consultants

- Delivery of the strategy
  - Integration of the Trust sites
  - Transformation of patient care
- Improved patient care & outcomes
- Increased productivity & efficiency
- Delivery of priorities – education & research
- Engage with Trust operational priorities

Annual cycle for delivery of strategy



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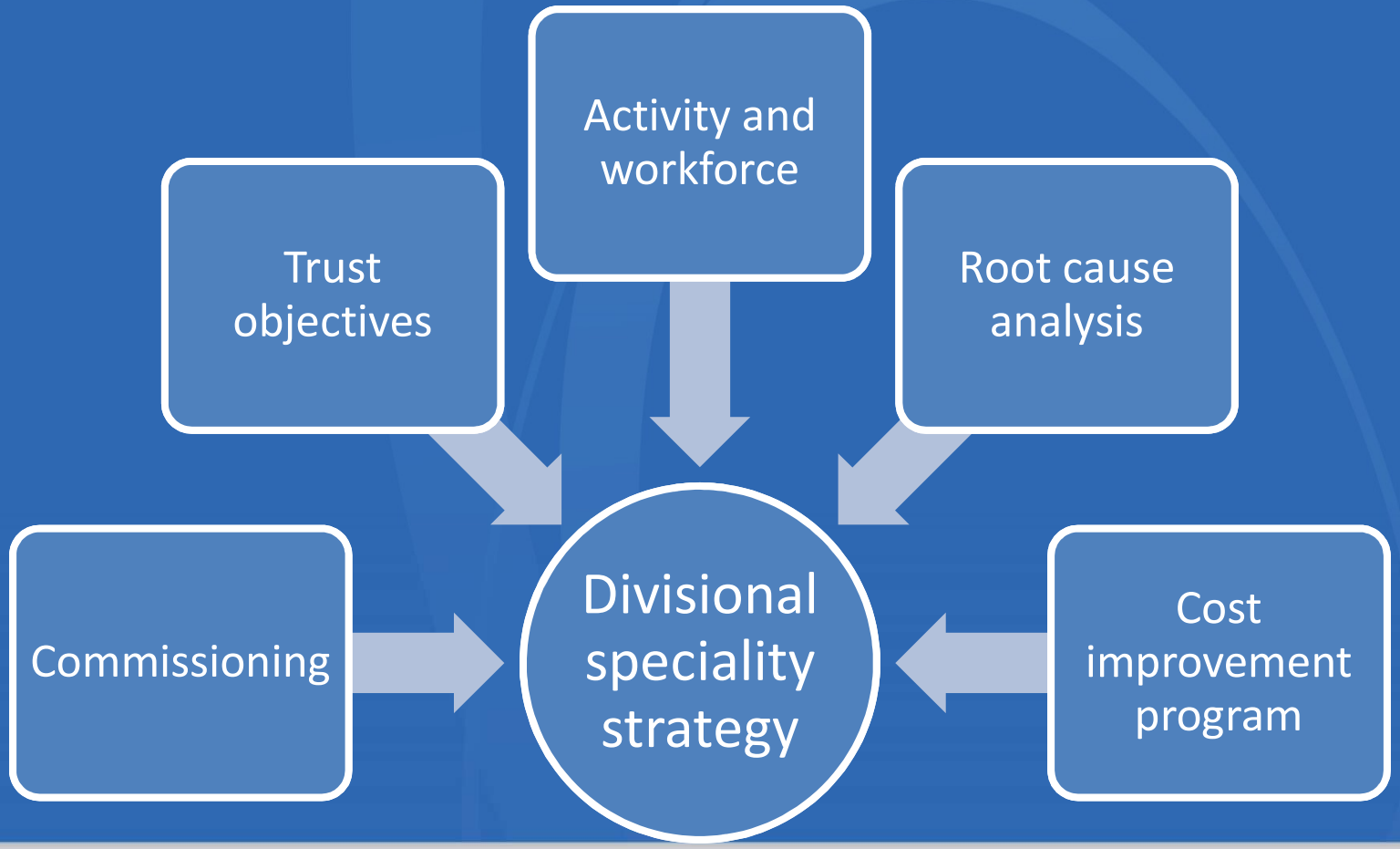
July – September The Divisions plan their priorities for the specialities



Team Job Planning (DCC & SPA)

- What DCC activity needs to be delivered, how and when for the department
- What SPA activity do we need to deliver as a team
  - Medical student teaching
  - Educational supervision
  - Audit Lead
  - College Tutor
  - Governance, safety, mortality review
  - Coding
  - Innovation
  - Pathway redesign / transformation
  - Research

July – September, specialities meet and plan their priorities

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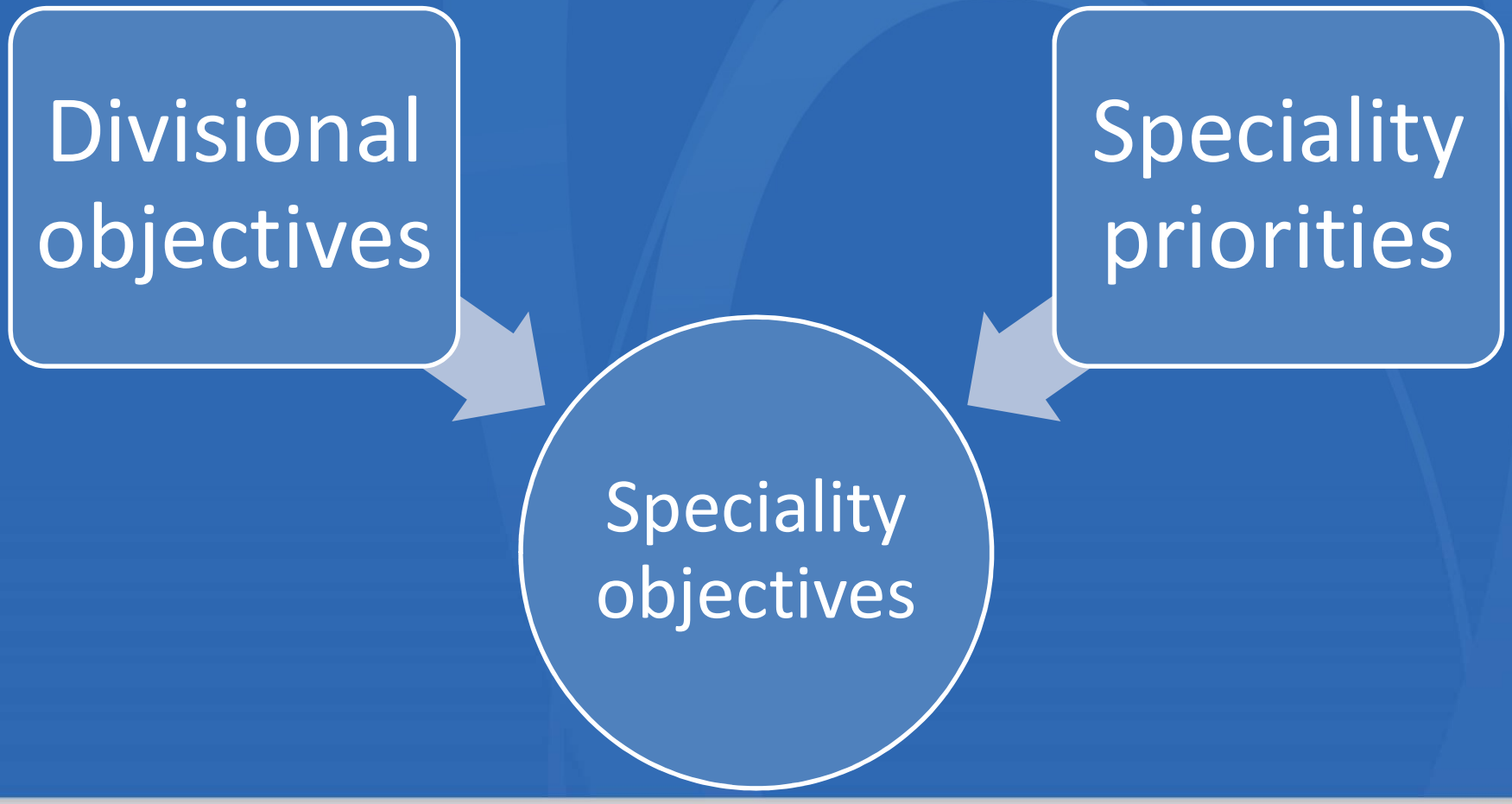
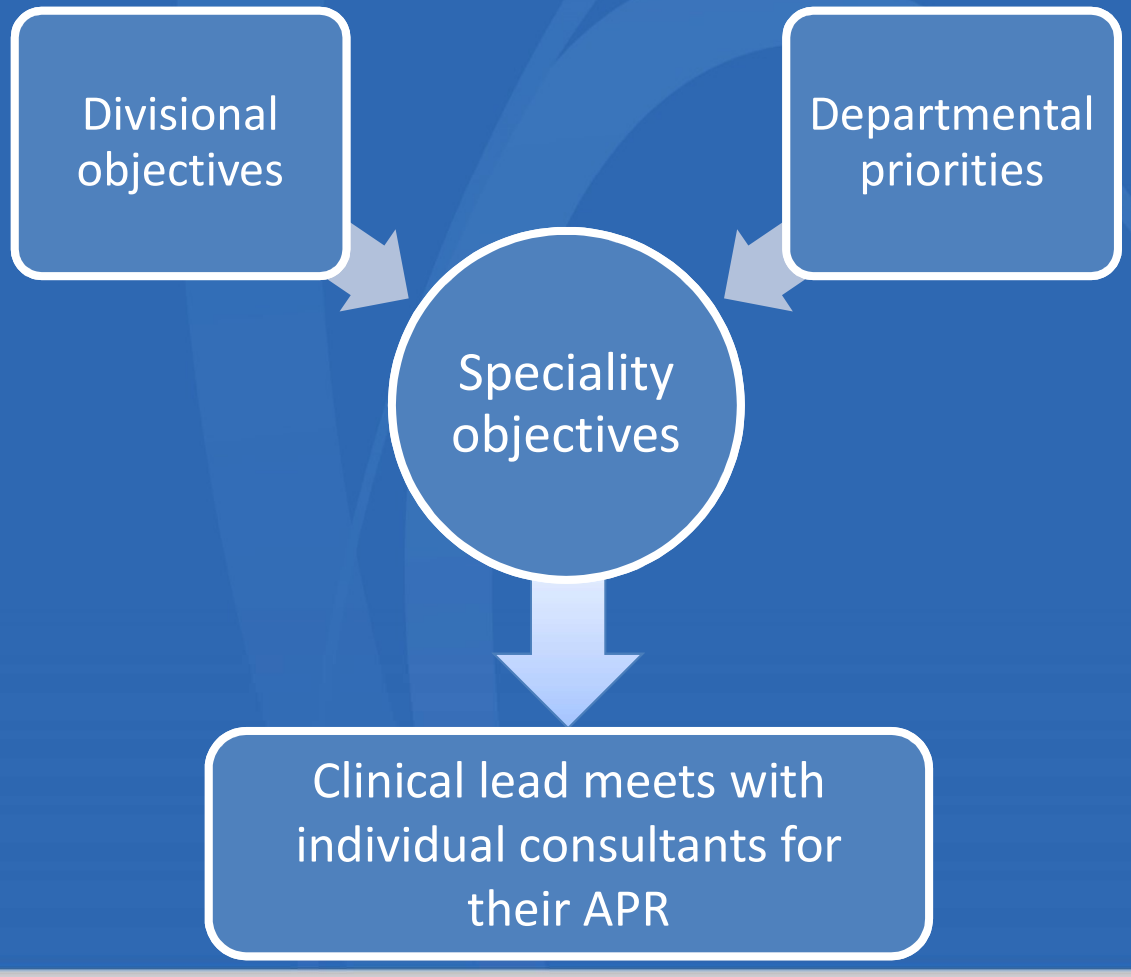
September – October, divisions and specialities meet and agree objectives for the year



October - December, clinical lead meets with individual consultants



Key questions to consider by the Trust

- What is the present demand?
- What is the capacity?
- What is the pattern of demand?
- What is the actual activity and gap if any?
- What is the future demand?
- What is the quality of the activity?
- What is the patient experience of the activity?
- Can we deliver the service efficiently?
- How do reduce WLIs, outsourcing, temporary spend?
- What are the risks associated with the activity?
- Does payroll tally with job plans?
  - If not where are the discrepancies?

What can effective APR deliver

- Better ward cover
- Uniform cover Monday - Friday
- Daily Consultant rounds
  - Decreased LOS
  - Right care, right place, right time
- Less theatre / OPD cancellation
- Better training
- A research agenda for the specialty
- Better matching of capacity and demand
- Flexible working / annualised type plans where appropriate
- Increased 7 day working – especially in unscheduled care areas
- Reduced WLIs, locums, improved efficiency, better WLB

Practicalities (1)

- Step 1
  - Be knowledgeable of trust objectives and service requirements
  - Read the Trust job planning policy!!!
- Step 2
  - Develop team / service objectives
  - DD meet with the CSL agree what service objectives for the year
  - Discuss how this should be translated into consultant JPs with the team

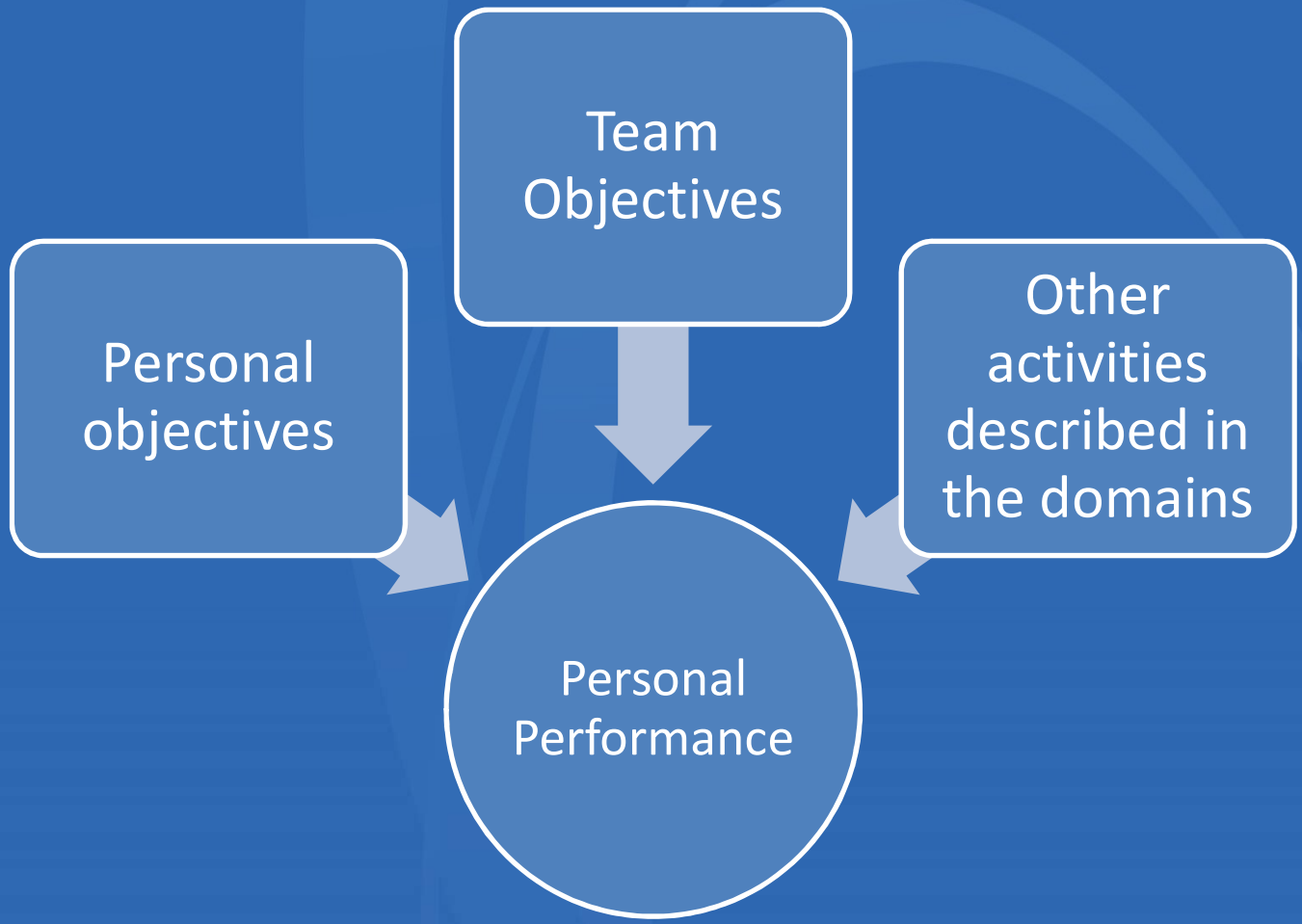
Practicalities (2)

- Step 3
  - Remove duplication in SPAs
  - Ensure all SPA roles are supported by Trust
- Step 4
  - Individual Objectives
  - Individual Job Plans
- Step 5
  - Ensure together individual plans deliver the whole

What's new about the new reward scheme?

- Focused on local priorities
- More local control over detail
- Enable an operational focus to performance as well as clinical
- Series of domains
- Some will be nationally defined
- Some locally defined

Consultant uses a range of evidence to describe how they excel in their role

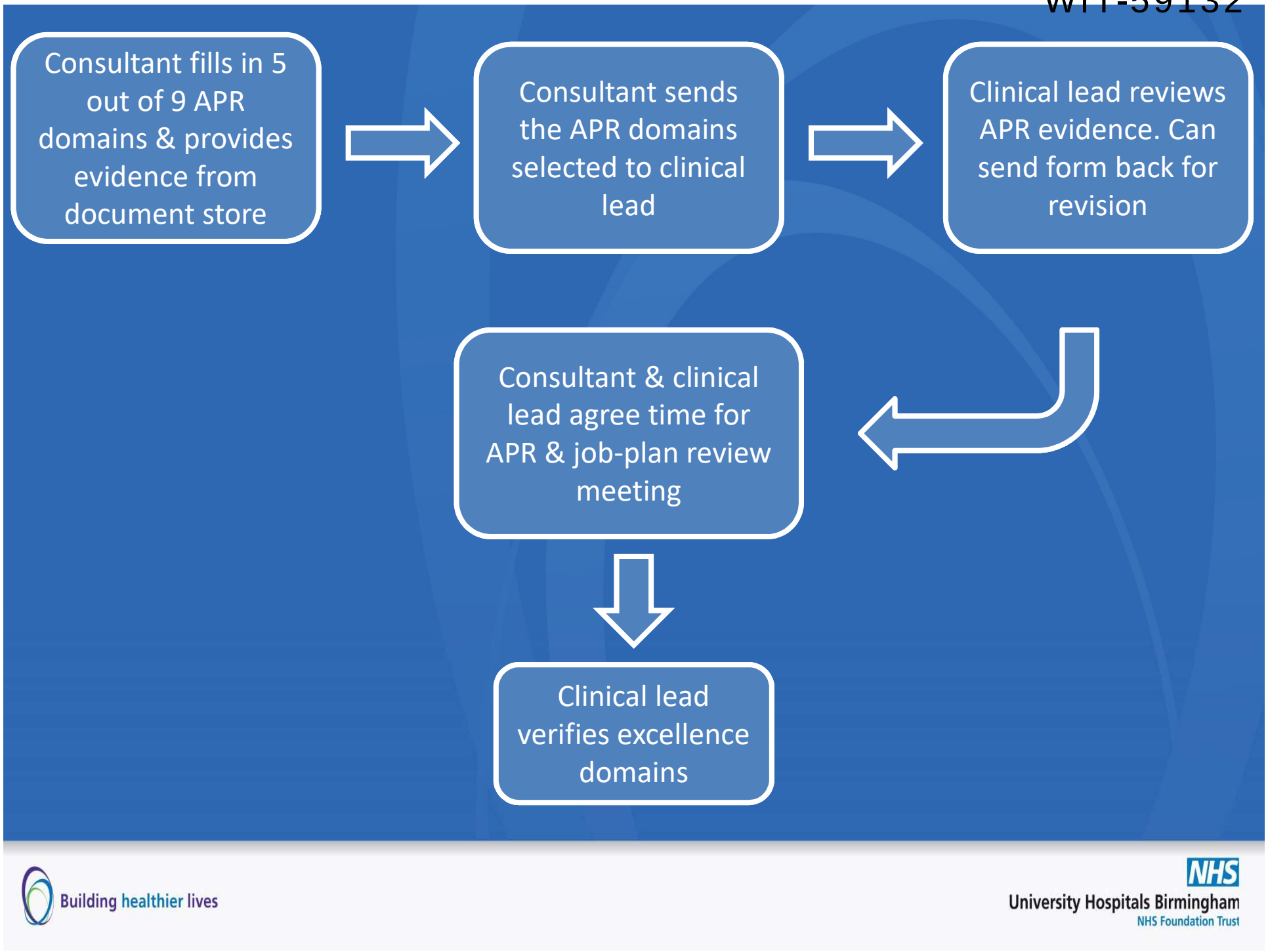


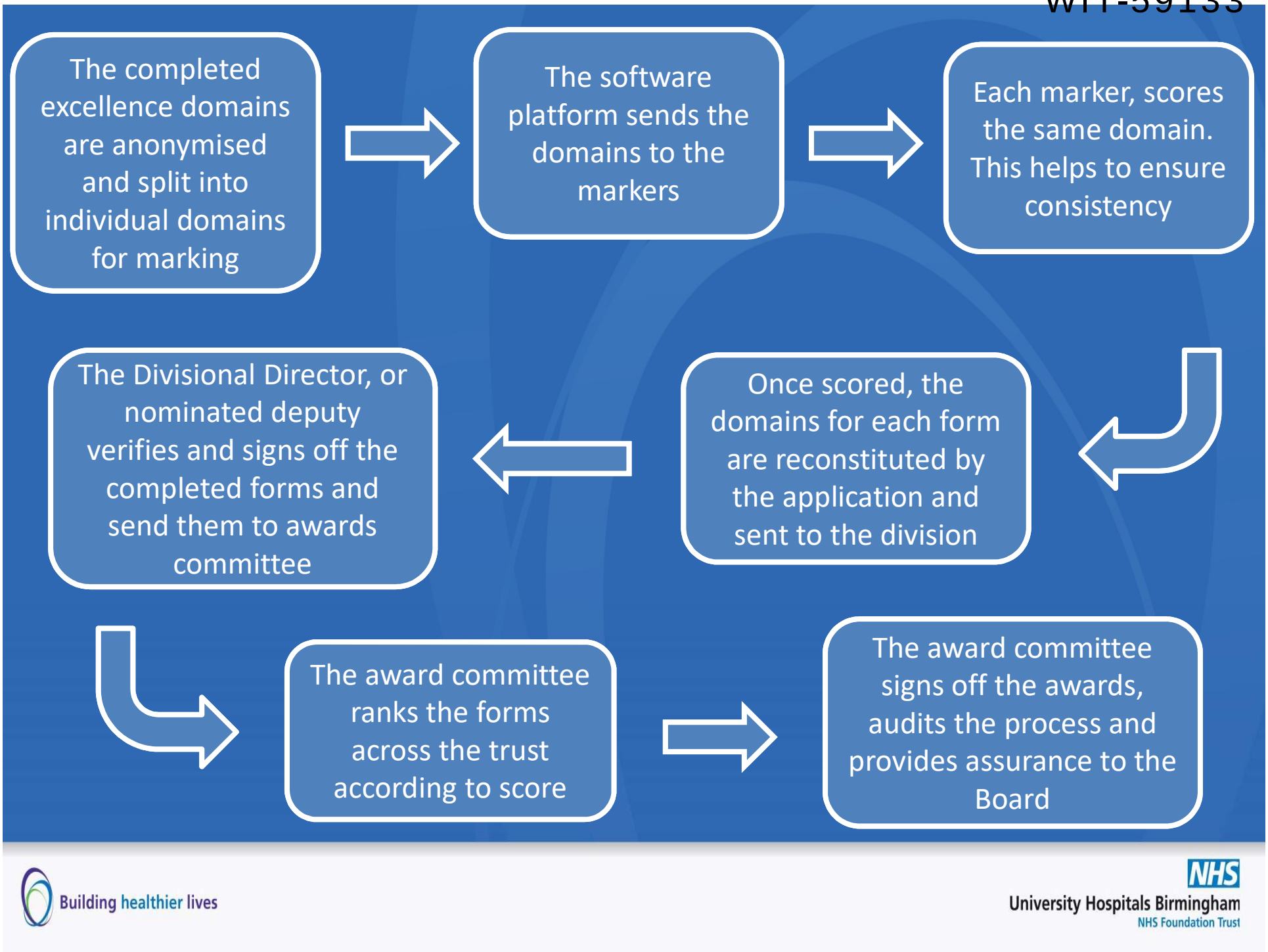
APR meeting

- Set any prospective objectives linked to Trust strategy
- Review last year
- Domain system used to describe and assess objectives & other activities
  - Consistency in approach
  - Enable objective scoring

Possible domains

- Delivering an excellent patient experience
- Ensuring patient safety
- Advancing healthcare through research
- Developing a world-class workforce
- Managing and leading in healthcare
- Education and teaching
- Delivering cost-effective healthcare
- Working across systems and collaborating with other providers
- Improving healthcare through innovation





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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.

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Private Practice / Medico-Legal Structured Reflective Template

Principles agreed by the Academy of Medical Royal Colleges April 2020

Name of doctor:	GMC No:
Date reflective template completed:	Appraisal Year:

Where have you undertaken your private practice / medico-legal over the last twelve months? (Tick all that are appropriate)

	Y/N	Estimated % of Private Practice
NHS Hospitals	☐	
Independent Clinics	☐	
Home / Domestic Premises	☐	
Virtual Clinics	☐	
Medico-Legal Work	☐	

Job Planning – Is your private practice / medico-legal activity fully declared in your Trust job plan?

Medical Protection / Indemnity Arrangements
Describe your arrangements for medical protection / indemnity regarding your medico-legal / private or independent practice? GMC requires private practitioners to arrange adequate and appropriate insurance or indemnity (even if this work takes place on NHS or HSC body premises). This applies even if the work is in addition to work you do for an NHS or HSC body.

Scope of Practice – Describe the nature of your private practice / medico-legal work (Consider factors including; are you doing a low volume of work of this type? Are you deliberately limiting your scope of practice? Are you returning to this type of work after a prolonged break for some reason?):

Volume worked in the last twelve months – How much private practice / medico-legal work have you undertaken over the last twelve months of practice?

(Is your work evenly spread throughout the year or do you regularly have significant breaks e.g. > 6 weeks? Please describe your annual arrangements. When was the last time you did any work of this type?):

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Experience

What prior experience do you bring to this role? How long have you worked as a qualified doctor in this type of work?

And/or If appropriate, explain how many skills based clinical procedures of this type you have done in the past and how you have kept your skills up to date.

Duration of working in this way and future plans

How long have you been working in your current way, and what are your plans?

- If you do a low volume of work in this role, will you increase, maintain or decrease the volume of your work over the coming year?

And/or

- If you have a limited scope of practice, will you be changing this over the coming year?

And/or

- If you are coming back to work after a prolonged absence, what induction and support will you have / have you already had?

Record Keeping

Please describe how you manage and process private practice / medico-legal records

- As a private practitioner who collects and holds information about patients have you registered as a data controller with the Information Commissioner's Office?

- What processes do you have for responding to a Subject Access Requests? - that is, a request for access to the notes you hold about a patient. The request could be made for a number of different reasons, including clinical negligence claims.

- What processes do you have to meet requirements of General Data Protection Regulation 2018 (GDPR) and Department of Health Code of Practice for Records Management. Although, as a private practitioner, you are working outside the HSC / NHS, and are therefore technically exempt from the Public Records Acts, the GMC guidance in 'Confidentiality' (2009) makes clear that everyone should use the retention schedule and does not distinguish between private and HSC / NHS records.

- If you are planning to end your private practice, as long as you hold information, you will need to be able to fulfil your duties as a data controller under GDPR. Please give details of your arrangements to meet this requirement

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Overlap with other roles
Please describe the overlap between this part of your scope of practice and other roles you may currently have / have recently had. How well does the experience from your other roles help you to maintain your knowledge and skills for this one?

Benchmarking, integration and support
Are you able to compare your scope of practice in this role with that of your peers? For example:
Do you receive organisationally generated data on your activity which compares you to your peers? Do you meet regularly with your peers to discuss your work, e.g. multidisciplinary team meetings? Do you have easy access to support and advice from your peers (either through work or externally)?

Personal approach to risk and governance around your private practice
How do you limit the impact of your private practice / medico-legal on any risk to your patients?

Do you regularly ask for patient feedback that is undertaken by an independent body and can you provide examples/statistics?

What arrangements do you have in place to stay within the boundaries of your competence?

If you move around, what actions do you take to ensure you have access to adequate induction and systems information?

How do you ensure you are informed promptly of complaints and any other patient safety incidents? And, how do you report these to the organisations you work in?

Continuous Professional Development (CPD)
Please describe how your approach to CPD helps to ensure you are up to date for your scope of practice.

Does your CPD give you an ongoing exposure to the breadth of your potential workload such as to mitigate any reduction in experience?

Do you access any other learning through groups or social media discussion forums? Do you rely predominantly on advice from peers on site?

Are you able to confidently access up to date, authoritative factual information about issues relevant to your scope of practice?

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Actions

Going forward are there any further actions you feel may be necessary to ensure you retain your competencies across your scope of practice and support your development?

You may wish to formulate these as ideas for a Personal Development Plan or as actions to take forward with your employers in relation to the governance around your role

Feedback after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

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

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability
Candour	1	A statutory duty of candour should now be enacted in Northern Ireland so that: *(i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public.* *(ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.* *(iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).* *(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.* *(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.* *(vi)Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.* *(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.*	Regional update of IHRD Implementation Plan Work stream 1: Duty of Candour Staff views 5.1 Learning Culture Structure and Process Clarity simplicity and Consistency within organisations and Regionally Open Communication accesable systems clear processes Barriers fear of repercussions lack of resources lack of consistancy streamlining required -link to 9 Opinion is sought from staff around various developments, for example Trust response to COVID. Need to continue to encourage staff to be open and give their honest opinion. Re this piece of work site requires permissions to view-this is not in keeping with cultural shift toward inclusion and openness as required by being open. Strict hierarchy remains - consider membership of e.g. Bronze COVID Group. Need to use this opportunity to include a variety of staff patients and service users into this work to show by example that openness is welcomed in Trust. Consider responses in section 5 and 5.5 in particular. Independent advocacy support identified. in place. Regional Duty of Candour Group are looking at options re brining work forward. Working group service users and carers set up to develop guidance as part of framework for openness Introduction of Duty of Candour will require Minisrterial and Executive approval prior to introduction to Assembly No timeframe identified. Trust to work on Culture of openness in meantime	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	Vivienne Toal and Maria O'Kane to link Send instruction + Template to VT	Viviene Toal	Human Resources
Candour	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.	Awaiting Regional action. Joint statement re Duty of Candour NMC and BMA reviewed and clearly identifies requirement. HR contacted re job discriptions	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	3	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.	Awaited	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.	Standard requirement of Professional Codes therefore staff should be aware	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	5	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.	Most JDs refer to abide by professional code therefore implicit see link to HR base position Meetings to be arranged with VT + Team and pF	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	6	Support and protection should be given to those who properly fulfil their duty of candour.	Will link this with second phase when focus on SAIs as much work done from Donaldson Report onwards	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	7	Trusts should monitor compliance and take disciplinary action against breach.	Further Regional work required Regional update December 2019 says recommendation 5+7 will bedelayed until statutory DoC completed	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources

Candour	8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.	RQIA remit sub-group Department has developed a "principles of Regulation" Policy consultation document out 2020 second stage to look at role and powers and new role from IHRD implemmentation programme Link to recommendation 86 Articles 5 and 35 of RQIA founding legislation offer them leeway to do this already under statutory framework. Update of functions contained in IHRD Update Dec 2019 pg 22	RQIA Led Recommendation Parked at minute	Fill in Template□ Check Regional position with Karen Jeffrey		
Leadership	9	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.	Should be ongoing in SHSCT multiple initiatives across region which Trust taps into some such as Nightengale challenge innovative but curtailed by COVID. As with all leadership inextrpically linked to communication and shared values of Trust. Suggest we scope all internal and external pieces as spring board to further developments. COVID restrictions has required new ways of working which can be built upon to look at leading through innovation and change. Collate Directory of Leadeship activities/opportunities	Directorates to feedback to Director of HROD and SMT	VT will link this to Leadership strategy through SMT Resend Template to Vivienne > all Transfer templates can be filled at one meeting with her (had tried to arrange to no avail) Suggest try to arrange a face to face meeting and merge templates at this	Viviene Toal	Human Resources
Paediatric - clinical	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.	SHSCT version of Regional Policy required 3 appendicies to be completed. Same developed -sign off at meeting. Link to training programme Nurse training considered -will be detailed in Training update.Medical AHP and Pharmacy programmes to be determined- links to be identified and level of training agreed. Re Nursing scoping exercise re wards outside CYP that take 14-16 and 16-18 undertaken for future evidence and clarity (BSO report ID'd discrepancies in wards listed in various documents. Audit of current state re 10-30 in CYP and Acute wards has been piloted _results via audit update. Many aspects will be updated	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Clinical Templates need completed	Bernie McGibbon	Children & Young People
Paediatric - clinical	11	There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.	Transfer information- included in audit and updtaed by BMcG for presentation	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Clarity obtained by BMcG again will be presented by her for sign off	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	13	Foundation doctors should not be employed in children's wards.	Compliant	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.	Emails to HR a- litle more teasing out around Nursing(A/L timings rather than complexity) - essentially interview and shortlisting should ID history and requirements. Unreasonable to expect all Nurses to be assessed prior to employment in Acute. Deficits in training can be addressed via Mandatory + specialised additional training. Cross ref with training Matrix Identify aditional Learning Needs through Supervision, appraisal and self reflection. Medical training not explored as yet.	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Needs to stay as wider than IHRD Await response from Joanne Bell's email to Ronan (25 05 21) then update template will need to involve Maria Heather Bernie Acute Rep + ID the lead	Bernie McGibbon	Children & Young People
Paediatric - clinical	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Await response from Joanne Bell's email to Ronan (25 05 21)	Bernie McGibbon	Children & Young People
Paediatric - clinical	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People

Paediatric - clinical	17	Any change in clinical accountability should be recorded in the notes.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	This needs to be considered by Damian in conjunction with no 29	Bernie McGibbon	Children & Young People
Paediatric - clinical	18	The names of all on-call consultants should be prominently displayed in children's wards.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	20	Children's ward rounds should be led by a consultant and occur every morning and evening.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.	Included in Audit and possibly covered within BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Included in Audit. Also discussed with PCE leads around potential developments	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Included in Audit note does not say must be kept says available therefore audit guidance has covered this	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	24	All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart	Included in audit -may need guidance following audit of Adult wardsIncluded in audit -may need guidance following audit of Adult wards	Remains on Hyponatraemia agenda. Above leads to process map and bring back to Hyponatraemia Oversight Group	Joanne Bell has undertaken extensive preparatory work. Get updated Template from Joanne	Joanne McConville	Patient Data Safety
Paediatric - clinical	25	All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician.	Statement unsafe see response from pharmasist in email and covering draft sign off statement for Oversight Group	Transferred to Dr Tracey Boyce Pharmacy	Paula had sent to Tracey	Tracey Boyce	Pharmacy
Paediatric - clinical	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Also link this to 17 and 29 from Dr perspective PACE audits should show from Nursing perspective	Bernie McGibbon	Children & Young People
Paediatric - clinical	27	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.	The Regional Encompass Contract has been awarded to EPIC. Implementation will be staged and undertaken in one Trust at a time. SET first October 2022 then BT others not decided as yet so we will realistically need to consider prior to this	Parked - Awaits Regional Encompass System	Await response from Mark Toal		
Paediatric - clinical	28	Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent.	The SHSCT has no concerns regarding this recommendation provided the relevant guidance is followed and any procedure for the emailing of personal identifiable information is followed	Remains on Hyponatraemia agenda until update is received from Catherine Weaver, Information Governance	email and response from Catherine Weaver Hof IG. Will now separate this recommendation in 2		
Paediatric - clinical	29	Record keeping should be subject to rigorous, routine and regular audit.	Nursing as per KPS and NOAT audits also current IHRD Baseline Audit Also yearly Medicines audit. Position around Medical notes not determined as yet see Draft statement	Remains on Hyponatraemia agenda until further work is explored in relation to Medical Audits. Dr Gormley to link with Stephen Wallace with the aim of creating a Clinical Audits programme and feedback to Medical Director	email to DG + Stephen Wallace Remember to include 17 + 26 + 28 in conversation	Joanne McConville	Patient Data Safety
Serious Adverse Clinical Incident Reporting	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.	This is in addition to DATIX and hasn't been explored yet	Remains on Hyponatraemia agenda until definite lead agreed	Check with Viviene Toal	Viviene Toal	Human Resources

Serious Adverse Clinical Incident Reporting	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').	SAI work not undertaken by me- second stage as quite aware of it and that following Dondaldson review required changes are in progress. Good links established to progress. If Oversight Group in agreement initial position can be got through recommendation email question and subsequent sign off of draft position or identification of Actions required and Plan with date for completed Actions/update devised 31-42 inclusive	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Connie and Caroline will have main Lead for these recommendations> Majority transferred to their own work plans. DC Need to go through the Transfer Template with them	Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Reporting	32	Failure to report an SAI should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Hyponatraemia Lead to link with DoH	Viviene Toal	Human Resources
Serious Adverse Clinical Incident Investigation	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	35	Failure to co-operate with investigation should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Paula Fearon to complete	Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	36	Trust employees who investigate and accident should not be involved with related Trust preparation for inquest or litigation.		Transferred to Litigation	Check with Viviene Toal and Lynne Hainey	Viviene Toal	Human Resources
Serious Adverse Clinical Incident Investigation	37	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints. (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation. (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress. (iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases. (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports. (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive. (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing. (viii) Family GPs should, with family consent, receive copies of feedback provided. (ix) Families should be formally advised of the lessons learned and the changes effected. (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and	Cross Link with 22; 43-47; 52; 54; 59-60; 62	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37i	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator			

Serious Adverse Clinical Incident Investigation	37ii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37iii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37iv	A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37v	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37vi	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37vii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37viii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (viii) Family GPs should, with family consent, receive copies of feedback provided.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37ix	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ix) Families should be formally advised of the lessons learned and the changes effected.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37x	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	38	Investigations should be subject to multi-disciplinary peer review.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	39	Investigation teams should reconvene after an agreed period to assess both investigation and response.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.		Remains on Hyponatraemia Agenda until a discussion paper is created taking Duty of Candour into consideration. Discussion paper to be drafted by C&SCG, Litigation and Information Governance to be presented to the Hyponatraemia Oversight Group	Caroline should give you this in due course	Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance

In the event of a Death related to a Serious Adverse Clinical Incident.	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Response Trust Bereavement Lead While Trust procedures include timely notification to the GP following all patients' deaths, I am not aware whether Dr to GP discussion routinely takes place in SAI's. Bereavement information packs are in place across the Trust with the expectation that these are provided to relatives when a person dies. Additional resources are in place within wards and on Sharepoint including information on the Coroner's service when the Coroner is involved. The bereavement team contacts the next of kin following all hospital deaths within 2 weeks of the person's death. The team has limited information on the person's death. The bereavement co-ordinator is willing to provide a bespoke telephone response to families in the case of SAI's should a specific referral process be put in place. Appointment of the Corperate Service User Liaison post will enhance bereavement support to families.	Transferred to Bereavement Coordinator with input from Corporate CSCG Coordinator		Sharon McCloskey	Bereavement
In the event of a Death related to a Serious Adverse Clinical Incident.	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.	This is being addressed regionally BY DoH. The Trust Bereavement Co-ordinators have contributed to amending the regional post mortem consent policy/procedure and the post mortem consent forms. A process for securing the second signature is being finalised. This work has been delayed as a consequence of COVID-19.	Transferred to Deputy Medical Director	Meeting with Damian Gormley and Sharon McCluskey		Deputy Medical Director
In the event of a Death related to a Serious Adverse Clinical Incident.	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.	As above-this is being coordinated regionally by DoH	Transferred to Deputy Medical Director with input from Bereavement coordinator	Regional check with Karen		Deputy Medical Director
In the event of a Death related to a Serious Adverse Clinical Incident.	46	Where possible, treating clinicians should attend for clinic-pathological discussions at the time of post-mortem examination and thereafter upon request.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Deputy Medical Director to lead further discussion for decision on transfer to Divisional/Deputy Medical Director	Sharon and Barry Paula check this with Sharon also 44 45 46 47. Damian to discuss with Ahmed? Departmental Medical Director		Medical Director
In the event of a Death related to a Serious Adverse Clinical Incident.	47	In providing post-mortem reports pathologists should be under a duty to: (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them. (ii) Work in liaison with the clinicians involved. (iii) Provide preliminary and final reports with expedition. (iv) Sign the post-mortem report (v) Forward a copy of the post-mortem report to the family GP.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Remains on Hyponatraemia agenda until Hyponatraemia lead obtains nominated lead	Regional check with Karen	Sharon McCloskey	Bereavement
In the event of a Death related to a Serious Adverse Clinical Incident.	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach		Joanne McConville	Patient Data Safety
In the event of a Death related to a Serious Adverse Clinical Incident.	49	Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach.	Damian is checking if remote link to M+M is possible from all Trusts. Video conferencing should be part of Technology enablement Programme> Digital Work Place (Microsoft Office and Teams. Office 365 Microsoft Team) Contact for this is Stephen Hyland Template to be updated	Joanne McConville	Patient Data Safety
In the event of a Death related to a Serious Adverse Clinical Incident.	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved.	Not explored as yet	Compliant. Litigation to send evidence to Hyponatraemia Lead	Template needs completed	Viviene Toal	Human Resources
In the event of a Death related to a Serious Adverse Clinical Incident.	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.	Not explored as yet	Transferred to Director HROD	Need meeting with Viviene Toal	Viviene Toal	Human Resources

In the event of a Death related to a Serious Adverse Clinical Incident.	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Transferred to Director HROD		Viviene Toal	Human Resources
In the event of a Death related to a Serious Adverse Clinical Incident.	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed	Not explored as yet	Remains on Hyponatraemia agenda. Policies are being drafted regionally, this work has been suspended and will reconvene upon the workstreams meeting again.		Viviene Toal	Human Resources
In the event of a Death related to a Serious Adverse Clinical Incident.	54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow- up service and facilitated access to family support groups.	Not all families will require professional bereavement counselling. Families require access to bereavement support in a manner that is responsive to their need. The Service User Liaison Officer will enhance bereavement support for families in this situation and a pathway for referral onto	2 Family Liaison Posts Appointed	Link with Family Liason officers and Bereavement coordinator	Sharon McCloskey	Bereavement
Training and Learning	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources
Training and Learning	56	All Trust Board Members should receive induction training in their statutory duties.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources
Training and Learning	57	Specific clinical training should always accompany the implementation of important clinical guidelines.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recommendation template post collating and addressing findings (post A/L x 2wks) don't anticipate this will be a long piece	Remains on Hyponatraemia agenda.	Link with Caroline Beattie	Caroline Beattie	Acute Governance
Training and Learning	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and hyponatraemia.	Training re nurses undertaken by short life group Sharon Burnside will update. As part of assurance around this work scoping exercise around current practice, documents, guielines, policies explored discrepancies revealed and addressed. Oversight Group to give clear steer -see accompanying documentation	Transferred to Nursing and Midwifery structure	Further meeting Paula and Dawn C 2nd/3rd> will update you with Transfer Process Map	Dawn Ferguson	Nursing & Midwifery
Training and Learning	59	There should be training in the completion of the post-mortem examination request form.	In place as a requirement of the HTA Licence	Transferred to Bereavement coordinator		Sharon McCloskey	Bereavement
Training and Learning	60	There should be training in the communication of appropriate information and documentation to the Coroner's office.	Training is undertaken by medical colleagues.	Transferred to Medical Directors office	Sharon will send through DoH expectations. Sharon will link Guidance. P will send email to Sharon but leave Template update + Action Plan for S+DC to update so DC gets feel for this	Damian Gormley	Medical Director
Training and Learning	61	Clinicians caring for children should be trained in effective communication with both parents and children.	Not explored in detail as yet but aware some relevant training available	Potential transfer to ELD. Hyponatraemia Lead to confirm with Director HROD	Suggest Meeting with Vivienne	Bernie McGibbon	Children & Young People
Training and Learning	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death	Link with 22 and relevant SAI pieces	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Connie Connolly	Corporate Governance
Training and Learning	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.	Some exploratory work undertaken with LN CYP and PCE Leads and Care opinion Link below and with 22	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People
Training and Learning	64	Parents should be involved in the preparation and provision of any such training programme.	Link to 22 and above not formally scoped yet	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People
Training and Learning	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.	Training is available detail not requested as yet	Transferred to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Training and Learning	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	As above	Transferred to Medical Director – Lead HoPS (will need Heather for N+M +AHPs)	Needs processed mapped. See email comment to you 27 05 2021 re R 66 + also Paula to contact Karen	Lisa Houlihan	Patient Safety
Training and Learning	67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.	As above but mechanisms are in place through Professional leads and Trust Education channels to address within or without organisation	Transferred to Medical Director – Lead HoPS	Check out Nursing Midwifery + Nursing assistants	Lisa Houlihan	Patient Safety
Training and Learning	68	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.	Again mechanisims in place but not yet scoped. Post scoping analysis and if necessary Action Plan can be developed to improve this area	Transferred to Corporate CSCG Coordinator	Connie Aisling + Robin Browne looking into re revalidation + learning from experience forum + potential.	Connie Connolly	Corporate Governance

Trust Governance	69	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour (ii) Child Healthcare (iii) Learning from SAI related patient deaths	Unaware-require contact details to check. Ideally this work can present opportunity for sharing of insights and new approaches	Remains on Hyponatraemia agenda until Medical Director and Director CYPS liaise	My understanding is that it is Maria O'Kane and Paul Morgan	Maria O'Kane	Medical Director
Trust Governance	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.	As per 68. Important to utilise skills of those best placed to undertake this, as wider piece need to standardise format of documents; determine detail that should be captured, clear	Transferred to Board Assurance Manager	Sandra Judt. RE send to her transfer Template to be completed	Sandra Judt	Assurance
Trust Governance	71	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.	Not explored as yet but will link to current audits and current Governance oversight with linked working across Operational, professional and Corporate Directorates - personally feel this is improving	Remains on Hyponatraemia agenda until Hyponatraemia Lead speaks with Board Assurance Manager	This needs to go to the Chair Eileen Mullan via Sandra Judt. This sits with Eileen as the Chair of Trust and the Chair of Governance Committee	Eileen Mullan	Trust Chairperson
Trust Governance	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.	Not explored as yet	Links with recommendations 1-7. Director HROD to lead	I have Paula McKeown's section agreed in Template and Transferred to Communications but you will need to bring this to Vivienne re the update of rest of Template	Paula McKeown	Communications
Trust Governance	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.	Links established to HR re this	Transferred to Director HROD		Viviene Toal	Human Resources
Trust Governance	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.	Nursing JDs checked contained in all viewed. As per 74 re HR	Transferred to Director HROD		Viviene Toal	Human Resources
Trust Governance	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies.	HR further Regional work required	Transferred to Director HROD		Viviene Toal	Human Resources
Trust Governance	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.	Needs further clarity around which clinical standards perhaps Regional lead follow NICE etc.	Remains on Hyponatraemia agenda		Caroline Beattie	Acute Governance
Trust Governance	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.	Wide	Remains on Hyponatraemia agenda until position confirmed via Medical Director	Check with Karen		
Trust Governance	78	Implementation of clinical guidelines should be documented and routinely audited.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recomme	Remains on Hyponatraemia agenda	Caroline Beattie Staying as big area with project work ongoing will ultimately come off	Caroline Beattie	Acute Governance
Trust Governance	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.	Clarity -define significant changes and ID process and contact at HSCB	Hyponatraemia Lead to contact HSCB for clarity	Check with Karen		
Trust Governance	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.	Processes in place and further development of NQI audit support links through Nursing Governance channels. Focus on patient safety incidents. Most likely more than one	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.	Define immediate. Will be included in 2 phase re SAI recommendations	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths	Review existing policy	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.	Look back exercise	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.	Ongoing requires review of current structures so that recommendations can be implemented where necessary in simple LEAN way. Discuss at Oversight Group or as specific way forward meeting	Hyponatraemia Lead to link with Chair and Chief Executive's office to seek confirmation of ownership	Chair + Chief Executive opinion on this i.e Shane + Eileen		

Department	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person		
Department	86	The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person		
Department	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	There is pilot at minute SHSCT is engaged in it Damian is our link person. Damian will engage with Department when it starts.		
Department	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel.		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	Template needs completed		
Department	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Paula to send to Maria for Chief Medical Officer to define		
Department	90	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability. (ii) The identification of specific training requirements necessary for effective implementation.		Remains on Hyponatraemia agenda. Head of Risk and Learning to progress	Check with Karen		
Department	91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.		Transferred to Corporate CSCG Coordinator	In interim taken as Datix transferred to Connie	Connie Connolly	Corporate Governance
Department	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods		
Department	93	The Department should review Trust responses to the findings and recommendations of this Report.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods		
Culture and Litigation	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods		
Culture and Litigation	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.		Remains on Hyponatraemia agenda. Director HROD and Litigation Manager to lead	Link with 53 + 9. Protocol should be updated May 21 should bring clarity. Check with Karen		
Culture and Litigation	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.		Parked – Awaits the outcome of the public consultation			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Candour	1	A statutory duty of candour should now be enacted in Northern Ireland so that: *i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public.* *(ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.* *(iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).* *(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.* *(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.* *(vi)Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.* *(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.*	Regional update of IHRD Implementation Plan Work stream 1: Duty of Candour Staff views 5.1 Learning Culture Structure and Process Clarity simplicity and Consistency within organisations and Regionally Open Communication accesable systems clear processes Barriers fear of repercussions lack of resources lack of consistancy streamlining required -link to 9 Opinion is sought from staff around various developments, for example Trust response to COVID. Need to continue to encourage staff to be open and give their honest opinion. Re this piece of work site requires permissions to view- this is not in keeping with cultural shift toward inclusion and openness as required by being open. Strict hierarchy remains - consider membership of e.g. Bronze COVID Group. Need to use this opportunity to include a variety of staff patients and service users into this work to show by example that openness is welcomed in Trust. Consider responses in section 5 and 5.5 in particular. Independent advocacy support identified. in place. Regional Duty of Candour Group are looking at options re brining work forward. Working group service users and carers set up to develop guidance as part of framework for openness Introduction of Duty of Candour will require Minisrterial and Executive approval prior to introduction to Assembly No timeframe identified. Trust to work on Culture of openness in meantime	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	Vivienne Toal and Maria O'Kane to link Send instruction + Template to VT	Viviene Toal	Human Resources			
Candour	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.	Awaiting Regional action. Joint statement re Duty of Candour NMC and BMA reviewed and clearly identifies requirement. HR contacted re job discriptions	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	3	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.	Awaited	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			

Candour	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.	Standard requirement of Professional Codes therefore staff should be aware	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	5	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.	Most JDs refer to abide by professional code therefore implicit see link to HR base position Meetings to be arranged with VT + Team and pF	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	6	Support and protection should be given to those who properly fulfil their duty of candour.	Will link this with second phase when focus on SAIs as much work done from Donaldson Report onwards	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	7	Trusts should monitor compliance and take disciplinary action against breach.	Further Regional work required Regional update December 2019 says recommendation 5+7 will bedelayed until statutory DoC completed	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Leadership	9	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.	Should be ongoing in SHSCT multiple initiatives across region which Trust taps into some such as Nightengale challenge innovative but curtailed by COVID. As with all leadership inextrpically linked to communication and shared values of Trust. Suggest we scope all internal and external pieces as spring board to further developments. COVID restrictions has required new ways of working which can be built upon to look at leading through innovation and change. Collate Directory of Leadeship activities/opportunities	Directorates to feedback to Director of HROD and SMT	VT will link this to Leadership strategy through SMT Resend Template to Vivienne > all Transfer templates can be filled at one meeting with her (had tried to arrange to no avail) Suggest try to arrange a face to face meeting and merge templates at this	Viviene Toal	Human Resources			
Serious Adverse Clinical Incident Reporting	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.	This is in addition to DATIX and hasn't been explored yet	Remains on Hyponatraemia agenda until definite lead agreed	Check with Viviene Toal	Viviene Toal	Human Resources			

Serious Adverse Clinical Incident Reporting	32	Failure to report an SAI should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Hyponatraemia Lead to link with DoH	Viviene Toal	Human Resources			
Serious Adverse Clinical Incident Investigation	36	Trust employees who investigate and accident should not be involved with related Trust preparation for inquest or litigation.		Transferred to Litigation	Check with Viviene Toal and Lynne Hainey	Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved.	Not explored as yet	Compliant. Litigation to send evidence to Hyponatraemia Lead	Template needs completed	Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.	Not explored as yet	Transferred to Director HROD	Need meeting with Viviene Toal	Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Transferred to Director HROD		Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.	Not explored as yet	Remains on Hyponatraemia agenda. Policies are being drafted regionally, this work has been suspended and will reconvene upon the workstreams meeting again.		Viviene Toal	Human Resources			
Training and Learning	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources			
Training and Learning	56	All Trust Board Members should receive induction training in their statutory duties.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources			
Trust Governance	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.	Links established to HR re this	Transferred to Director HROD		Viviene Toal	Human Resources			
Trust Governance	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.	Nursing JDs checked contained in all viewed. As per 74 re HR	Transferred to Director HROD		Viviene Toal	Human Resources			
Trust Governance	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies.	HR further Regional work required	Transferred to Director HROD		Viviene Toal	Human Resources			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.	SHSCT version of Regional Policy required 3 appendicies to be completed. Same developed -sign off at meeting. Link to training programme Nurse training considered -will be detailed in Training update.Medical AHP and Pharmacy programmes to be determined- links to be identified and level of training agreed. Re Nursing scoping exercise re wards outside CYP that take 14-16 and 16-18 undertaken for future evidence and clarity (BSO report ID'd discrepancies in wards listed in various documents. Audit of current state re 10-30 in CYP and Acute wards has been piloted _results via audit update. Many aspects will be updated	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Clinical Templates need completed	Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	11	There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.	Transfer information- included in audit and updated by BMcG for presentation	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Clarity obtained by BMcG again will be presented by her for sign off	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	13	Foundation doctors should not be employed in children's wards.	Compliant	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.	Emails to HR a- litle more teasing out around Nursing(A/L timings rather than complexity) - essentially interview and shortlisting should ID history and requirements. Unreasonable to expect all Nurses to be assessed prior to employment in Acute. Deficits in training can be addressed via Mandatory + specialised additional training. Cross ref with training Matrix Identify aditional Learning Needs through Supervision, appraisal and self reflection. Medical training not explored as yet.	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Needs to stay as wider than IHRD Await response from Joanne Bell's email to Ronan (25 05 21) then update template will need to involve Maria Heather Bernie Acute Rep + ID the lead	Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Await response from Joanne Bell's email to Ronan (25 05 21)	Bernie McGibbon	Children & Young People		Acute	

Paediatric - clinical	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	17	Any change in clinical accountability should be recorded in the notes.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	This needs to be considered by Damian in conjunction with no 29	Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	18	The names of all on-call consultants should be prominently displayed in children's wards.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	20	Children's ward rounds should be led by a consultant and occur every morning and evening.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.	Included in Audit and possibly covered within BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Included in Audit. Also discussed with PCE leads around potential developments	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Included in Audit note does not say must be kept says available therefore audit guidance has covered this	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Also link this to 17 and 29 from Dr perspective PACE audits should show from Nursing perspective	Bernie McGibbon	Children & Young People		Acute	
Training and Learning	61	Clinicians caring for children should be trained in effective communication with both parents and children.	Not explored in detail as yet but aware some relevant training available	Potential transfer to ELD. Hyponatraemia Lead to confirm with Director HROD	Suggest Meeting with Vivienne	Bernie McGibbon	Children & Young People			
Training and Learning	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.	Some exploratory work undertaken with LN CYP and PCE Leads and Care opinion Link below and with 22	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People			
Training and Learning	64	Parents should be involved in the preparation and provision of any such training programme.	Link to 22 and above not formally scoped yet	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.	SHSCT version of Regional Policy required 3 appendicies to be completed. Same developed -sign off at meeting. Link to training programme Nurse training considered -will be detailed in Training update.Medical AHP and Pharmacy programmes to be determined- links to be identified and level of training agreed. Re Nursing scoping exercise re wards outside CYP that take 14-16 and 16-18 undertaken for future evidence and clarity (BSO report ID'd discrepancies in wards listed in various documents. Audit of current state re 10-30 in CYP and Acute wards has been piloted _results via audit update. Many aspects will be updated	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Clinical Templates need completed	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	11	There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.	Transfer information- included in audit and updtaed by BMcG for presentation	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Clarity obtained by BMcG again will be presented by her for sign off	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	13	Foundation doctors should not be employed in children's wards.	Compliant	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.	Emails to HR a- litle more teasing out around Nursing(A/L timings rather than complexity) - essentially interview and shortlisting should ID history and requirements. Unreasonable to expect all Nurses to be assessed prior to employment in Acute. Deficits in training can be addressed via Mandatory + specialised additional training. Cross ref with training Matrix Identify aditional Learning Needs through Supervision, appraisal and self reflection. Medical training not explored as yet.	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Needs to stay as wider than IHRD Await response from Joanne Bell's email to Ronan (25 05 21) then update template will need to involve Maria Heather Bernie Acute Rep + ID the lead	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Await response from Joanne Bell's email to Ronan (25 05 21)	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	

Paediatric - clinical	17	Any change in clinical accountability should be recorded in the notes.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	This needs to be considered by Damian in conjunction with no 29	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	18	The names of all on-call consultants should be prominently displayed in children's wards.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	20	Children's ward rounds should be led by a consultant and occur every morning and evening.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.	Included in Audit and possibly covered within BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Included in Audit. Also discussed with PCE leads around potential developments	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Included in Audit note does not say must be kept says available therefore audit guidance has covered this	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Also link this to 17 and 29 from Dr perspective PACE audits should show from Nursing perspective	Joanne Bell	Acute		Children & Young People	

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Training and Learning	57	Specific clinical training should always accompany the implementation of important clinical guidelines.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recommendation template post collating and addressing findings (post A/L x 2wks) don't anticipate this will be a long piece	Remains on Hyponatraemia agenda.	Link with Caroline Beattie	Caroline Beattie	Acute Governance			
Trust Governance	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.	Needs further clarity around which clinical standards perhaps Regional lead follow NICE etc.	Remains on Hyponatraemia agenda		Caroline Beattie	Acute Governance			
Trust Governance	78	Implementation of clinical guidelines should be documented and routinely audited.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recommendations	Remains on Hyponatraemia agenda	Caroline Beattie Staying as big area with project work ongoing will ultimately come off	Caroline Beattie	Acute Governance			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Serious Adverse Clinical Incident Reporting	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').	SAI work not undertaken by me- second stage as quite aware of it and that following Dondaldson review required changes are in progress. Good links established to progress. If Oversight Group in agreement initial position can be got through recommendation email question and subsequent sign off of draft position or identification of Actions required and Plan with date for completed Actions/update devised 31-42 inclusive	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Connie and Caroline will have main Lead for these recommendations> Majority transferred to their own work plans. DC Need to go through the Transfer Template with them	Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	35	Failure to co-operate with investigation should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Paula Fearon to complete	Connie Connolly	Corporate Governance			

Serious Adverse Clinical Incident Investigation	37	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints. (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation. (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress. (iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases. (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports. (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive. (vii) Families should be afforded the	Cross Link with 22; 43-47; 52; 54; 59-60; 62	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37ii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37iii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37iv	A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			

Serious Adverse Clinical Incident Investigation	37v	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37vi	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37vii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37viii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (viii) Family GPs should, with family consent, receive copies of feedback provided.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37ix	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ix) Families should be formally advised of the lessons learned and the changes effected.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37x	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	38	Investigations should be subject to multi-disciplinary peer review.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	39	Investigation teams should reconvene after an agreed period to assess both investigation and response.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			

Serious Adverse Clinical Incident Investigation	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.		Remains on Hyponatraemia Agenda until a discussion paper is created taking Duty of Candour into consideration. Discussion paper to be drafted by C&SCG, Litigation and Information Governance to be presented to the Hyponatraemia Oversight Group	Caroline should give you this in due course	Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
In the event of a Death related to a Serious Adverse Clinical Incident.	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Response Trust Bereavement Lead While Trust procedures include timely notification to the GP following all patients' deaths, I am not aware whether Dr to GP discussion routinely takes place in SAI's. Bereavement information packs are in place across the Trust with the expectation that these are provided to relatives when a person dies. Additional resources are in place within wards and on Sharepoint including information on the Coroner's service when the Coroner is involved. The bereavement team contacts the next of kin following all hospital deaths within 2 weeks of the person's death. The team has limited information on the person's death. The bereavement co-ordinator is willing to provide a bespoke telephone response to families in the case of SAI's should a specific referral process be put in place. Appointment of the Corperate Service User Liaison post will enhance bereavement support to families.	Transferred to Bereavement Coordinator with input from Corporate CSCG Coordinator		Connie Connolly	Corporate Governance		Bereavement	
Training and Learning	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.	Link with 22 and relevant SAI pieces	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Connie Connolly	Corporate Governance			
Training and Learning	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.	Training is available detail not requested as yet	Transferred to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			

Training and Learning	68	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining	Again mechanisims in place but not yet scoped. Post scoping analysis and if necessary Action Plan can be developed to improve this area	Transferred to Corporate CSCG Coordinator	Connie Aisling + Robin Browne looking into re revalidation + learning from experience forum + potential.	Connie Connolly	Corporate Governance			
Trust Governance	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.	Processes in place and further development of NQI audit support links through Nursing Governance channels. Focus on patient safety is increasing. Most likely more than one avenue may be pertinent need to consider further to prevent silos. Need to scope and process map current mechanisims including success in changing outcomes/reducing risk	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Trust Governance	81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member	Define immediate. Will be included in 2 phase re SAI recommendations	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Trust Governance	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths	Review existing policy	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Trust Governance	83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.	Look back exercise	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Department	91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.		Transferred to Corporate CSCG Coordinator	In interim taken as Datix transferred to Connie	Connie Connolly	Corporate Governance			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
In the event of a Death related to a Serious Adverse Clinical Incident.	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.	This is being addressed regionally BY DoH. The Trust Bereavement Co-ordinators have contributed to amending the regional post mortem consent policy/procedure and the post mortem consent forms. A process for securing the second signature is being finalised. This work has been delayed as a consequence of COVID-19.	Transferred to Deputy Medical Director	Meeting with Damian Gormley and Sharon McCluskey		Deputy Medical Director		Bereavement	
In the event of a Death related to a Serious Adverse Clinical Incident	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.	As above-this is being coordinated regionally	Transferred to Deputy Medical Director with input from Bereavement coordinator	Regional check with Karen		Deputy Medical Director		Bereavement	
In the event of a Death related to a Serious Adverse Clinical Incident	46	Where possible, treating clinicians should attend for clinic-pathological discussions at the time of post-mortem examination and thereafter upon request.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Deputy Medical Director to lead further discussion for decision on transfer to Divisional/Deputy Medical Director	Sharon and Barry Paula check this with Sharon also 44 45 46 47. Damian to discuss with Ahmed? Departmental Medical Director		Medical Director			
Training and Learning	60	There should be training in the communication of appropriate information and documentation to the Coroner's office.	Training is undertaken by medical colleagues.	Transferred to Medical Directors office	Sharon will send through DoH expectations. Sharon will link Guidance. P will send email to Sharon but leave Template update + Action Plan for S+DC to update so DC gets feel for this	Damian Gormley	Medical Director			
Trust Governance	69	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour (ii) Child Healthcare (iii) Learning from SAI related patient deaths	Unaware-require contact details to check. Ideally this work can present opportunity for sharing of insights and new approaches	Remains on Hyponatraemia agenda until Medical Director and Director CYPS liaise	My understanding is that it is Maria O'Kane and Paul Morgan	Maria O'Kane	Medical Director		Child & Family Services	

Trust Governance	69	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour (ii) Child Healthcare (iii) Learning from SAI related patient deaths	Unaware-require contact details to check. Ideally this work can present opportunity for sharing of insights and new approaches	Remains on Hyponatraemia agenda until Medical Director and Director CYPS liaise	My understanding is that it is Maria O'Kane and Paul Morgan	Paul Morgan	Child & Family Services		Medical Director	

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Directorate Applicability	RAG
Training and Learning	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and hyponatraemia.	Training re nurses undertaken by short life group Sharon Burnside will update. As part of assurance around this work scoping exercise around current practice, documents, guielines, policies explored discrepancies revealed and addressed. Oversight Group to give clear steer - see accompanying documentation	Transferred to Nursing and Midwifery structure	Further meeting Paula and Dawn C 2nd/3rd> will update you with Transfer Process Map	Dawn Ferguson	Nursing & Midwifery			
Training and Learning	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	Training is available detail not requested as yet	Transferred to Medical Director – Lead HoPS (will need Heather for N+M +AHPs)	Needs processed mapped. See email comment to you 27 05 2021 re R 66 + also Paula to contact Karen	Heather Trouton	Nursing & Midwifery		Patient Safety	

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
In the event of a Death related to a Serious Adverse Clinical Incident.	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Response Trust Bereavement Lead While Trust procedures include timely notification to the GP following all patients' deaths, I am not aware whether Dr to GP discussion routinely takes place in SAI's. Bereavement information packs are in place across the Trust with the expectation that these are provided to relatives when a person dies. Additional resources are in place within wards and on Sharepoint including information on the Coroner's service when the Coroner is involved. The bereavement team contacts the next of kin following all hospital deaths within 2 weeks of the person's death. The team has limited information on the person's death. The bereavement co-ordinator is willing to provide a bespoke telephone response to families in the case of SAI's should a specific referral process be put in place. Appointment of the Corperate Service User Liaison post will enhance bereavement support to families.	Transferred to Bereavement Coordinator with input from Corporate CSCG Coordinator		Sharon McCloskey	Bereavement		Corporate Governance	
In the event of a Death related to a Serious Adverse Clinical Incident.	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.	This is being addressed regionally BY DoH. The Trust Bereavement Co-ordinators have contributed to amending the regional post mortem consent policy/procedure and the post mortem consent forms. A process for securing the second signature is being finalised. This work has been delayed as a consequence of COVID-19.	Transferred to Deputy Medical Director	Meeting with Damian Gormley and Sharon McCluskey	Sharon McCloskey	Bereavement		Deputy Medical Diector	
In the event of a Death related to a Serious Adverse Clinical Incident.	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.	As above-this is being coordinated regionally by DoH	Transferred to Deputy Medical Director with input from Bereavement coordinator	Regional check with Karen	Sharon McCloskey	Bereavement		Deputy Medical Diector	
In the event of a Death related to a Serious Adverse Clinical Incident.	47	In providing post-mortem reports pathologists should be under a duty to: (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them. (ii) Work in liaison with the clinicians involved. (iii) Provide preliminary and final reports with expedition. (iv) Sign the post-mortem report (v) Forward a copy of the post-mortem report to the family GP.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Remains on Hyponatraemia agenda until Hyponatraemia lead obtains nominated lead	Regional check with Karen	Sharon McCloskey	Bereavement			

In the event of a Death related to a Serious Adverse Clinical Incident.	54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow- up service and facilitated access to family support groups.	Not all families will require professional bereavement counselling. Families require access to bereavement support in a manner that is responsive to their need. The Service User Liaison Officer will enhance bereavement support for families in this situation and a pathway for referral onto additional services can be developed but is not currently formalised. Bereavement guidance in Covid-19 is anticipated in the coming months from DoH and it will include a tiered response pathway which will be applicable in these situations.	2 Family Liaison Posts Appointed	Link with Family Liason officers and Bereavement coordinator	Sharon McCloskey	Bereavement			
Training and Learning	59	There should be training in the completion of the post-mortem examination request form.	In place as a requirement of the HTA Licence	Transferred to Bereavement coordinator		Sharon McCloskey	Bereavement			

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Trust Governance	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director	Not explored as yet	Links with recommendations 1-7. Director HROD to lead	I have Paula McKeown's section agreed in Template and Transferred to Communications but you will need to bring this to Vivienne re the update of rest of Template	Paula McKeown	Communications			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	25	All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician.	Statement unsafe see response from pharmasist in email and covering draft sign off statement for Oversight Group	Transferred to Dr Tracey Boyce Pharmacy	Paula had sent to Tracey	Tracey Boyce	Pharmacy			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Trust Governance	71	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.	Not explored as yet but will link to current audits and current Governance oversight with linked working across Operational, professional and Corporate Directorates - personally feel this is improving	Remains on Hyponatraemia agenda until Hyponatraemia Lead speaks with Board Assurance Manager	This needs to go to the Chair Eileen Mullan via Sandra Judt. This sits with Eileen as the Chair of Trust and the Chair of Governance Committee	Eileen Mullan	Trust Chairperson			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Trust Governance	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.	As per 68. Important to utilise skills of those best placed to undertake this, as wider piece need to standardise format of documents; determine detail that should be captured, clear succinct and meaningful records that can be easily opened and understood by all- reflects Duty of Candour. Again as wider piece consider considerable skills of our libraians re proof reading cataloguing and possibly ghost writing on bigger poliy pieces. ToR standardised and simplified	Transferred to Board Assurance Manager	Sandra Judt. RE send to her transfer Template to be completed	Sandra Judt	Assurance			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	24	All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart.	Included in audit -may need guidance following audit of Adult wardsIncluded in audit -may need guidance following audit of Adult wards	Remains on Hyponatraemia agenda. Above leads to process map and bring back to Hyponatraemia Oversight Group	Joanne Bell has undertaken extensive preparatory work. Get updated Template from Joanne	Joanne McConville	Patient Data Safety			
Paediatric - clinical	29	Record keeping should be subject to rigorous, routine and regular audit.	Nursing as per KPS and NOAT audits also current IHRD Baseline Audit Also yearly Medicines audit. Position around Medical notes not determined as yet see Draft statement	Remains on Hyponatraemia agenda until further work is explored in relation to Medical Audits. Dr Gormley to link with Stephen Wallace with the aim of creating a Clinical Audits programme and feedback to Medical Director	email to DG + Stephen Wallace Remember to include 17 + 26 + 28 in conversation	Joanne McConville	Patient Data Safety			
In the event of a Death related to a Serious Adverse Clinical Incident.	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach.		Joanne McConville	Patient Data Safety			
In the event of a Death related to a Serious Adverse Clinical Incident.	49	Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach.	Damian is checking if remote link to M+M is possible from all Trusts. Video conferencing should be part of Technology enablement Programme> Digital Work Place (Microsoft Office and Teams. Office 365 Microsoft Team) Contact for this is Stephen Hyland Template to be updated	Joanne McConville	Patient Data Safety			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Training and Learning	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	As above	Transferred to Medical Director – Lead HoPS (will need Heather for N+M +AHPs)	Needs processed mapped. See email comment to you 27 05 2021 re R 66 + also Paula to contact Karen	Lisa Houlihan	Patient Safety		Nursing & Midwifery	
Training and Learning	67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.	As above but mechanisms are in place through Professional leads and Trust Education channels to address within or without organisation	Transferred to Medical Director – Lead HoPS	Check out Nursing Midwifery + Nursing assistants	Lisa Houlihan	Patient Safety			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Candour	8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.	RQIA remit sub-group Department has developed a "principles of Regulation" Policy consultation document out 2020 second stage to look at role and powers and new role from IHRD implemmentation programme Link to recommendation 86 Articles 5 and 35 of RQIA founding legislation offer them leeway to do this already under statutory framework. Update of functions contained in IHRD Update Dec 2019 pg 22	RQIA Led Recommendation Parked at minute	Fill in Template□ Check Regional position with Karen Jeffrey					
Paediatric - clinical	27	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.	The Regional Encompass Contract has been awarded to EPIC. Implementation will be staged and undertaken in one Trust at a time. SET first October 2022 then BT others not decided as yet so we will realistically need to consider prior to this	Parked - Awaits Regional Encompass System	Await response from Mark Toal					
Paediatric - clinical	28	Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent	The SHSCT has no concerns regarding this recommendation provided the relevant guidance is followed and any procedure for the emailing of personal identifiable information is followed	Remains on Hyponatraemia agenda until update is received from Catherine Weaver, Information Governance	email and response from Catherine Weaver Hof IG. Will now separate this recommendation in 2					
Serious Adverse Clinical Incident Investigation	37i	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator						
Trust Governance	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.	Wide	Remains on Hyponatraemia agenda until position confirmed via Medical Director	Check with Karen					
Trust Governance	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.	Clarity -define significant changes and ID process and contact at HSCB	Hyponatraemia Lead to contact HSCB for clarity	Check with Karen					
Trust Governance	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.	Ongoing requires review of current structures so that recommendations can be implemented where necessary in simple LEAN way. Discuss at Oversight Group or as specific way forward meeting.	Hyponatraemia Lead to link with Chair and Chief Executive's office to seek confirmation of ownership	Chair + Chief Executive opinion on this i.e Shane + Eileen					
Department	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person					

Department	86	The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person					
Department	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	There is pilot at minute SHSCT is engaged in it Damian is our link person. Damian will engage with Department when it starts.					
Department	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	Template needs completed					
Department	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Paula to send to Maria for Chief Medical Officer to define					
Department	90	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability. (ii) The identification of specific training requirements necessary for effective implementation.		Remains on Hyponatraemia agenda. Head of Risk and Learning to progress	Check with Karen					
Department	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods					
Department	93	The Department should review Trust responses to the findings and recommendations of this Report.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods					

Culture and Litigation	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods					
Culture and Litigation	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.		Remains on Hyponatraemia agenda. Director HROD and Litigation Manager to lead	Link with 53 + 9. Protocol should be updated May 21 should bring clarity. Check with Karen					
Culture and Litigation	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.		Parked – Awaits the outcome of the public consultation						

To: **IHRD Programme Members**

Date: **28 May 2021**

From: **Andrew Dawson**
Director of Quality, Safety and Improvement

IHRD Programme – Update

Dear All

I hope you are well.

The Department's last communication to you was from my predecessor, Donna Ruddy, on 3 November 2020, advising you of some changes to the programme structure and to provide you with an update on the work of the programme. I would just like to take this opportunity to provide an update on the current situation.

Donna has returned to her previous post and I trust you will join me in sending Donna sincere thanks for all of her work and dedication. Donna has reverted to her role as Head of Quality, Regulation and Improvement Branch, and I have taken on the role of IHRD Programme Director. I am looking forward to working with you.

While the suspension of workstream meetings meant that much of the work was paused, some work was able to continue in the background.

Some key pieces of work which have continued include work relating to the Statutory Duty of Candour, guidance on Being Open, the HSC Arm's-Length Body (ALB) Board Member Handbook and the Statement of Rights relating to Serious Adverse Incidents (SAI).

The Programme's Duty of Candour Workstream has taken on board evidence and feedback from stakeholders, and developed policy proposals for formal public consultation. The consultation launched on 12 April 2021 and will run for 16 weeks,

closing on 2 August 2021. Events have been held for HSC Trust oversight groups and Boards to raise awareness of the consultation and to provide an opportunity for a Q&A with Quintin Oliver, Chair of the Duty of Candour Workstream. Further events are being held throughout the consultation period with stakeholders and service users. For more information, please see:

https://consultations.nidirect.gov.uk/doh-1/duty-of-candour

Work is underway to develop guidance on Being Open for individuals, staff and organisations.

The HSC Board Member Handbook is now published on the Department's website. This can be viewed at HSC Board member Handbook | Department of Health (health-ni.gov.uk).

An IME service is currently in operation reviewing a percentage of deaths in 3 Trusts (NHSCT, SHSCT and WHSCT) with Belfast joining the prototype on 1 June. This prototype has already helped to identify some of the issues and action has already been undertaken in order to resolve these. The learning from this prototype will help us develop firm proposals for a statutory system. When final proposals are developed these will require full consultation and Executive approval as well as the introduction of legislation. It is extremely unlikely this could be achieved within the current mandate.

An SAI workstream meeting has been planned for 11 June 2021 with the objective of getting a final sign off for the Statement of Rights. The statement will be passed to HSC organisations for implementation. The remaining SAI Workstream actions will be implemented in the coming months. This work will be taken forward in conjunction with wider changes on the SAI policy overseen by the Department's SAI policy lead and the forthcoming RQIA review on SAIs report.

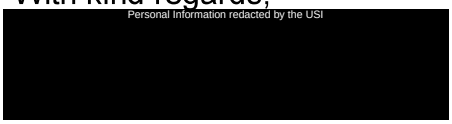
The IHRD Implementation team is now working to identify those recommendations that they can expedite over the next 3 – 6 months working closely with departmental

staff, taking into account the Department's Business Continuity arrangements and the need to address competing priorities.

As the pressure on the system eases, it is my intention to re-engage with the Chairs, Service Users & Carers and the Workstream members and I will be arranging introductory meetings during June and July. I look forward to meeting you all.

I hope you find this update helpful and that you all continue to keep well and stay safe.

With kind regards,



Andrew Dawson
Director of Quality, Safety & Improvement

Health and Social Care Board

Public Health Agency

12-22 Linenhall Street
Belfast BT2 8BS

Tel: 0300 555 0115 / 0300 555 0114

Shane Devlin
Chief Executive
Southern Health and Social Care Trust

BY EMAIL

3 June 2021

Dear Shane

Serious Adverse Incident involving the family of Personal Information redacted by the USI **– Ref** Personal Information redacted by the USI

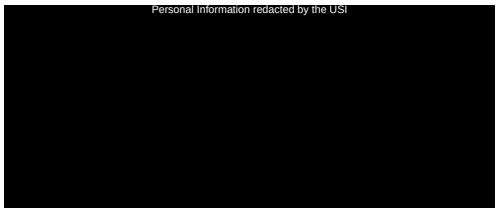
I refer to the above SAI and the request from the family, via the Patient Client Council, to meet with representatives from the HSCB and PHA. The letter (attached), requesting the above, was shared with SHSCT colleagues at a recent SAI Improvement meeting held on 19 May 2021.

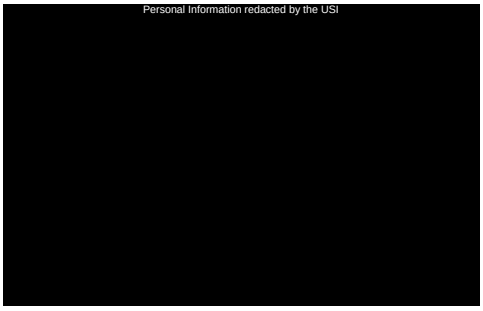
At the meeting, Dr O'Kane informed us that this review was nearing completion. We advised the DRO within the HSCB/PHA had not yet approved the Terms of Reference or panel membership, as further information had been requested from the Trust, to allow the DRO to make an informed decision if the SAI should be escalated to a level 3. Given the Trust had initially written to the DRO to request this advice, we were surprised to learn a level 2 review was nearing completion.

We have since met with Personal Information redacted by the USI on 24 May 2021 to discuss their concerns and, in particular, the application of the SAI process. It was evident, throughout the duration of our meeting, that the sequence of events that led to their mother's death, as well as their involvement to date in the SAI process has been extremely distressing. They also made their discontentment with the current Terms of Reference and panel membership very clear, in particular the Chair, who they do consider to be independent to the Trust.

In light of the above and based on the information the HSCB/PHA have received to date, we would request a level 3 review is now undertaken for this SAI and led by a fully independent panel that will ensure robust engagement with the family throughout the duration of the review.

Yours sincerely





Lisa McWilliams
Director of Strategic Performance
Health and Social Care Board

Rodney Morton
Director of Nursing, Midwifery & AHP's
Public Health Agency

Enc. Letter from PCC

Cc: Gary Wilson - Patient Client Council
Patricia Kingsnorth - Southern Trust
Caroline Doyle - Southern Trust

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

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 8th June 2021
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:

-

-Outcome of SMT Discussion:

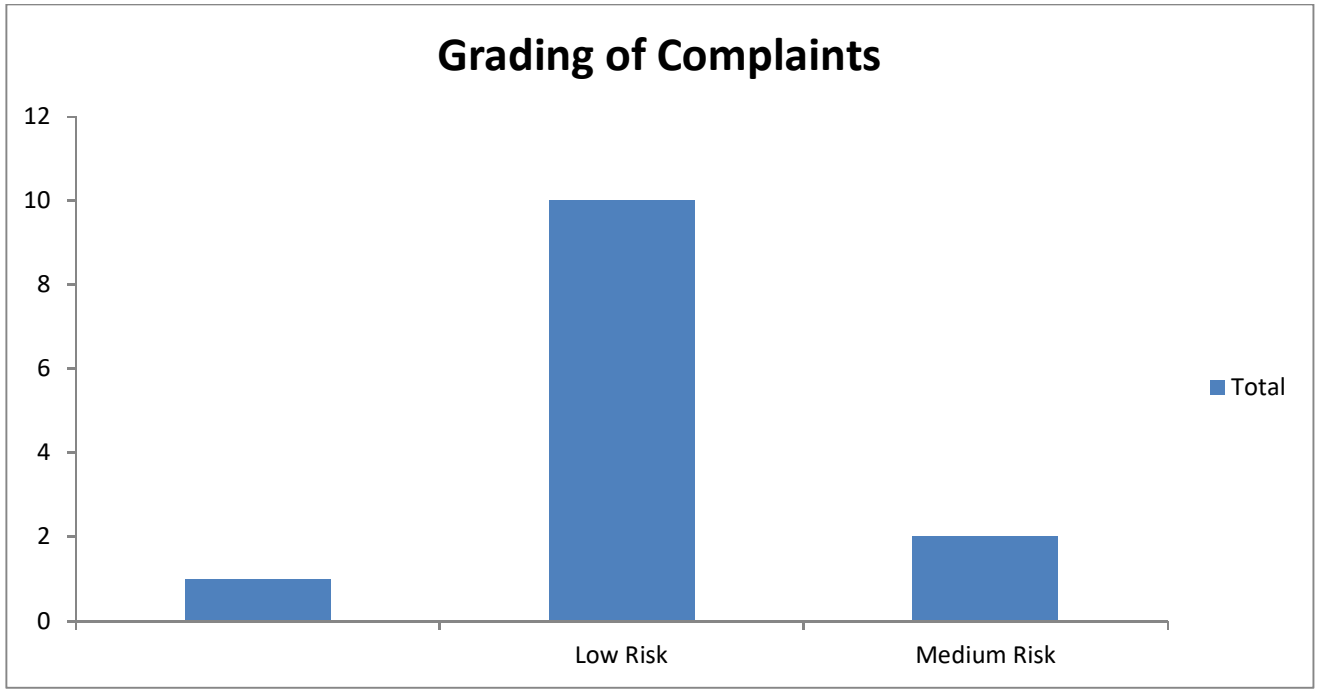
Summary of Weekly Governance Activity 24.05.2021 - 30.05.2021

	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAI's Notification's	0	0	0	0	0
SAI Reports submitted to HSCB	1	0	0	2	3
Ongoing SAI's*	26	40	6	6	78
High Risk Complaints	0	0	0	0	0
NIPSO Case Accepted for Investigation	0	0	0	0	0
NIPSO Draft/Final Reports Received	0	0	0	0	0
Early Alerts	0	2	0	3	5

*Below highlights the change in ongoing SAI figures from 81 last week to 78 this week:

Ongoing SAIs reported last week – 23/05/2021		81
Add New SAI notifications:		0
		81
Less SAI reports submitted:	Acute	1
	CYPS	2
Ongoing SAIs reported week ended 30/05/2021		78

Grading of Formal Complaints Received 24.05.2021 – 30.05.2021



*Grading not available for one complaint at time of report.

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 24.05.2021 - 30.05.2021

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	Total
6	13	7	26

2. **SAI Reports**

Datix ID	Incident Date	SAI Description	Recommendations
Personal Information redacted by	24/07/2020	On the 18 July 2020 a patient was admitted to Daisy Hill Hospital (DHH) Male Medical Ward following a collapse outside in the street. The patient was treated for aspiration pneumonia, alcohol withdrawal and rib fractures. The patient's condition deteriorated on the Ward requiring increasing oxygen requirements and was transferred to High Dependency Unit for AIRVO management. On the 24th July 2020 the patient's condition deteriorated further and subsequently required intubation and ventilation.	All nursing staff should be adequately trained in the use of the NEWS tool and be aware that they can agree trigger points with medical teams. This issue will be placed on the agenda of the Senior Nursing and Midwifery Governance Forum within 3 months of the publication of this report. All nursing staff will be reminded of the requirement to follow the recognised escalation process should they have ongoing clinical concerns about the medical management of a patient. This should be carried out within 3 months by the Executive Directorate of Nursing. The Trust should ensure it has arrangements in place for the safe and effective handover of patients, during the out of hours period, so therefore a complete review of the hospital at night process should be undertaken to include details of how patients are added to the report, how outcomes are listed and how discussions are noted and kept for future reference. This should be led by the Assistant Director of Acute Services with responsibility for Patient Flow within 6 months of the publication of this report.

3. Catastrophic Incidents

Datix ID	Incident Date	Description
Personal Information redacted by the USI	Personal Information redacted by the USI	Death of Child in ED

Discussion at meeting	Action
Dr O'Kane and Patricia discussed the SJR model. Dr O'Kane is going to raise this with the Regional Medical Directors 28/05/2021 then link in with Dr Gormley on his return from leave.	No specific actions for this meeting.

4. Intertrust Incident

Personal Information redacted by the USI

Patient transferred from other hospital for direct admission. Hospital failed to carry out covid swab pre admission, give inadequate pain relief, this resulted in delay on admission theatre.

5. Never Events

None

6. Issues escalated by Corporate or Directorate office at meeting

26/5/2021 Personal Information redacted by the USI - Ruptured tumour following discharge.

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)

5. Status of SAI's

Summary of the status of SAI's between 24.05.2021 - 30.05.2021

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
19	17	2	2	40

6. Early Alerts

28/05/2021 – 2 x Inquest Hearings

7. Never Events

None

8. **Issues escalated by Corporate or Directorate office at meeting**

Incidents related to staffing shortages

A) Organisational – Service Disruptions inc Human Resources – Human resources availability – Insufficient number of staff breaks down by Healthcare and non-professional

B) Staff – Exposure to Hazard – Workplace Stressor/Demands – Staffing Levels

Discussion at meeting	Action
Work is progressing in relation to the issues raised at the Serious Concerns meeting with the RQIA regarding Personal Information Work progressing with the Quality Improvement team. Meetings ongoing to discuss the actions.	No specific actions
There is a meeting 20/05/2021 to discuss the MCA between MH Directors, DoH and the HSCB.	No specific actions.

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)

9. Status of SAI's

Summary of the status of SAI's between 24.05.2021 - 30.05.2021

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	Total
4	2	-	6

10. SAI Reports

Datix ID	Incident Date	SAI Description	Recommendations
Personal Information	Personal Information redacted by the USI	On 25 September 2020 the Southern H&SC Trust were advised that a young person, XX, Personal Information old female tragically died in a road traffic accident on Personal Information redacted by the USI. The PSNI are investigating circumstances of accident. XX was on the Child Protection Register under the categories potential sexual and emotional abuse. XX was in receipt of services from Family Intervention Service (co-ordination of child protection plan) Child and Adolescent Mental Health Service, NSPCC and Adolescent project.	N/A
Personal Information	Personal Information redacted by the USI	Sudden unexpected death of XX in the community on Personal Information redacted by the USI. XX was a Looked After Child and subject to a Care Order. XX had been in a long term foster placement from November 2017 until his untimely death. The PSNI had issued a missing person appeal via social media on [redacted] as XX had failed to return to his foster home at the agreed time of 18.30 hours on Personal Information redacted by the USI. This was noted to be out of character of XX. Regional Emergency Social Work Services were informed. A CMR notification to SBNI will be progressed.	The review team did not identify any recommendations.

11. Never Events

None

12. Issues escalated by Corporate or Directorate office at meeting.

None

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)

13.Status of SAI's

Summary of the status of SAI's between 24.05.2021 - 30.05.2021

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
3	2	1	6

14. Early Alert

26/05/2021 – Personal Information redacted by the USI Care Home

27/05/2021 – Whistleblow statement at STH

28/05/2021 – GP OOH

15. Never Events

None

16. Actions from Previous Week

Discussion at meeting	**Action**

Review of Covid deaths in Care Homes. Connie advised that at the Regional Governance meeting held this week, the Trust was advised there had been a letter sent to confirm if the Incident meets the criteria of SAI then an SAI is to be raised. Ambiguity remains in relation to the Governance Framework around all of these incidents.	Letter received and the ambiguity still remains. Stephen Wallace, Damian Gormley and Trudy Reid to discuss the review of the Covid deaths in Care Homes in more detail. Update 20/05/2021 – This was discussed at the meeting with the PHA 19/05/2021 and the position remains unclear. Further discussions regarding other HCAI and if they would then meet the criteria for SAI.
The group discussed the Shared Learning templates for Falls incidents.	Dr Gormley to link with [redacted] and feedback to Heather and Dr O'Kane. Update 20/05/2021 – Heather Trouton confirmed the Falls Group is being reinstated from the beginning of June. Lisa Houlihan is linking with the PHA to strengthen the process re the submission of Learning templates from Moderate and above falls. The audit that was carried out did not provide assurance that this process is robust. It was agreed that all Incidents reported as a Hospital or Community Fall will be reported at this meeting. Further discussions between Carmel Harney and Heather Trouton how this fits in with the wider discussions around Enhanced Care Home Network. Claire to link with Monica McAllister regarding the reinstatement of the Independent Sector Governance meeting.

LITIGATION

17. New Clinical negligence

New clinical negligence claims: 24.05.2021 – 28.05.2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
Personal Information redacted by the USI	ACUTE	MUC	Unknown	TBC	28.05.2021	28.05.2021	Writ Lodged with the High Court. No details relating to the claim. Awaiting further and better particulars

18. Clinical Negligence Claims Listed for Hearing in June 2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description	Update
Personal Information redacted by the USI	ACUTE	MUC	Fail/Delay treatment	Irrelevant redacted by the USI	20/11/2015	04/12/2015	It is alleged that there was a failure in ED to diagnose tendon damage to hand **Trial listed for 1 June 2021**	Court Case commenced on 1st June and is delayed until 24th June 2021.

19. Vaginal Mesh Cases

The Trust has 17 open cases where the allegations relate to vaginal mesh. One case is listed for trial on 6 December 2021 (for 4 days). Since last week, one of the cases below has lodged proceedings formally with the Court.

Stage	Number of Mesh Cases
Letter of Claim	0
Discovery	4
Investigation	8
Proceedings Issued	4
Trial date Set	1

20. Urology Cases - no update from previous week – one case that was pre-proceedings has now lodged a Writ with the High Court.

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 in the Trust, it is anticipated that there will be an increase in related medico-legal requests and litigation cases. New Claims received had been added to this section. This has been reviewed to include any older claims (that remain open) where it is known that the Urology Consultant in question has been involved in the care of the patients. There are a total of 7 open cases identified at present which involve the above Consultant. Since last week, one of the below cases has lodged proceedings formally with the Court.

Stage	Number of Urology Cases
Letter of Claim	0
Discovery	3
Investigation	1
Proceedings Issued	2
Trial date Set	1

A trial for one of the above claims is listed to take place on 21st February 2022 (for 3 days).

21. Coroner's Inquiries and Inquests

- The following are new Coroners Inquiries received 24.05.2021 – 28.05.2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Description
Personal Information redacted by the USI	ACUTE	MUC	Accident	Personal Information redacted by the USI	28/05/2021	The Coroner directed a Post Mortem and the Pathologist's *preliminary* finding is: Subarachnoid and Subdural Haemorrhage with Cerebral Oedema and associated with Fracture of Skull

- The following Inquest Hearing is scheduled in June 2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description	Governance Process
Personal Information redacted	MHD	MHS	Self-harm	Personal Information redacted by the USI	08/02/2018	9-10 June 2021	The deceased died of suspected suicide (hanging) on Personal Information redacted by the USI following discharge from CAH	SEA Report

- The following preliminary Inquest Hearings are scheduled in June 2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description	Governance Process
Personal Information redacted by the USI	MHD	MHS	Homicide	Personal Information redacted by the USI	05/07/2018	03/06/2021	This relates to the homicide of an elderly couple in their home by an individual known to mental health services	SAI
Personal Information redacted by the USI	MHD	MHS	Self-harm	Personal Information redacted by the USI	30/07/2019	23/06/2021	The deceased was a patient known to Mental Health Services who completed death by suicide (hanging)	SAI
Personal Information redacted by the USI	CYP	SOCIAL	Self-harm	Personal Information redacted by the USI	04/07/2019	24/06/2021	The deceased was known to the Trust's Gateway Service and died of suspected suicide	SEA
Personal Information redacted by the USI	OPPC	Older People		Personal Information redacted by the USI	21/01/2019	28/06/2021	The deceased was a resident in a nursing home, who was admitted to hospital after a fall	Falls proforma. No SAI
Personal Information redacted by the USI	ACUTE	IMWH	Maternal Death	Personal Information redacted by the USI	09/03/2018	30/06/2021	PM Report records cause of death as post-partum haemorrhage following emergency c-section in association with lacerations of uterus, uterine atony, breech position of the foetus and premature rupture of membranes	SAI

22. Judicial Reviews & pre-action correspondence re Judicial Reviews

Further report to be provided by DLS at end of June 2021

23. 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 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. Approval has since been provided and the recruitment process is under-way, however there have been delays, and further unexpected absences within the team which is impacting on the ability to deal with requests.

Discussion took place with Deputy Director of HR re structures and this is now being reviewed to ensure further resources, as required are allocated to this area of work to address the significant back-log, some of which are outstanding for a significant period of time. Members of the current team have worked additional hours to try and reduce the back-log as much as possible. This has helped reduce the back-log but it still remains significant and further work will continue within the team, however the issue still remains about available resources outside of the Medico-Legal Team for review of records, consideration of redaction (where appropriate), task of redaction and consent to release.

There is currently a back-log of 269 requests that are in excess of 90 days across the following areas:-

Directorate	Acute Services	C&YP	MH&D	OPPC	HROD	TOTAL
Number of Outstanding Requests	207	24	32	6	0	269
New requests opened 24.05.2021:28.05.2021	50	1	2	0	1	53

As above, the back-log has Decreased from the previous week, due to additional hours being undertaken by team members as a short-term measure whilst further resources are sources. 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

24. Medication Incidents between 10.05.2021 – 16.05.2021

25. 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

New adult safeguarding activity week beginning 17.05.2021 – 23.05.2021 by Directorate

Adult Safeguarding Activity 24.05.21 – 30.05.21	Trustwide	MHD	OPPC	Acute	CYP
1.0 No of new adult safeguarding referrals (APP1 sec 1)	40	22	6	11	0
2.0 No of new adult safeguarding referrals meeting threshold for Adult Protection Gateway team (APP1 Sec 2)	16	8	3	4	
3.1 No of new referral assessed as Adult in Need of Protection by APGT (APP1 Sec 3)	4	3	0	1	0
3.2 No of new referrals managed as adult at risk of harm (APP1 Sec 2/3)	16	12	3	1	0
3.3 No of new referrals with NFA under Adult Safeguarding (APP1 Sec 2/3)	11	2	2	6	0
Referrals by category of allegation					
▪ Physical	22	15	1	6	0
▪ Psychological	7	4	2	1	0
▪ Sexual	2	1	0	0	0
▪ Financial	1	0	1	0	0

▪ Neglect	8	2	2	4	0
▪ Institutional	0	0	0	0	0
▪ Exploitation	0	0	0	0	0
No of adult protection cases open on PARIS system * **REF STATUS** *	158	79	67	11	1

**3 referrals pending assessment at section 2 by delegated appointed person (1 acute: 2 MHD)
6 referrals pending assessment at section 3 by APGT (2 acute: 1 OPPC: 3 MHD)

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

- 1 Ongoing SAI in MHD where adult protection investigation was undertaken. SAI on hold pending JP investigation. PSNI investigation ongoing. Review Strategy scheduled 3rd June
- 1 SAI in MHD ongoing. APP investigation closed.
- 1 SAI on hold OPPC - Ongoing Joint Protocol – awaiting PPS decision – Personal Information care Home
- 1 SAI OPPC – relates to JP case common assault in Personal Information care home. Case in court 1/6/21
- 1 OPPC - APP case being prepared for PPS re theft by staff member – Personal Information redacted by the USI PNH. Internal Audit finalising report.
- 1 ongoing complaint in OPPC where adult protection investigation has been closed. Review of ASG file requested by HoS for completeness
- 2 adult protection investigations in Acute where there has also been a complaint.
- 1 adult protection investigation ongoing in Acute related to pressure care.

- Personal Information redacted by the USI Care Home – ongoing support being provided by SHSCT to address wider care and governance issues. Reviewed monthly. Individual adult protection JP case – staff member pleaded guilty to common assault. Awaiting presentenced report. Due back in court 6/21 for sentencing. Individual likely to be referred by Judge to DBS.
- Large scale investigation in OPPC – number of patients involved with HR interface. Joint Protocol Investigation. Early alert completed.

INFORMATION GOVERNANCE

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

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	9	-	9	25	-	-	-	-

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.

27. Data Breaches reported to the ICO

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

There have been one data breaches reported to the ICO in this period in relation to inappropriate access to a Patient record by a member of staff. In this period the Trust received 4 complaints from the Information Commissioners Office, One in relation to a data breach and three in relation to the time taken to respond to Subject Access Requests, these three relation to Children's Social Care records. One of these complaints is now closed and the Trust is working with the Requestor to deliver copies of their records.