45 When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.[8]

Establish and maintain partnerships with patients

46 You must be polite and considerate.

47 You must treat patients as individuals and respect their dignity and privacy.[16]

48 You must treat patients fairly and with respect whatever their life choices and beliefs.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care,[21] including:

- **a** their condition, its likely progression and the options for treatment, including associated risks and uncertainties
- **b** the progress of their care, and your role and responsibilities in the team
- **c** who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

d any other information patients need if they are asked to agree to be involved in teaching or research.[12]

50 You must treat information about patients as confidential. This includes after a patient has died.[14]

51 You must support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:

a advising patients on the effects of their life choices and lifestyle on their health and well-being

b supporting patients to make lifestyle changes where appropriate.

52 You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.[23]

Domain 4: Maintaining trust

Show respect for patients

53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.[16]

54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.[23]

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

- **a** put matters right (if that is possible)
- **b** offer an apology
- **c** explain fully and promptly what has happened and the likely short-term and long-term effects.

Treat patients and colleagues fairly and without discrimination

56 You must give priority to patients on the basis of their clinical need if these decisions are within your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety, dignity or comfort may be seriously compromised, you must follow the guidance in paragraph 25b (see section *Domain 2: Safety and quality*).

57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

58 You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment.

59 You must not unfairly discriminate against patients or colleagues by allowing your personal views[24] to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance, and follow the guidance in paragraph 25c (see section *Domain 2: Safety and quality*) if the behaviour amounts to abuse or denial of a patient's or colleague's rights.

60 You must consider and respond to the needs of disabled patients and should make reasonable adjustments[25] to your practice so they can receive care to meet their needs.

61 You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.

62 You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.[26]

63 You must make sure you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK.

64 If someone you have contact with in your professional role asks for your registered name and/or GMC reference number, you must give this information to them.

Act with honesty and integrity

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

66 You must always be honest about your experience, qualifications and current role.

67 You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.[4]

Communicating information

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

69 When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.[14, 27]

70 When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[22] You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.

Openness and legal or disciplinary proceedings

72 You must be honest and trustworthy when giving evidence to courts or tribunals.[28] You must make sure that any evidence you give or documents you write or sign are not false or misleading.

- **a** You must take reasonable steps to check the information is correct.
- **b** You must not deliberately leave out relevant information.

73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in *Confidentiality*.

74 You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness.[28]

75 You must tell us without delay if, anywhere in the world:

- **a** you have accepted a caution from the police or been criticised by an official inquiry
- **b** you have been charged with or found guilty of a criminal offence
- **c** another professional body has made a finding against your registration as a result of fitness to practise procedures.[29]

76 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.

Honesty in financial dealings

77 You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.[30]

78 You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.

79 If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest formally, and you should be prepared to exclude yourself from decision making.

80 You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.

Endnotes

1 Colleagues include anyone a doctor works with, whether or not they are also doctors.

2 You can find all the explanatory guidance on our website.

3 *Leadership and management for all doctors* (2012) GMC, London

4 *Good practice in research* (2010) GMC, London

5 *Developing teachers and trainers in undergraduate medical education* (2011) GMC, London

6 *Continuing professional development: guidance for all doctors* (2012) GMC, London

7 This paragraph was added on 29 April 2014. Section 35C(2)(da) of the *Medical Act 1983*, inserted by the *Medical Act 1983 (Amendment) (Knowledge of English) Order 2014*.

8 *Delegation and referral* (2013) GMC, London

9 *Good practice in prescribing and managing medicines and devices* (2013) GMC, London

10 *Treatment and care towards the end of life: good practice in decision-making* (2010), GMC, London

11 *Making and using visual and audio recordings of patients* (2011) GMC, London

12 *Consent to research* (2013) GMC, London

13 Follow the guidance in paragraph 23c if the risk arises from an adverse incident involving a medical device.

14 *Confidentiality: good practice in handling patient information* (2017) GMC, London

15 *Raising and acting on concerns about patient safety* (2012) GMC, London

16 Maintaining boundaries (2013) GMC, London

- *Intimate examinations and chaperones* (paragraphs 47, 25c)
- *Maintaining a professional boundary between you and your patient* (paragraph 53)
- *Sexual behaviour and your duty to report* (paragraphs 53, 25c)

17 Some patients are likely to be more vulnerable than others because of their illness, disability or frailty or because of their current circumstances, such as bereavement or redundancy. You should treat children and young people under 18 years as vulnerable. Vulnerability can be temporary or permanent.

18 *0–18 years: guidance for all doctors* (2007) GMC, London

19 *Protecting children and young people: the responsibilities of all doctors* (2012) GMC, London

20 Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.

21 *Decision making and consent* (2020) GMC, London

22 *Writing references* (2012) GMC, London

23 *Personal beliefs and medical practice* (2013) GMC, London

24 This includes your views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by legislation: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

25 'Reasonable adjustments' does not only mean changes to the physical environment. It can include, for example. Being flexible about appointment time or length, and making arrangements for those with communication difficulties such as impaired hearing. For more information see the EHRC website.

26 *Ending your professional relationship with a patient* (2013) GMC, London

27 *Doctors' use of social media* (2013) GMC, London

28 *Acting as a witness in legal proceedings* (2013) GMC, London

29 *Reporting criminal and regulatory proceedings within and outside the UK* (2013) GMC, London

30 *Financial and commercial arrangements and conflicts of interest* (2013) GMC, London

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General Medical Council

NMC Nursing & Midwifery Council

The Code

Professional standards of practice and behaviour for nurses, midwives and nursing associates

prioritise people

practise effectively

preserve safety

promote professionalism and trust

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015
Effective from: 31 March 2015

Updated to reflect the regulation of nursing associates:
10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:
www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates[1] must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing[2] and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

1. *Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.*
2. *We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.*

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc.org.uk/standards.

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5 take all steps to make sure that records are kept securely

10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at www.nmc.org.uk/indemnity.

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care

13.5 complete the necessary training before carrying out a new role

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

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The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals

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16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at www.nmc.org.uk/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at www.nmc.org.uk/standards.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at www.hse.gov.uk.

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 maintain the level of health you need to carry out your professional role

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at www.nmc.org.uk/standards.

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment

21.2 never ask for or accept loans from anyone in your care or anyone close to them

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

21.5 never use your status as a registered professional to promote causes that are not related to health

21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

22.1 keep to any reasonable requests so we can oversee the registration process

22.2 keep to our prescribed hours of practice and carry out continuing professional development activities

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at www.nmc.org.uk/standards.

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment

23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at www.nmc.org.uk.

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.1 never allow someone's complaint to affect the care that is provided to them

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

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www.nmc.org.uk

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland

Registered charity in England and Wales (1091434) and in Scotland (SC038362)

Present:	Dr Richard Wright Mrs Vivienne Toal Mrs Esther Gishkori
In attendance:	Mr Simon Gibson Mr Malcolm Clegg

Medical MHPS Cases, Doctors in Difficulty, GMC & NIMDTA Issues

Personal Information redacted

The oversight group was uncertain if Personal Information redacted had received information on the outcome of the investigation report. Personal Information redacted by USI contract as a rotational doctor in training ended on Personal Information redacted by USI and she is currently engaged as a locum (via Direct Medics) i Personal Information redacted by USI

It was agreed that Dr Moan and Lynne Hainey (HR) should meet and present the report to her. Personal Information redacted should be informed of the following;

- that we will be monitoring her situation very closely
- had she still been employed by the SHSCT, it is most likely she would have been issued with a warning
- we have decided not to refer her to the GMC at present
- if she has not already done so, she needs to inform the RO of Direct Medics (Personal Information redacted by USI) and let us know when she has done this – 1 week allowed
- Dr Wright will confirm this has been done with Personal Information redacted by USI
- Dr Moan/ Lynne to make a file note of the meeting.

ACTION:

1. **Malcolm Clegg to inform Lynne Hainey of this**

AOB:

The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

Personal Information redacted by the USI

This doctor is currently on a Personal Information redacted by USI and has asked if he should seek voluntary erasure from the GMC register. Dr Wright has received a legal report which has caused him some concerns. There are also some other concerns coming to light including an SAI from a couple of years ago. Possible probity issues.

ACTIONS:

1. **Malcolm Clegg to inform** Personal Information redacted by the USI **that Dr Wright will need some time to consider his request for voluntary erasure, but will respond within the next few weeks**
2. **Simon Gibson to seek more information on the concerns recently identified**

Personal Information redacted by the USI

The group were informed that this doctor has now resigned. He has applied for his pension; however the Department has agreed to 'hold' this pending a Personal Information redacted by USI

Personal Information redacted by the USI

The group were informed that this doctor has been summarily dismissed, however he is likely to appeal this decision. He is due to attend a preliminary enquiry case at Personal Information redacted by USI following his decision to appeal the PPS decision to prosecute.

ACTION:

Esther Gishkori to make an informal call to the PSNI re the charge relating to the period of time prior to the Personal Information redacted by the USI incident

Personal Information redacted

Simon Gibson explained that this case was progressing with Robin Brown as the investigator

Job planning Steering Group

It was agreed by the group that a meeting of the Job Planning Steering Group should be organised, chaired by the Chief Executive.

ACTION:

Malcolm Clegg to check Francis's availability with Elaine Wright and then proceed to organise the meeting.

Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:

Personal Information redacted by the USI

It was agreed by the Oversight Committee that the investigation into Personal Information redacted by the USI would be through the Harassment at Work procedure, underneath the auspices of Maintaining High Professional Standards.

It was noted that the meeting with Personal Information redacted by the USI was taking place on 13th October, and that a Case Investigator (Dr Dermot Hughes, Medical Director – Western Trust) and Case Manager (Stephen McNally – Director of Finance – Southern Trust) had been agreed. Personal Information redacted by the USI had already been met with on Friday 7th October to advise that the complaint would be dealt with formally.

The Oversight Committee agreed that, given the high expectations placed upon the behaviour of senior medical leaders in AMD roles, and their role in challenging others within this position, it was appropriate to ask Personal Information redacted by the USI to step down from his role as Personal Information redacted by the USI during the investigation. This would be considered a precautionary measure to protect all parties, and would not remove [redacted] Personal Information redacted by the USI remuneration for this role.

Mr A O'Brien
Mrs Gishkori reported that Mr O'Brien was Personal Information redacted by the USI likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of Personal informatio n leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

Personal Information redacted by the USI

The Oversight Committee considered a screening report which summarised a range of clinical incidents relating directly to Personal Information redacted by the USI which, considered collectively, gave cause for concern. It was noted that Personal Information redacted by the USI was out of the UK on a Personal Information redacted by USI sabbatical and was enquiring about being delisted from the GMC register whilst on sabbatical.

The Oversight Committee agreed that, given the issues identified, it was appropriate that in any response to the GMC in relation to Personal Information redacted by the USI request to be delisted should he pursue this, the Southern Trust would highlight that there were concerns regarding Personal Information redacted by the USI clinical practice.

In addition, the Southern Trust would respond that, on Personal Information redacted by the USI return from his sabbatical, the Southern Trust would intend to commence a supportive piece of work with NCAS to consider Personal Information redacted by the USI clinical practice and areas – if identified – where he could potentially benefit from initiatives such as peer mentoring or retraining.

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January [redacted], but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on [redacted] leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

Southern Health & Social Care Trust

Oversight Committee
10th January 2017

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Siobhan Hynds, Head of Employee Relations
Ronan Carroll, Assistant Director, Acute Services
Tracey Boyce, Director of Pharmacy, Acute Governance Lead

Dr A O'Brien

Dr Wright summarised the progress on this case to date, following the meeting with Mr O'Brien on 30th December, including the following appointments to the investigation:

- John Wilkinson is the Non-Executive Director
- Ahmed Khan is the Case Manager
- Colin Weir is the Case Investigator
- Siobhan Hynds is the HR Manager supporting the investigation

Ronan Carroll summarised the meeting with Urologists, who were supportive of working to resolve the position. Ronan Carroll updated the Oversight Committee in relation to the three issues identified, plus a fourth issue subsequently identified.

Issue one - Untriaged referrals
It was reported that, from June 2015, there are 783 untriaged referrals, all of which need to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. All 4 consultants will be participating in this review, which was now commencing.
Action: Ronan Carroll

There are 4 letters which hadn't been recorded on PAS which have been handed over by Dr O'Brien (consultant to consultant referrals).

Issue two – Notes being kept at home
307 notes were returned by Mr O'Brien from his home.
88 sets of notes located within Mr O'Briens office
27 sets of notes, tracked to Mr O'Brien, were still missing, going back to 2003. Work is continuing to validate this list of missing notes. It was agreed to allow an additional seven days to track these notes down, in advance of informing the CEx and SIRO, and Information Governance Team.
Action: Ronan Carroll

It was agreed that Dr Khan would write to Mr O'Brien, informing him who the NED was and, if necessary, asking him whether the 27 sets of notes were still at his house.
Action: Siobhan Hynds to draft letter

Issue three – undictated outcomes
It was reported that 668 patients have no outcomes formally dictated from Mr O'Briens outpatient clinics.
272 From the SWAH clinic
289 From other clinics.
The remaining 107 patients were still being investigated
Action: Ronan Carroll

Issue four – private patients
A review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients appear to be significantly less than for other patients. It would appear that there is an issue of Mr O'Brien scheduling his own patients in non-chronological manner.

It was recognised that the Ronan Carroll would continue to lead the operational team in working through the issues identified to reach clear outcomes for all patients. It was agreed by the Oversight Committee that this work would be recognised at WLI rates, with consultants undertaking additional 4 hour sessions to progress the issues identified.
Action: Ronan Carroll

Southern Health & Social Care Trust

Case Conference
26th January 2017

Present:
Vivienne Toal, Director of HROD, (Chair)
Dr Richard Wright, Medical Director (by teleconference)
Anne McVey, Assistant Director of Acute Services (on behalf of Esther Gishkori)

Apologies
Esther Gishkori, Director of Acute Services

In attendance:
Dr Ahmed Khan, Case Manager
Colin Weir, Case Investigator
Siobhan Hynds, Head of Employee Relations

Notes:
Simon Gibson, Assistant Director, Medical Director's Office

Mr A O'Brien

Context
Vivienne Toal outlined the purpose of the meeting, which was convened in accordance with MHPS Page 15, Section II, Para 10 to consider the preliminary report from Mr Weir, Case Investigator regarding the issues of concern relating to Mr O'Brien. Vivienne reminded those present that Mr O'Brien had been placed on immediate exclusion on 30th December, for a maximum period of time of up to 4 weeks, i.e. 27th January 2017.

Preliminary investigation
As Case Investigator, Colin Weir summarised the investigation to date, including updating the Case Manager and Oversight Committee on the meeting held with Mr O'Brien on 24th January, and comments made by Mr O'Brien in relation to issues raised.

Firstly, it was noted that 783 GP referrals had not been triaged by Mr O'Brien in line with the established process for such referrals. This backlog was currently being triaged by the Urology team, and was anticipated to be completed by the end of January. Mr Weir reported that to date there would appear to be a number of patients who have had their referral upgraded. Mr Weir reported that at the meeting on 24th January, Mr O'Brien stated

that as Urologist of the Week he didn't have the time to undertake triage as the workload was too heavy to undertake this duty in combination with other duties.

Secondly, it was noted that there were 668 patients who have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months. A review of this backlog is still on-going. Mr Weir reported that Mr O'Brien indicated that he often waited until the full outcome of the patient's whole outpatient journey to communicate to GPs. Mr Weir noted this was not a satisfactory explanation. Members of the Case Conference agreed, that this would not be in line with GMCs guidance on Good Medical Practice, which highlighted the need for timely communication and contemporaneous note keeping.

Thirdly, there were 307 sets of patients notes returned from Mr O'Briens home, and 13 sets of notes tracked out to Mr O'Brien were still missing. Mr Weir reported that the 13 sets of notes have been documented to Mr O'Brien for comment on the whereabouts of the notes. Mr Weir reported that Mr O'Brien was sure that he no longer had these notes; all patients had been discharged from his care, therefore he felt he had no reason to keep these notes. Mr Weir felt that there was a potential of failure to record when notes were being tracked back into health records, although it was noted that an extensive search of the health records library had failed to locate these 13 charts. Members of the Case Conference agreed further searches were required taking into consideration Mr O'Brien's comments.

Historical attempts to address issues of concern.
It was noted that Mr O'Brien had been written to on 23rd March 2016 by who? in relation to these issues (were they the same issues?), but that no written response from who? had been received.(was he asked for one?) There had been a subsequent meeting (when?) with the AMD for Surgery, Mr Mackle and Head of Service for Urology, Mrs Martina Corrigan, to address this issue. Mr Weir noted that Mr O'Brien had advised that at this meeting, Mr O'Brien had asked Mr Mackle what actions he wanted him to undertake. Mr O'Brien stated Mr Mackle made no comment and rolled his eyes, and no action was proposed.

It was noted that Mr O'Brien had successfully revalidated in May 2014, and that he had also completed satisfactory annual appraisals since then (when was the 2015 and 2016 appraisal meetings?). Dr Khan reflected a concern that the appraisal process did not appear to have addressed concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal – for what purpose?.

Discussion
In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon.

Mr Weir reported that at the meeting on 24th January, Mr O'Brien expressed a strong desire to return to work. Mr O'Brien accepted that he had let a number of his administrative processes drift, but gave an assurance that this would not happen again if he returned to work. Mr O'Brien gave an assurance to the Investigating Team that he would be open to monitoring of his activities, he would not impede or hinder any investigation and he would willingly work within any framework established by the Trust.
Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this.

Decision
As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. Dr Khan advised that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers.

This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required.

Action: Mr Weir

Formal investigation
There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

- Protecting patients
- Protecting the integrity of the investigation
- Protecting Mr O'Brien

Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

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

The case conference members noted the detail of what this monitoring would look like was not available for the meeting, but this would be needed. It was agreed that the operational

team would provide this detail to the case investigator, case manager and members of the Oversight Committee.
Action: Esther Gishkori / Ronan Carroll

It was agreed that, should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to review the position.
It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.
Action: Esther Gishkori/Ronan Carroll/ Mr Weir

Following consideration of the discussions summarised above, Dr Khan, as Case Manager, decided that Mr O'Brien should be allowed to return to work.

This decision was agreed by the Medical Director, Director of HR and deputy for Director of Acute Services.

It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone in order to alleviate his level of anxiety, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

Action: Dr Khan

It was noted that Mr O'Brien was still off Personal Information redacted by the USI, and that Personal Information redacted by the USI review appointment was scheduled for 9th February, following which Personal Information redacted by the USI report would be provided. This may affect the timetable of Dr O'Brien's return to work, and

the above agreed actions would need to be reviewed in light of any advice from Personal Information redacted by the USI.

It was agreed to update NCAS in relation to this case.

Action: Dr Wright

AIDAN O'BRIEN FRCSI
Consultant Urologist

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

5th September 2016

Personal Information redacted by USI
Personal Information redacted by the USI

Dear Personal Information redacted by USI

Patient 119
Personal Information redacted by the USI

I write to you regarding this Personal year old man whom you referred to Kathy Travers, Continence Nurse Specialist in 2015 for assessment of severe, lower urinary tract symptoms which he had had for several years, and which had not been significantly improved as a consequence of having remained on Tamsulosin for some time. When assessed by Kathy in May 2015, he reported a poor and intermittent urinary flow usually followed by a sensation of inadequate voiding, post micturitional incontinence and severe nocturia, having to rise at least 3 times each night to pass urine and not unfrequently having to rise up to 5 times. She found him to have a poor, maximum flow rate of 6 mls/sec and to have a post micturitional, residual urine volume of 170mls. He had then been recently prescribed Finasteride in addition to Tamsulosin. She initiated clean, intermittent, self catheterisation.

When I met Patient 119 as an outpatient in July 2015, his urinary symptoms had improved since the addition of Finasteride. His flow remained reduced, he still did have a sensation of unsatisfactory voiding following micturition, but the nocturia was less severe, he having to rise once or twice each night to pass urine. On clinical examination I found him to have a moderately enlarged and clinically benign prostate gland, in keeping with very normal serum total PSA levels of 1.1 ng/ml in 2013 and 1.4 ng/ml in 2015. I was also pleased to note that his biochemical renal function was normal in April 2015.

Patient 119 had ultrasound scanning of his urinary tract performed on 20th July 2015 when both upper urinary tracts were found to be normal and when bladder voiding was found to be much improved and normal with a residual volume of 14mls only.

I advised Patient 119 in July 2015 that he would be better served by having his prostate gland resected. As you may be aware from recent correspondence from Kathy Travers, she has found his flow rate to remain very poor, even though bladder voiding has remained satisfactory. I have therefore arranged for Patient 119 to be admitted to our Department on Wednesday 21st September 2016 for endoscopic resection of his prostate gland later that day.

dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist

Date dictated: 5th September 2016
Date typed: 5th September 2016/LH

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number Personal Information redacted by the USI is complete.

The remit of Patient 10 Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials Personal Information redacted by chart was not able to be found on Trust property at this time. Personal Information redacted by the chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Personal Information redacted by the consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Personal Information redacted by the patient chart could not be found on Trust premises. Personal Information redacted by the chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Personal Information redacted by the letter was not triaged by week ending 30 October 2014. Personal Information redacted by was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

Carroll, Ronan

From: Carroll, Ronan
Sent: 03 May 2022 13:01
To: Carroll, Ronan
Subject: FW: Concerns raised by an SAI panel
Attachments: sai panels concerns.pdf

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

-----Original Message-----
From: Boyce, Tracey Personal Information redacted by the USI
Sent: 16 December 2016 16:34
To: Carroll, Ronan Personal Information redacted by the USI; Gishkori, Esther Personal Information redacted by the USI
Cc: Stinson, Emma M Personal Information redacted by the USI
Subject: Concerns raised by an SAI panel

Hi Ronan and Esther
Could we have chat about this next week - I am at a regional strategy day on Monday - perhaps we could get together on Tuesday?

Kind regards

Tracey

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

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

-----Original Message-----
From: tracey.boyce@ Personal Information redacted by the USI
Sent: 16 December 2016 16:30
To: Boyce, Tracey
Subject: Scan from YSoft SafeQ

Scan for the user Tracey Boyce (tracey.boyce) from the device CAH - Pharmacy Corridor - C308

Carroll, Ronan

From: Doyle, Edith
Sent: 03 May 2022 16:18
To: Carroll, Ronan
Subject: FW: Management of PP's / non chronological listing
Attachments: Personal Information redacted by the USI.pdf

Importance: High

From: Carroll, Ronan Personal Information redacted by the USI
Sent: 11 January 2019 08:36
To: Hynds, Siobhan Personal Information redacted by the USI
Subject: FW: Management of PP's / non chronological listing
Importance: High

Yes looks like it – this came to me in an email from Mark

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

From: Hynds, Siobhan
Sent: 10 January 2019 22:53
To: Carroll, Ronan
Subject: FW: Management of PP's / non chronological listing

Ronan

Is this the relevant correspondence?

Siobhan

From: Gibson, Simon
Sent: 28 December 2016 15:34
To: Hainey, Lynne; Wright, Richard
Subject: FW: Management of PP's / non chronological listing
Importance: High

Dear both

In relation to previous e-mail.

Kind regards

Simon

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

Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted by

From: Carroll, Ronan
Sent: 28 December 2016 11:15
To: Boyce, Tracey; Wright, Richard; Gibson, Simon
Subject: FW: Management of PP's / non chronological listing
Importance: High

Please see email received from Mr Haynes which is self-explanatory. Mr Haynes came across this letter as a result of reviewing this pt with AOB being off sick & pulled this letter off NIECR
AOB Waiting time for routine – 149wks & urgent 139wks for TURPs
I have asked Wendy to run a report on all AOB TURP's completed (which is what this man had) to see are there others who have been listed the same way.
Ronan

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

From: Haynes, Mark
Sent: 23 December 2016 10:39
To: Carroll, Ronan
Subject: Management of PP's / non chronological listing

Morning Ronan

I mentioned in discussion the management of PP's by Mr O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events I feel this practice should also be looked into.

Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 5th September privately (given the headed paper the letter is on) and placed on his NHS theatre list on weds 21st September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

Do you think this should be fed into the overall investigation?

Mark

Health and Social Care Board

Performance and Corporate Services

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

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

HSC Trust Directors of Planning and Performance

Our Ref: MB516
Date: 11 July 2017

Dear Colleagues

DRAFT HSC PERFORMANCE MANAGEMENT FRAMEWORK – PERFORMANCE IMPROVEMENT TRAJECTORIES

At its meeting on 28 June 2017, the Transformation Implementation Group (TIG) approved the draft HSC Performance Management Framework subject to a number of minor changes, for submission to an incoming Minister for approval and subsequent issue by way of a Departmental Policy Guidance Circular.

In preparation for that, it has been agreed that work should commence on progressing an important element of the Framework for implementation during 2017/18 – the introduction of Performance Improvement Trajectories. The purpose and basis of Performance Improvement Trajectories is set out in paragraphs 7 to 15 of the Draft Framework enclosed with Richard Pengelly's letter to TIG members on 22 June 2017. This includes an acknowledgement that *"the pace of improvement will be dependent on a range of factors, not least the very challenging financial environment in the year ahead"* and that trajectories *"should set out the expected level and pace of improvement towards achievement of targets in light of financial and workforce pressures and other circumstances".*

As indicated at paragraph 10 of the Draft Performance Management Framework, the initial focus for Performance Improvement Trajectories will be on Unscheduled Care (4 hour), Ambulance response times (Cat A), Elective Care (delivery of core capacity), Cancer waiting times (14, 31 and 62 days), and Mental Health waiting times (9 and 13 weeks).

We agreed at the Directors of Planning and Performance meeting on 3 July that our teams will work together over the summer to develop a consistent approach to the development of trajectories in the above areas by the end of August, and to propose what the next phase of measures should be, including important quality measures and reflecting wider aspects of assurance and accountability.

Lisa McWilliams will facilitate an initial discussion to start this process, and I would ask you to advise Lisa who she should contact from your Trust. The outcome of this exercise will need to be the development of realistic yet stretching trajectories by 31 August 2017 for Departmental approval, representing the best outcome that each Trust can reasonably be expected to deliver in Quarters 2 and 3 of 2017/18. Trajectories should be based on robust improvement plans to deliver the agreed level of performance, that can be monitored over the second half of the year.

Please advise Lisa of your representative to attend a meeting to take this work forward by 21 July, and we will discuss again further at the August DoPs meeting.

Yours sincerely

MICHAEL BLOOMFIELD
Director of Performance and Corporate Services

cc Jackie Johnston, DoH
Lisa McWilliams, HSCB

Pers.No.	Last name	First name	Org Assignment Start Date	Org Assignment End Date	Organizational Unit	Current Employee	2016	2017	2018	2019	2020
Personal Information redacted by the USI	O'Brien	Aidan	01/04/1993	17/07/2020	CAH Urology Medical	N	01/12/2017	31/10/2018	17/10/2019	Not Complete	Not Complete
	Young	Michael	14/04/1998	27/05/2022	CAH Urology Medical	Y	25/09/2017	30/04/2018	30/12/2019	22/03/2021	27/10/2021
	Glackin	Anthony Jude	01/08/2012	31/12/9999	CAH Urology Medical	Y	31/05/2017	31/10/2018	01/04/2020	04/01/2021	16/10/2021
	Suresh	Kothandaraman	11/12/2013	26/10/2016	CAH Urology Medical	N	Not Complete	N/A	N/A	N/A	N/A
	Haynes	Mark	12/05/2014	31/12/9999	CAH Urology Medical	Y	17/07/2018	13/09/2018	15/10/2019	Not Complete	Not Complete
	O'Donoghue	John	04/08/2014	31/12/9999	CAH Urology Medical	Y	08/11/2017	03/08/2018	31/12/2019	07/04/2021	25/11/2021
	Hennessey	Derek	27/04/2018	31/05/2019	CAH Urology Medical	N	N/A	N/A	Not Complete	Not Complete	N/A
	Hasnain	Sabahat	02/01/2019	31/10/2021	CAH Urology Medical	Y	N/A	26/03/2018	Not Complete	29/06/2021	10/05/2021

Urology job planning 2016 – 2021

1 April 2016 – 31 March 2017

	Full/3rd sign-off completed	Locked down
Mr Anthony Glackin	Yes	
Mr Mark Haynes	Yes	
Mr John Paul O'Donoghue	Yes	
Mr Aidan O'Brien*		
Mr Kothandaraman Suresh	Yes	
Mr Michael Young***		

*There is no record of any signed-off job plans for Mr O'Brien on the zircadian e-job planning system. The system went live in 2011.

**Mr Matt Tyson was on a [redacted]

*** There are no signed-off job plans recorded for Mr Young until November 2021. His 2021/22 job plan was fully signed-off.

Blank spaces reflect no activity or where job plans have rolled over into the following year without sign-off

1 April 2017 – 31 March 2018

	Full/3rd sign-off completed	Locked down
Mr Anthony Glackin		
Mr Mark Haynes	Yes	
Mr John Paul O'Donoghue		
Mr Aidan O'Brien*		
Mr Michael Young***		Yes

1 April 2018 – 31 March 2019

	Full/3rd sign-off completed	Locked down
Mr Anthony Glackin		
Mr Mark Haynes		
Mr John Paul O'Donoghue		
Mr Aidan O'Brien*		
Mr Michael Young***		

1 April 2019 – 31 March 2020

	Full/3rd sign-off completed	Locked down
Mr Anthony Glackin		Yes
Mr Mark Haynes		
Mr John Paul O'Donoghue		Yes
Mr Aidan O'Brien*		Yes
Mt Matt Tyson**		Yes
Mr Michael Young***		Yes

1 April 2020 – 31 March 2021

	Full/3rd sign-off completed	Locked down
Mr Anthony Glackin	Yes	
Mr Mark Haynes	Yes	
Mr John Paul O'Donoghue		Yes
Mr Aidan O'Brien*		
Mr Matt Tyson**		Yes
Mr Michael Young***		Yes

1 April 2021 – 31 March 2022 - **(100% sign-off)**

	Full/3rd sign-off completed	Locked down
Mr Anthony Glackin	Yes	
Mr Mark Haynes	Yes	
Mr John Paul O'Donoghue	Yes	
Mr Matt Tyson**	Yes	
Mr Michael Young***	Yes	

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

Reference: HSC (SQSD) 5/19

Date of Issue: 27th February 2019

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB and PHA for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System

HSC (SQSD) 07/14: Proper use of the Early Alert System

Superseded documents:

HSC (SQSD) 64/16: Early Alert System

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue revised guidance for the procedure to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle 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, and which meets 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 interest;*

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 not include any deaths routinely referred to the Coroner, unless:*

    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:*

    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 or a child on the Child Protection Register;*
    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.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex A** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the 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 pro forma attached at **Annex B**, and forwarded, within **24 hours** of notification of the event, to the Department at Personal Information redacted by the USI and the HSC Board at Personal Information redacted by the USI

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert pro forma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the pro forma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A
EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST
FEBRUARY 2019

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston [redacted]

Primary Care/ Out of Hours Services
Mark Lee [redacted]

Secondary Care
Kiera Lloyd [redacted]

Workforce Policy/Human Resources
Andrew Dawson [redacted]

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly [redacted]

Capital Development
Brigitte Worth [redacted]

Information Breaches/ Data Protection
La'Verne Montgomery [redacted]

Finance Director
Neelia Lloyd [redacted]

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland [redacted]

Child Protection/ Looked After Children (LAC's)
Eilis McDaniel [redacted]

Mental Health/ Learning Disability/ Elderly & Community Care
Jerome Dawson [redacted]

Social Services
Jackie McIlroy [redacted]

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride [redacted]

Deputy Chief Medical Officers
Dr Paddy Woods [redacted]

Population Health
Liz Redmond [redacted]

Chief Dental Officer
Simon Reid [redacted]

Acting Chief Pharmaceutical Officer
Cathy Harrison [redacted]

Senior Medical Officers
Dr Carol Beattie [redacted]
Dr Naresh Chada [redacted]
Dr Gillian Armstrong [redacted] Healthcare-Associated Infections (HCAIs) (both confirmed and unconfirmed)

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle [redacted]

Deputy Chief Nursing Officer
Rodney Morton [redacted]

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: [redacted] and the HSC Board at: [redacted]

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

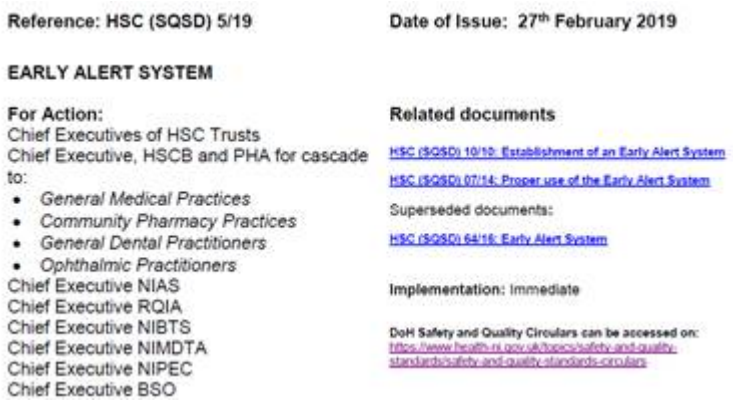
Carroll, Ronan

From: Wamsley, Chris
Sent: 04 May 2022 08:48
To: Carroll, Ronan
Subject: RE: Acrobat Document.pdf
Attachments: Acrobat Document.pdf

Hi Ronan

Within the document the blue lines under related documents are hyperlinked to the original document, if you double click the original document will load through Microsoft Edge.

Many thanks
Chris



Reference: HSC (SQSD) 5/19 **Date of Issue: 27th February 2019**

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB and PHA for cascade to:
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- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
HSC (SQSD) 07/14: Proper use of the Early Alert System

Superseded documents:

HSC (SQSD) 64/18: Early Alert System

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

From: Carroll, Ronan [redacted]
Sent: 03 May 2022 12:57
To: Wamsley, Chris [redacted]
Subject: Acrobat Document.pdf
Importance: High

Chris this document is 2019 …it refers to a 2010 version could I get this pls

Southern Health and Social Care Trust

Quality Care - for you, with you

Southern Health and Social Care Trust

Incident Management Procedure

October 2014

Procedure Checklist

Name of Procedure:	Incident Management Procedure
Purpose of Procedure:	To describe the Trusts systems and processes in relation to Incident Management
Directorate responsible for Procedure:	Corporate Governance, Office of the Chief Executive
Name & Title of Author:	Mrs Margaret Marshall, Interim Asst Director CSCG
Does this meet criteria of a Procedure?	Yes
Trade Union consultation?	No
Equality Screened by:	
Date Procedure submitted to Policy Scrutiny Committee:	
Members of Policy Scrutiny Committee in Attendance:	
Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible:	Chief Executive
SMT Approved/Rejected/ Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet:	
Date for further review	

Contents

1.0 Introduction:

The consistent identification, monitoring and review of incidents is central to the Trust"s strategic and operational processes to ensure it can achieve its vision for safe and effective care. As recommended in the document „Safety First: a Framework for Sustainable Improvement in the HPSS" (HPSS 2006) the Trust recognises that incident reporting is a fundamental element of its Risk Management Strategy.

1.1 Purpose:

The purpose of this procedure is to guide all employees of the Trust in the following:

- Identification, reporting, review, monitoring and learning from all incidents which have resulted in or had the potential to result in injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure.
- Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimise exposure to associated risks.
- Enable staff to participate in, and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice.
- Notification and recording of incidents from third party organisations from which the Trust commissions services.
- Notification of incidents where appropriate to other relevant agencies, for example the Regional Health and Social Services Board (RHSCB), Regulation Quality and Improvement Authority (RQIA), Department of Health, Social Services and Public Safety (DHSSPS) via appropriate Early Alerts, HM Coroner, Northern Ireland Adverse Incident Centre (NIAIC), Health & Safety Executive Northern Ireland (NIHSE), Police Service of Northern Ireland (PSNI), etc. Please see **Appendix 2.**

1.2 Scope of the Procedure:

The following procedure applies to all employees of the SHSCT. Some aspects, including reporting a serious adverse incident, also applies to independent providers / contractors commissioned or engaged by the Trust. It addresses the Trust's governance responsibilities in relation to incidents and is one element of the Trust's Risk Management Strategy.

2.0 The Roles and Responsibilities:

2.1 Chief Executive:

The Chief Executive is the responsible Officer for the Trust"s statutory duty of quality and is required to drive the delivery of the Trust"s corporate priorities, particularly the priority to provide safe, high quality care. Through the overview of this Trust Policy and Procedure, the Chief Executive will seek to embed the Trust"s corporate values throughout the organisation, to promote the Trust"s values of all staff being open and honest and acting with integrity, to listen and learn and to embrace change for the better.

The Assistant Director for Clinical and Social Care Governance (AD CSCG) reports directly to the Chief Executive and will provide the Chief Executive, Trust Board, Senior Management Team (SMT) and Governance Committee with an on-going overview of this Policy and Procedure through the continuous corporate review and monitoring of Incidents and Serious Adverse Incidents (SAIs).

2.2 Assistant Director of Clinical and Social Care Governance (AD CSCG):

The AD CSCG will provide leadership to ensure a systematic and organisation-wide approach to the reporting of clinical and social care incidents and near misses and will work with SMT to embed a culture of appropriate and timely reporting, analysis and learning across the organisation.

The Assistant Director will participate in monthly meetings with the Clinical and Social Care Governance Coordinators in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

It is the responsibility of the AD CSCG to present a trend analysis report quarterly of all incidents reported in the Trust to:

- Senior Management Team (SMT)
- the Governance Committee
- CSCG Working Body

This report will be used by the SMT to inform organisational risk management and governance priorities and will escalate concerns in relation to trends and /or learning.

On behalf of the Chief Executive and SMT, the AD CSCG will provide assurance reports to Governance Committee in relation to the adoption and implementation of procedures relating to incident reporting, monitoring and learning. This includes evidence of cross organisational learning through appropriate forums including the Trust Governance Working Body.

The AD CSCG will act as a conjugate between the Directorates and the Chief Executive, appraising the latter of all major and catastrophic incidents, internal reviews and Serious Adverse Incidents. They will also liaise on behalf of the Trust with the Department, the Public Health Agency (PHA) and the HSCB to ensure the Trust contributes to and is involved in any Regional opportunities for learning.

2.3 Directors:

- Directors are responsible for leading a culture of openness, transparency and learning within their area of responsibility and for ensuring that the actions from any learning are appropriate and the most effective way to minimise risk and provide good care services
- Directors shall ensure that processes are in place to effectively identify, report, review, monitor and learn from all incidents within their Directorate and that the processes are as laid out within this procedure
- They shall ensure that the reviewing, learning from and monitoring of incidents is included on the agenda of all directorate, divisional and team governance meetings
- They shall ensure that action plans and learning to be implemented from incidents are an effective response with an appropriate timescale, prioritised and are reviewed on an on-going basis at directorate governance meetings
- Directors shall consider learning from moderate, major and catastrophic incidents and any trends identified from insignificant / minor incidents to inform directorate governance priorities, education, training and directorate and organisational learning. The latter should be identified through the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- They shall ensure that all current risks recognised from this governance of incidents are considered for the Directorate / Corporate Risk Register
- Training – liaise with the appropriate Executive Directors with responsibility for professional and organisational training

2.4 Assistant Directors & Associate Medical Directors (AMD's for clinical incidents):

All incidents recorded on Datix Web must be reviewed by an ***Incident Review Team*** on a ***weekly*** basis***.*** It is the responsibility of all Assistant Directors / Associate Medical Directors (AMDs) to put in place ***Incident Review Teams*** within their divisions/teams. The membership of an Incident Review Team should include a Head of Service / Senior Manager and an identified Clinician where ***clinical incidents*** are under review.

The Assistant Director / AMDs must also:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services

- Include the management, review, monitoring and learning from incidents on the agenda of divisional, service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at divisional meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying directorate and divisional governance priorities, education, training and organisational learning in a timely way
- Organisational learning should be identified through to the Directorate Governance forum and be escalated to the AD CSCG for dissemination via the Trust Governance Working Body
- Identify training needs to the appropriate Heads within the Trust
- Ensure through their Heads of Service that any barriers to implementing the learning from moderate, major or catastrophic incidents is risk assessed using the SHSCT risk assessment matrix, highlighted at Directorate Governance Fora and placed on the appropriate risk register if not immediately actioned

2.5 Head of Service/ Team Manager:

It is the Head of Service/Team Manager"s responsibility to:

- Lead a culture of openness, transparency and learning within their area of responsibility and ensure that the actions from any learning are appropriate and the most effective way to minimise risk and provide high quality care and services
- Include the management, review, monitoring and learning from incidents on the agenda of service and team governance meetings
- Ensure that action plans and learning to be implemented from incidents are an effective response, appropriately time bound, prioritised and are reviewed on an on-going basis at team meetings
- Consider learning from moderate, major and catastrophic incidents and any trends highlighted from insignificant / minor incidents when identifying service and team governance priorities, education, training and organisational learning in a timely way
- Escalate any barriers to implementation of action plans relating to incidents to the appropriate Assistant Director and consider if they need to be placed on the appropriate Risk Register
- Ensure through the function of the ***Incident Review Team*** that feedback is provided to the incident reporter on the outcome of incident investigations for all moderate, major and catastrophic incidents

2.6 Incident Review Team:

- The purpose of the ***Incident Review Team*** is to review all incidents, determine any learning from them, make recommendations as to what would constitute an effective response which will minimise risk and communicate this within their teams (and to Heads of Service / Team Manager if they are not part of the Incident Review Team). Learning / effective response to any risks highlighted should then be communicated to the appropriate Head of Service / Team Manager for action within the operational teams. Any barriers to implementation of action plans relating to incidents should be escalated by the appropriate Head of Service to the Assistant Director.

The Review Teams should also consider and review the following:

- The information submitted by the reporter including the incident grade
- Consider the need for additional internal and/or external reporting e.g. Health and Safety, RIDDOR, NIAIC, HSCB, RQIA, Adult Safeguarding (PVA). See **Appendix 2**
- Develop time bound and prioritised action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require an action plan which **must** include relevant learning points
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of incident
- Close all incidents following completion of the review process

All Incident Review Teams should adhere to the Datix Web User Guide for Managers/Reviewers which can be accessed from the Trust intranet site. See Hyperlink:

http://vsrintranet.southerntrust.local/SHSCT/documents/DatixWeb_InvestigatorsFinalApproversguidance2012.pdf

2.7 The Directorate CSCG Coordinator:

The CSCG Coordinator will ensure that processes are in place for the recording, reviewing, monitoring and learning from incidents and will provide timely and appropriate information on incidents to the Directorate. Reports will be tailored for Directors, Assistant Directors, Heads of Service and Team Managers.

The CSCG Coordinator will also be responsible for interpreting and analysing incident information to identify risks and/or trends. They will feedback this information to the Directorate through the Directorate Governance structures.

The CSCG Coordinator will provide regular and timely information to the Directorate on the action plans and learning arising from incidents and SAI"s and the progression of these action plans.

On behalf of the Director, the CSCG Coordinator is responsible for monitoring that within each service team, incident information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety and facilitate teams to make any links required from issues identified in incident management to appropriate Risk Registers. They will also ensure that a process is in place to escalate any concerns relating to incidents to the appropriate Director, and that there are appropriate processes in place to identify SAIs in line with the Health & Social Care Board (HSCB) process.

The CSCG Coordinator will participate in monthly meetings with the Assistant Director of Clinical and Social Care Governance in order that there is a corporate oversight in relation to incidents, risks, trends and learning within the organisation.

2.8 All SHSCT Staff:

All SHSCT staff are required to provide safe, high quality care and this includes the reporting of incidents for organisational learning and good risk management as defined below and further in **Appendix 1**, in accordance with this procedure and participate in any subsequent review if required.

3.0 Procedure for the Identifying and Reporting of Incidents – ALL STAFF

3.1 Incident Identification:

A useful definition of an incident is:

"Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation."

The incident may arise during the course of the business of the Trust or any of its commissioned / contracted services.

However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.

3.1.1 Other Systems for Reporting:

An incident can sometimes also be reported through other systems such as Adult Safeguarding, Case Management Review, Mortality and Morbidity meetings, etc.

The Trust mechanism for recording all incidents is **Datix Web** and the electronic incident form (IR1) should be completed as soon as possible after the incident occurs or is discovered to have occurred. Staff should then think through what other reporting systems, such as notifying their Line Manager, may need to be considered.

3.1.2 Incidents Occurring Within Services Contracted or Commissioned by the Trust:

Incidents occurring in contracted / commissioned services which are not observed / witnessed by Trust staff and / or not reported to Trust staff are dealt with under the regional contractual arrangement with independent providers. This states that all incidents occurring within the regulated sector which are notifiable to RQIA will also be notified to the appropriate Trust via a central email. From here they will be distributed to the appropriate Directorate for review as per section 4 of this procedure.

If a member of Trust staff observes or witnesses an incident occurring within a service contracted or commissioned by the Trust or has an incident reported to them by a Trust client and / or their family / carers which relates to care provided by a contracted or commissioned service i.e. domiciliary care services, private nursing home, etc. then the member of staff has a duty to report the incident using the Trust Datix web system. The staff member will also instruct the contracted service to report the incident via their reporting mechanisms (which include notifying RQIA and Trust of significant incidents) and this instruction should be documented by Trust staff. If reported to the Trust by the contracted service the Datix incident reports should be merged by the appropriate governance team. **The original incident should be reviewed as per section 4 of this procedure.**

3.1.3 Immediate Action Checklist Following Identification of an Incident:

When an incident is identified and before it is reported please complete the following **immediate action checklist:**

- The extent of injuries/damages to person(s) or property should be ascertained and a determination made regarding the need for emergency or urgent treatment / action. For patient / client care related incidents, contact the relevant medical team to assess where required. The situation must be made safe
- Appropriate obvious treatment / actions should be taken to minimise the likelihood of the incident recurring
- Any equipment involved in the incident should be removed from use and clearly labeled, “Do not use”, until appropriate checks can be carried out. Do not dispose of equipment involved in an incident
- **The patient/client and/or their relatives / carers** should be informed, as soon as possible of the incident and of any treatment that may be necessary taking into consideration any consent issues and referring to the Trust‟s “Being Open” guidance in **Appendix 4**

- Any incident involving a patient or client, and the action taken, should be recorded in their healthcare record
- If the incident is major or catastrophic and requires an immediate action plan to prevent further harm the line manager (if out of hours, the Senior Out of Hours Manager) should be informed
- For incidents requiring further in-depth investigation e.g. SAIs/Internal Root Cause Analysis (RCA"s) / Reviews, patient/client records should be returned as soon as is practical to the Directorate Governance Coordinator to ensure all recorded information is available for review. Retrospective notes are permitted as long as these are clearly marked as being made in retrospect
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation.
- Security staff and/or the PSNI should be informed where appropriate
- Consideration should also be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures)

3.2 Reporting an Incident:

Where: All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on „Datix Web")**

By Whom: This form must be completed by either the member of staff involved in or who has witnessed the incident, or by the person the incident has been reported to.

When: All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred **or** its occurrence became known.

How: Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:*

http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf

Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager, relevant Assistant Director and the Assistant Director of Governance in an email via Datix Web.

In circumstances where the incident is considered as a potential **Serious Adverse Incident (SAI),** *(see **Appendix 1** for the definition of an SAI)* immediate telephone contact should be

made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Associate Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. This group must complete a major/catastrophic incident checklist for all incidents screened as possible SAIs. This checklist, regardless of the outcome of the screening process, will be held by the Directorate CSCG Coordinator and copied to the Assistant Director of Governance via the Corporate Governance Office**. (**See **Appendix 6)** In the event of the incident meeting the Serious Adverse Incident criteria; **section 5.0** of this procedure should be followed and where appropriate, the Director should brief the Chief Executive on SAIs as soon as possible.

4.0 Procedure for Reviewing, Monitoring and Learning from Incidents:

All incidents are to be reviewed on a weekly basis by the service area‟s Incident Review Team. As indicated earlier the purpose of the Incident Review Team is to undertake a local assessment / review of the incident in a timely manner. This review should include:

- Quality assure the information submitted via the Datix system and the initial severity rating given to the incident. Where the review team believes the severity rating should be changed – the incident reporter should be contacted and this should be discussed and agreed
- Calculate the actual and potential risk rating for the incident using the Risk Grading Matrix and impact Table – this is explained on the Datix screen and also in **Appendix 3**
- Consider the need for additional internal and /or external reporting e.g. RIDDOR, NIAIC, HSCB, RQIA, Vulnerable Adults (PVA), Fire **(See Appendix 2 for guidance on advisory contacts re: these additional reporting routes)**
- If the incident is also an adult safeguarding review (this will be recorded on Datix) then the Incident Review team should link with the adult safeguarding Designated Officer (DO) for that incident. If the incident is proceeding to a safeguarding investigation the Incident Review Team should participate in that or at a minimum, review the learning from that investigation and implement as appropriate
- Develop and agree learning and action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require a time bound action plan which **must** include relevant learning points. This learning should be communicated and actioned within teams
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter
- Inform the Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of the incident
- Any barriers to implementation of action plans relating to incidents should be escalated to the appropriate Head of Service and the Assistant Director

- Close all incidents following completion of the review process

4.1 Incident Review:

The following risk assessment process should be applied to all incidents at the time of occurrence in order to decide what level of investigation is required and at what level within the Trust the investigation should be conducted.

***Step One* – What was the impact of the incident at the time of the incident? (Actual Harm)**

4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident"s severity in the range Insignificant to Catastrophic.

4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis.

4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required.

***Step Two* – What might the impact be if the incident happens again? (Potential harm)**

4.1.4 Where the potential harm of the incident is being considered, staff must ask the following in the context of "if no further action was taken".

- Was the harm caused by a chance happening?
- Could the actual harm caused realistically have been a lot worse?
- How many people might be hurt if it happened again?
- How seriously might someone be hurt if it happened again?
- What are the control measures already in place, today?

4.1.5 It is important that grading on actual harm and potential harm are completed as separate exercises. This will ensure that the most severe incidents where the level of actual harm is higher are dealt with as a priority. All incidents with a lower level of actual harm but with a potential for a higher level of harm must be managed appropriately.

Step one	Deciding what was the impact / harm of the incident today **(actual)**
Step two	Where there is insignificant to moderate actual impact/harm, deciding what might the realistic impact/harm be if the incident were to happen again under similar circumstances. **(potential impact)**
Step three	Decide what are the chances of the incident happening again under similar circumstances. At this stage consideration should also be given

	to reviewing similar incidents that have happened in the past. **(Likelihood)**
Step four	Decide what the overall risk grading for the event is by plotting: **Impact** multiplied by **likelihood = risk grading**

The level of review applied to an incident is determined by the actual severity (impact) of the incident and/or the potential impact and is as follows:

INSIGNIFICANT AND MINOR – These incidents will usually not require detailed review, however the following questions should be asked to establish any learning:

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

However, these incidents could be subject to detailed review if similar incidents are found to occur frequently i.e. where there is a trend. It is the review team"s responsibility to identify such trends and advise the appropriate Head of Service/Team Manager or Assistant Director regarding improvements or action plans required if a trend is identified. Heads of Service and Assistant Directors should also be identifying and analysing trends through their Team / Service / Divisional Governance meetings. Action plans and lessons learnt from this trend analysis should be discussed and actions recorded in the notes of team, service and divisional governance meetings.

MODERATE – These incidents **must** be reviewed as part of the incident review process on a weekly basis. The review team must ensure that an investigation is completed within four weeks and that there is a documented action plan and learning points recorded on Datix Web. These actions and the learning should then be reviewed by the team, division and directorate with respect to progress of implementation.

In undertaking a Moderate Incident review the following questions should be answered **as a minimum:**

- What happened?
- Did what happened vary from what should have or was expected to happen?
- If so, why?
- What is the learning from this incident?

Further guidance on incident review is available in **Appendix 7.**

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation. Action plans and implementation of learning should also be reviewed at the Directorate Governance forum by the Director.

MAJOR AND CATASTROPHIC - This level of incident will, as previously described, have been automatically notified by the Datix system to the Head of Service, relevant Assistant Director and the Assistant Director of Governance at the time of reporting. It is the responsibility of the relevant Assistant Director to inform the Director and Associate Medical Director (AMD) (in the case of clinical incidents) and the appropriate CSCG Coordinator for that area of the incident.

The incident must be considered against the HSCB (October 2013) criteria for a Serious Adverse Incident (SAI) by the relevant Director, Assistant Director, AMD and CSCG Coordinator. This review of the incident should be documented by the CSCG Coordinator on the major / catastrophic incident checklist which must be completed by the group. Regardless of the outcome of the screening, the completed checklist should be shared with the Assistant Director of Governance via the Corporate Governance Office. In the event of the incident meeting the SAI criteria, **section 5.0** of this procedure should be followed.

If the incident does not meet the SAI criteria the relevant Director may either appoint an independent internal team to review the incident using a Root Cause Analysis methodology (the method used to review an SAI -see section 5) or the incident may be reviewed by the service Incident Review Team. **(**See **Appendix 7)**

Whatever the method of reviewing the incident – either as an SAI, an internal review by an independent team within the Trust or by the clinical review team within the division itself, the service team involved in the incident **must** be informed of the decision regarding how the incident is to be reviewed at the earliest opportunity, by the Assistant Director / Associate Medical Director, and **before** the review commences.

Where an incident is to be reviewed internally by an independent team or if it is the subject of an SAI, the patient /client and/or family/carer must be informed of this review at the earliest opportunity (as per the HSCB SAI guidance April 2014) as should the coroner where the case has previously been referred to them. This action forms part of the major / catastrophic incident checklist and should be documented. In exceptional cases where it is not appropriate to share this decision with the patient /client and/or family/carer, the reasons for this decision **must** be documented on the checklist and on the SAI notification form.

The findings and recommendations of the review - irrespective of how it is carried out, will be discussed and documented at relevant team, service, division, Morbidity and Mortality meetings and directorate governance meetings.

The Heads of Service and Assistant Directors are responsible for reviewing implementation of any actions and learning following an investigation.

Action plans and implementation of learning will also be reviewed at the Directorate Governance forum by the Director.

Cross Directorate learning points should be escalated to the Assistant Director of Governance by the CSCG Coordinators when they meet monthly.

The findings and recommendations of an internal review of an incident or an SAI should be shared with the patient / client and/or family / carer, RQIA and the coroner (if previously referred) at the earliest opportunity.

5.0 Procedure for Reporting and Completing a Review of a Serious Adverse Incident (SAI):

Following the review meeting of the relevant Director, Assistant Director, AMD and CSCG Coordinator where it is agreed to report an incident as a SAI, the SAI notification should be electronically reported to the HSCB, via the Corporate Governance Office, as per the HSCB Procedure for the Reporting of SAIs (HSCB October 2013)

See Hyperlink:
http://www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

The Directorate CSCG Coordinator will populate the HSCB SAI notification form on behalf of the appropriate Director and forward to the Corporate Governance Office for the attention of the Assistant Director of Governance. All SAI notification forms **must** be fully completed and accurate with an appropriate Datix ID number when submitted to the Corporate Governance Office and should be done so **within 72 hours** of the incident occurring. The Director / their designate should also report the SAI to the Chief Executive.

If the SAI concerns the death of a patient and the death has been reported to the Coroner by the appropriate medical professional this will have been recorded on the major/catastrophic review checklist and the SAI Notification. In this case the Corporate Governance Office will automatically inform Litigation (litigation generic email account) of the SAI review and this will on completion be submitted to the Coroner.

Where the SAI notification form indicates that the RQIA should be informed the Corporate Governance Office will automatically share the notification and report (when finalised) with the RQIA.

If the SAI requires an Adult Safeguarding Investigation, the Adult Safeguarding Investigation will inform the SAI process. The PVA Designated Officer will liaise with the appropriate Governance Coordinator, relevant HoS, and a representative from the Adult Safeguarding Team to compose the Adult Safeguarding Investigation review team membership. That review team must be approved by the Director, Assistant Director, and where appropriate AMD. The PVA Investigation Officer will produce an Adult Safeguarding Investigation report which will be submitted to HSCB/RQIA and to the Coroner if appropriate etc as the SAI report.

5.1 Procedure for Conducting a SAI Review (This procedure should also be applied when conducting an Independent Internal Review):

Timescale	Action	Lead
0 -72hrs	Discuss with Director, Assistant Director, AMD and CSCG Coordinator. Consider the incident against HSCB (Oct 2013) definition of a SAI and using the Major/Catastrophic incident checklist.	Director / CSCG Coordinator
0-72hrs	If above group decides the incident is an SAI they will inform the service team involved in the incident of their decision and the patient/client and/or their relatives. This group should identify nominations for the SAI review team including a Chair. (Advice for Chairpersons - see Appendix 8) Those nominated should have had no involvement in the incident for review, should be from another site / team and should be available to participate during the subsequent 12 weeks. There is the option to nominate external independent persons from other organisations onto the review team – this is done via the Director and Chief executive. This option may be useful when there is a need to engage the appropriate expertise, the incident is particularly distressing for staff involved or is particularly sensitive, where carers and relatives have expressed significant dissatisfaction with a service team or the organisation at an early stage, where a service team is small and based on one site only, where the case may be subject to external or legal scrutiny at a later stage or at any other time where it may be deemed to offer a benefit.	Director / AD/AMD/CSCG Coordinator
0-72hrs	Following confirmation of their involvement all review group nominees will receive an email with the following information: • Notification of their nomination and who nominated them. • Membership and Chair of the group • A brief description of the incident • Timescale for completion of the report • Guide to RCA methodology. The relevant A/D will check and ensure the case note /records have been forwarded to the CSCG Coordinator.	CSCG Coordinator
Week 1	CSCG Coordinator and Chair of review group will agree draft terms of reference for the review. Draft terms of reference and a copy of the case note / records will be circulated with potential dates for meeting 1 of the review. All relevant information will be distributed to the group for consideration prior to meeting 1 of the group.	Chair/CSCG Coordinator
Week 2-3	Meeting 1 will take place. This meeting will normally agree a terms of reference – including the scope of the review. The timeline of events will be discussed - and all relevant points for further analysis identified together with any points needing further clarity from the professional team involved in the incident. It is often useful and appropriate to meet with some / all of the staff involved in the incident so they can give their account to the review team in person, indicate their thought processes at the time and clarify any	Review Team

	outstanding issues. The appropriate members of the review can meet those of similar profession from the team involved in the incident.	
Week 3-6	Actions from meeting 1 will be completed, including follow up meetings with staff involved in the incident and all information can be forwarded to CSCG Coordinator.	Review team
Week 6	Meeting 2 can take place. It may be appropriate in less complex cases to have Draft 1 of the report tabled at this meeting for further discussion. However this meeting is more likely to pull together all information received and to analyse the incident and make conclusions, recommendations and propose an action plan.	Review team / CSCG Coordinator
Week 7-9	A complete draft of the report will be prepared by members of the review team and circulated to all for comment.	Review team /CSCG Coordinator
Week 9-10	Comments from the review team will be reviewed by the Chair and CSCG Coordinator / review facilitator and a final draft agreed and then circulated to the review team.	Chair/ CSCG Coordinator
Week 10-12	The final draft will be circulated / shared with all members of the service team involved in the incident for factual accuracy checking and information. The Final Draft will then be forwarded to the appropriate Director, Associate Medical Director and Assistant Director for quality assurance prior to presentation at Directorate governance meetings.	Chair/CSCG Coordinator
Week 12	Following approval by AD CSCG the report will be submitted to HSCB/ RQIA via the Corporate Governance Office. The report may also be submitted to SMT for information sharing / discussion and if a case involves a death being reviewed by the Coroner it will be shared with their office also.	CSCG Coordinator / Corporate Governance

5.2 Points of Best Practice When Undertaking a SAI Review (Applicable when undertaking an Internal Review of an Incident also):

- The service team involved in the incident are provided with support and assistance following the incident and during and after the review. See **Appendix 5**
- The patient / client and/ or relatives are informed of the review taking place, **BEFORE** it commences, to provide assurance to them that any learning related to the incident is identified and acted upon. See **Appendix 4**
- The service team involved in the incident are informed as soon as possible and **BEFORE** it commences how the incident will be reviewed. They are kept informed with respect to review progress and they can interface with the review team to provide additional information and or clarity when required. The draft review report should be shared with the service team involved in the incident for factual accuracy and information
- The review must be chaired by someone with relevant professional experience and expertise from another geographical area of the Trust who has had no involvement in the case or direct line management responsibility for any of the team involved in the incident

- The review team should be multidisciplinary and have the appropriate expertise to review the incident appropriately. They must be independent from being involved in the care and treatment provided to the patient / client
- There is the option of seeking external independent review team members and this should be considered at the outset by the Director, Assistant Director, and Associate Medical Director and CSCG Coordinator. This option can be used at any time throughout the review
- The facts, findings and recommendations from the review will be shared with the patient /client and /or family / carers. See **Appendix 4**
- Where the case has previously been referred to the Coroner, their office will receive a copy of the review report
- Learning and action plans from SAI"s will be managed in the same way as that from other incidents – **see section 4**

(subject to service users consent)

APPENDIX 1:

KEY DEFINTIONS

Definitions: The following terms describe events, which are defined as incidents and will be recorded and reported within the scope of this procedure and through Datix Web.

Terminology	Definitions
Incident/ Near Miss	Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of an HSC organisation / Special Agency or commissioned service (including a breach of security or confidentiality). However this is not an exhaustive definition and using the incident reporting system specifically for clinical outcomes which are unexpected and / or unexplained, but are not believed to be associated with an adverse incident, is also encouraged by the Trust as a means of triggering a thorough review of such cases. These reviews are a beneficial mechanism of providing assurance to staff, patients, clients, carers and relatives that any learning related to any aspect of the case is sought and acted upon.
Near Miss	**Incidents** that do not lead to harm but could have, are referred to as near misses.
Serious Adverse Incident (SAI)	The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident (SAI) **Serious Adverse Incident Criteria:-** serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self-harm*) of : a service user a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two years) a staff member in the course of their work a member of the public whilst visiting an HSC facility. unexpected serious risk to a service user and/or staff member and/or member of the public unexpected or significant threat to provide service and/or maintain business continuity serious assault (*including homicide and sexual assaults*) by a service − on other service users, − on staff or − on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years). - serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.
Harm	Injury (physical or physiological), disease, suffering, disability or death. In most instance harm can be considered to be unexpected if it is not related to the natural cause of the service user"s illness or underlying harm („Doing Less Harm, National Patient Safety Agency)
Concern	A worry or "gut feeling" about something that could lead to an incident. To highlight a situation which could lead to a full blown incident or suboptimal standards of equipment, practice or performance.

APPENDIX 2:

When and How an Incident Should Also Be Reported To Other Sources

All adverse incidents should initially be reported using the Datix Web incident management system. However some incidents should also be reported to other sources either internally within the Trust and / or externally to other agencies. The following table provides a list of types of incident and where they should be reported to following being recorded as an incident. There is also a list of useful contacts and Web links for additional advice and help.

TYPE OF INCIDENT	WHERE ELSE IT SHOULD BE REPORTED TO	USEFUL CONTACTS AND LINKS ON HOW TO REPORT IT
Potential Adult Safeguarding Incident	Definition available on the link opposite	Info available from Trust Intranet: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/SAFEGUARDINGVULNERABLEADULTSPROCEDUREGUIDANCEVERSION4.pdf Report form available on: http://vsrintranet/SHSCT/HTML/PandP/documents/PVA1BLANK.pdf
Health and Safety Incident	Via the Datix Web form Incidents should be automatically reviewed by Health and Safety	Contact: (Internal) Health & Safety Dept Number: 028 3741 2671 Email: http://vsrintranet.southerntrust.local/SHSCT/HTML/HR/documents/ReportableDiseases.pdf
MHRA	Should be notified (although voluntary) when an Adverse Drug Reaction occurs (ADR)	A paper form can be found in the back of every BNF or alternatively can be completed online at www.mhra.gov.uk/yellowcard
RIDDOR	An Incident is RIDDOR reportable if: **1)**The injury sustained is major, **2)** If a member of the public on Trust premises is killed or taken to hospital **3)** If the injury is sustained is an „Over 3 day injury" **4)** If there has been a Dangerous occurrence	Appropriate information should be completed on the Datix Web IR1 form which alerts the Trust"s Internal Health and Safety Dept. The above department is also contactable on [redacted] or

	5) If a notification of a reportable work-related disease has been received Further guidance available on Trust Intranet	
SABRE **SHOT**	For adverse blood reactions and events the MHRA (above) has a web based system for reporting known as ***SABRE*** - ****Serious Adverse Blood Reactions and Events**** The hospital blood bank should be informed who will inform a member of the Trust Transfusion Team and the Haemovigilance practitioner will complete online reporting to SABRE. There is an option in the SABRE reporting system also to report to the ***Serious Hazards of Transfusions (SHOT)*** enquiry. All SABRE incidents are discussed at the Hospital Transfusion Committee meetings.	For further information on both SABRE and SHOT please visit www.mhra.gov.uk
CMR	Case Management Review	*New processes have been put in place under Safeguarding Board NI.*
Fire	Relates to all fire Incidents:	An FPN 11 Form should be completed within 24 hours of the Fire Incident. FPN 11 form is available on the Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html and should be sent to: Fire Safety Department, Meadowview, Daisy Hill Hospital, when completed.
RQIA	***RQIA are notified about Incidents such as*** -serious injury to, or the unexpected/unexplained death -unexpected serious risk to service user and / or staff member and / or member of the public -unexpected or significant threat to provide service and / or maintain business continuity.	Corporate Governance Office to notify RQIA on receipt of appropriate SAI Notification form.

	-serious assault (*including homicide and sexual assaults*) by a service user -serious incidents of public interest or concern involving theft, fraud, information breaches and data losses	
HM Coroner	There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.	Guidance on reporting a death to the coroner available at: http://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland%20(PDF).pdf and on the Trust Intranet at: http://vsrintranet.southerntrust.local/SHSCT/HTML/clinical_guidelines.html Corporate Governance Office to also notify Coroner on receipt of SAI Notification form
NIAIC	An incident is NIAIC reportable if it relates to a Medical Device	Contact: Specialist Estates Services Dept (internal) Medical Devices Liaison Officer Email: [redacted]
DHSSPS Early Alert	Guidance available on Early Alerts at: http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html	Notification sent by Corporate Governance Office
HSCB Early Alert	As above -	Notification sent by Corporate Governance Office

Appendix 3

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

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
	• Minimal disruption to routine activities of staff and organisation.	and organisation, rapidly absorbed.	delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	and organisation - absorbed with some formal intervention with other organisations.	delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

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

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

APPENDIX 4:

Guidelines on being open with patients, service users, families and carers when things go wrong or outcomes are unexpected and /or unexplained

- Any incident involving a service user should be discussed with this individual as soon as is appropriate by a senior member of the service team and preferably the lead professional. If the service user is a child or is unable to give consent due to their physical condition or mental capacity the incident should be discussed with their named next of kin contact. If the service user is able to provide consent and wishes the incident to be discussed with another carer or relative, the service team should facilitate this request.

- Specifically those incidents graded moderate, major and catastrophic should be discussed immediately with the service user and/or their relatives / carers, with consent. Those incidents of an insignificant and minor nature which occur out of hours can be discussed with those required at the most appropriate time within the next 24 hours.

- When discussing an incident with a service user and / or designated relatives / carers, the lead professional should outline the facts of the incident as known, the actual and potential consequences for the service user and how the team will review the incident for future learning. If the service user and/or designated carers / relatives wish to have the outcome of the incident review fed back to them the service team should consider this as good practice and should be conducted with consent of the service user if applicable. These interactions should be documented and attached to the incident report on Datix.

- If an incident meets the criteria for notification as an SAI or internal RCA, (**refer to Section 5**) the service user and / or designated relatives / carers must be informed of this decision before the SAI / RCA review begins. Where possible this should be undertaken by the Lead professional involved in the service user"s care. Where this is not possible to due relations being strained or it is judged to be inappropriate the Chair of the SAI /RCA review group supported by the Directorate CSCG Coordinator will undertake this role. This

individual will continue as the point of contact for the service user and / or designated relatives / carers throughout the period of the review and until the findings have been fed back.

- When an SAI / RCA review is completed and has been approved by the Directorate the point of contact for the service user and / or designated relatives / carers should offer to feed back the factual findings and recommendations of the review. This can include a meeting between parties and / or giving the review document to the service user and / or designated relatives / carers. How this process of review feedback is managed should be guided as far as possible by the wishes of the service user and / or designated relatives / carers.

APPENDIX 5:

Guidance on Support for Staff following an Incident

The Trust promotes an open, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed to enable lessons to be identified, active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to support staff when an adverse incident occurs and during its review.

Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.
- Contacting the relevant staff member(s) as soon as possible following the incident to discuss.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it. It is usually best to do this in a team setting with all those involved in the incident present.
- Informing staff of the Directorate"s processes in relation to incident review; keeping staff informed of likely next steps in that process and informing staff of who they can contact for advice including the Directorate Governance Office who coordinate all serious adverse incident reviews.
- At any time staff can seek advice from outside their team, for example from Directorate and Corporate Governance Offices, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Line managers should be visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an review and provides an accessible resource for clarification of any issues staff may have.
- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.

APPENDIX 6:

Major / Catastrophic Incident Checklist

Directorate:	
Reporting Division:	
Date of Incident:	
Incident (IR1) ID:	
Grade of Incident:	
If Incident involved the death of a service user, was the coroner informed:	
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	
Brief Summary of Incident:	
Summary of discussions re SAI / RCA/ Major / Catastrophic incident review:	
Decision on Level Review Type AND rationale for this:	
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	

Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☐ YES ☐ NO
Contact for service user and / or designated relatives / carers:*(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	
(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

This form once completed, regardless of Outcome, should be shared with the AD of Governance via Corporate Governance Office

APPENDIX 7:

Incident Review Guidance

A key principle of the CSC governance framework is that incidents are reviewed and analysed to find out what can be done to prevent their recurrence. Therefore, a key principle of the incident review is that when an incident occurs the important issue is not „who is to blame for the incident?" but „how and why did it occur?

Although there will be some incidents which require review using methodologies as contained within e.g. individual agency reviews, adult safeguarding reviews, health and safety reviews, the majority of incidents can be reviewed using the National Patient Safety Agency (NPSA) Root Cause Analysis Tools. Nonetheless all incident reviews will ask the core questions of:

- What actually happened? *(The facts)*
- How did what happened vary from what should have or was expected to happen?
- Why did it happen in that way? *(The causes)*
- Is there any learning to share with the team or wider Trust services to minimise the likelihood of recurrence?

The above can be expanded to include where appropriate:

- Was there anything about the task/procedure involved?
- Was there anything about the way that the team works together or perceives each other's roles?
- Was there anything about the equipment involved?
- Was there anything related to the working environment or conditions of work?
- Was there anything about the training and education of the staff in relation to their competence to:-

  (a) provide the care/service required, and

(b) manage the incident when it occurred?

- Was there anything relating to communication systems between individual members of the team, departments, or electronic communications, for example, test results via computer?
- Was there anything about the availability, or quality of any guidance notes, polices or procedures?
- Was there anything about the Trust"s strategy, its strategic objectives and priorities?

Further detailed advice in relation to incident review techniques including Root Cause Analysis (RCA) Methodologies can be sought from the Directorate Governance Coordinators or visiting the NPSA RCA toolkit resource here.

APPENDIX 8

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

The Chairperson leads an SAI Review Team. The Chairperson's main aim is to ensure that the SAI Review Team explores in an open, fair and critical manner the circumstances surrounding the incident, and establishes what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise the likelihood of reoccurrence of the incident. The review should identify not only areas for improvement but also areas of good practice. The Chairperson will be assisted by the relevant Governance Coordinator or their nominated review facilitator.

The main responsibilities of the review Chairperson are:

1.0 Prior to the Review

1.1 Reviewing all relevant case notes, statements, synopsis of care reports and relevant sections of policies and procedures related to the incident to enable them to lead the initial meeting of the Review Team.

1.2 In conjunction with the Governance Coordinator, prepare a draft Terms of Reference for consideration by the Review Team at the initial meeting.

2.0 During the Review

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

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

2.3 Ensuring that the review is open, fair and participative. That if required appropriate members of the Review Team are delegated to meet members of the service team involved in the incident to obtain clarity on events.

2.4 Chairing the Review in a manner which ensures that: all salient facts, a clear chronology of events and interventions, areas of strength/weakness of policy or practice are identified and clear action plans are formulated and agreed.

2.5 Ensuring that Review Team members, service teams and patients / clients and /or relatives and carers are kept informed with respect to the review and its progress as required. See **Appendix 4** and **section 5.**

3.0 Following the Review

3.1 Liaising with the Governance Coordinator to ensure that a comprehensive report with recommendations / action points and timescales (where relevant) is produced and agreed ensuring that the service team involved in the incident are given an opportunity to check the information they have contributed to the report for factual accuracy. The Chairperson should sign off/approve the report prior to it being sent to the AMD /Assistant Director / Director.

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

3.3 Report practices, systems or other issues which the Review Team feel require immediate attention to the relevant Assistant Director, Head of Service and AMD, where appropriate.

3.4 If the Chairperson is the nominated contact with the patient/client and or family/ carers, they will be responsible for sharing the facts/ recommendations and action plan with them as outlined in **Appendix 4.**

Southern Health and Social Care Trust

Quality Care - for you, with you

Risk Management Strategy 2019 -2022

Risk Management Strategy	
Author	Stephen Wallace Interim Assistant Director of Clinical and Social Care Governance
Date of Issue	September 2019
Date of Approval by Trust Board	22nd October 2020
Date of Review	September 2022

Contents

Foreword

The Southern Health & Social Care Trust (the Trust) seeks to deliver high quality care in all aspects of its services to patients/service users, staff, visitors, and the local communities. Risks occur daily in most activities undertaken within the Trust. Failure to manage these risks can result in injury or loss to patients/service users, staff or visitors, claims against the Trust and resources lost from patient care. It is therefore vital to implement a strategy to effectively manage risks, which will result in better quality of care.

The strategy is based on best practice, statutory requirements, national guidance and complies with the following:

- BSI ISO 31000:2018 – Risk Management Guidelines
- HM Treasury's 'Management of Risk – Principles and Concepts (the 'Orange Book')
- Assurance Frameworks –HM Treasury-December 2012
- DoH guidance document - An Assurance Framework : a Practical Guide for Boards of DHSSPS Arm's Length Bodies 2009
- Institute of Risk Management
- Audit and Risk Assurance Committee Handbook (NI) 2018
- Good Governance Institute –Risk Appetite Matrix
- This document complies with a number of Departmental circulars including
    - Circular HSS (PPM) 4/2005 – Risk Management
    - Circular HSS (PPM) 5/2003 (updated 2016/17) - Governance in the HPSS – Risk Management

This strategy will assist the Trust understand what might prevent achievement of Trust objectives (the risk). It also assists in responding to our risks. This means trying to reduce the chance of each risk happening, or reducing the consequences if it does occur. It is not about totally eliminating risk, as this is not possible within a health and social care environment. Therefore we must then decide which risks are urgent and more likely to occur, and the importance of their consequences.

The Trust and HSCB works in a constantly changing environment, with circumstances evolving both within and outside the Trust. This strategy reflects current best practice across the National Health Service (NHS) and Health & Social Care (HSC) and the guidance's in Departmental circulars and related areas such as risk management, controls assurance and clinical and social care governance.

The Trust is fully committed to the effective management of risks in all areas. This strategy provides the tools to make our risk management systems robust and systematic. Please use it to help you understand and appreciate why your job is so important in the management of risk.

This document should be read in conjunction with other Trust Risk management documents which include:

- Health & Safety Risk Assessment Guidance

- Control of Substances Hazardous to Health: Guidance Note on Risk Assessment
- Display Screen Equipment (DSE) Guidance
- LOLER & Manual Handling Policy
- Guidance on the Risk Assessment process for New and/or Expectant Mothers at Work
- Guidance for Risk Assessment of Young Persons at Work
- Guidance on Shared Work Premises
- Incident Management Strategy
- Health and Safety Policy and Whistleblowing Policy also highlight the responsibility on each employee to report any relevant issues
- Trust Business Continuity Management Plans

Section 1 – Context

Optimising and improving Patient and Service User quality and safety are core aims of the Southern Trust. Sound Clinical and Social Care Governance and Risk Management and Assurance processes are essential in realising these aims. The Clinical and Social Care Governance Strategy and its measures are dealt with in a separate publication. These strategies are to be read in conjunction with the Southern Trust Patient and Service User Strategy.

Risk Management Policy Statement

It is the policy of the Trust that a proactive approach to risk management is taken in order to:

- Bring about the desired continual improvements in the care/services the Trust provides;
- Ensure the Trust does its reasonable best to ensure the safety of staff and clients and the security of Trust premises for those that visit, live or work in them;
- Improve the way the Trust conducts its business;
- Enhance the services, reputation and efficient management of resources of the Trust
- Comply with the statutory and public duties placed upon the Trust.
- To ensure that there is a consistent approach to the assessment and recording of risk across the organisation

Trust Vision and Key Objectives

The Risk Management Strategy has been developed in line with the Trust vision and key objectives.

Vision and Purpose

The Trust's vision is to deliver safe, high quality care, that is co-produced and co-designed in partnership with service users and staff who deliver our serves

Our vision and values guide all that we do and will do in the future. Alongside this we want to be very clear about what we want to achieve. The Trust's priorities are set out in our six key objectives:

The Corporate Objectives are:-

Aims and Objectives

The aims and objectives of the Risk Management Strategy underpin the vision and corporate objectives of the Trust and are outlined below.

The aim of the Trust Risk Management Strategy is to:

- Cultivate and foster an 'open and fair' culture in order to encourage openness, honesty, reporting and facilitate learning for all staff
- Ensure a systematic approach to the identification, assessment and analysis of risk, and the allocation of resources to eliminate, reduce and control risk.
- Mitigate risks and/or manage those risks which are deemed as acceptable.

The objectives of the Risk Management Strategy which underpin the above aims are to:

- Manage risks to the quality of services provided and the safety of service users, clients, visitors, staff and contractors
- Manage risks associated with the corporate functions of Human Resources, Finance and Informatics
- Manage risks associated with service continuity
- Manage risks associated with the reputation, community expectation and equity of services of the Trust
- Minimise damage and financial losses that arise from avoidable, unplanned events

Section 2 - Definitions of Risk and Risk Management

This section of the Strategy provides a definition of risk and risk management. It also establishes the Trust's risk management strategy statement and associated objectives.

Definition of Risk

Risk is the chance, great or small, that damage or an adverse outcome of some kind will occur as a result of a particular hazard. It is the threat that an event or some action will adversely affect the Southern Trust's ability to successfully execute its strategies and achieve its objectives. Risk also includes failing to exploit opportunities and maintain organisational resilience.

Based on the ISO 31000: 2018 the following definition of risk is used regionally:-

Risk is the "effect of uncertainty on objectives".

Risk is also often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.

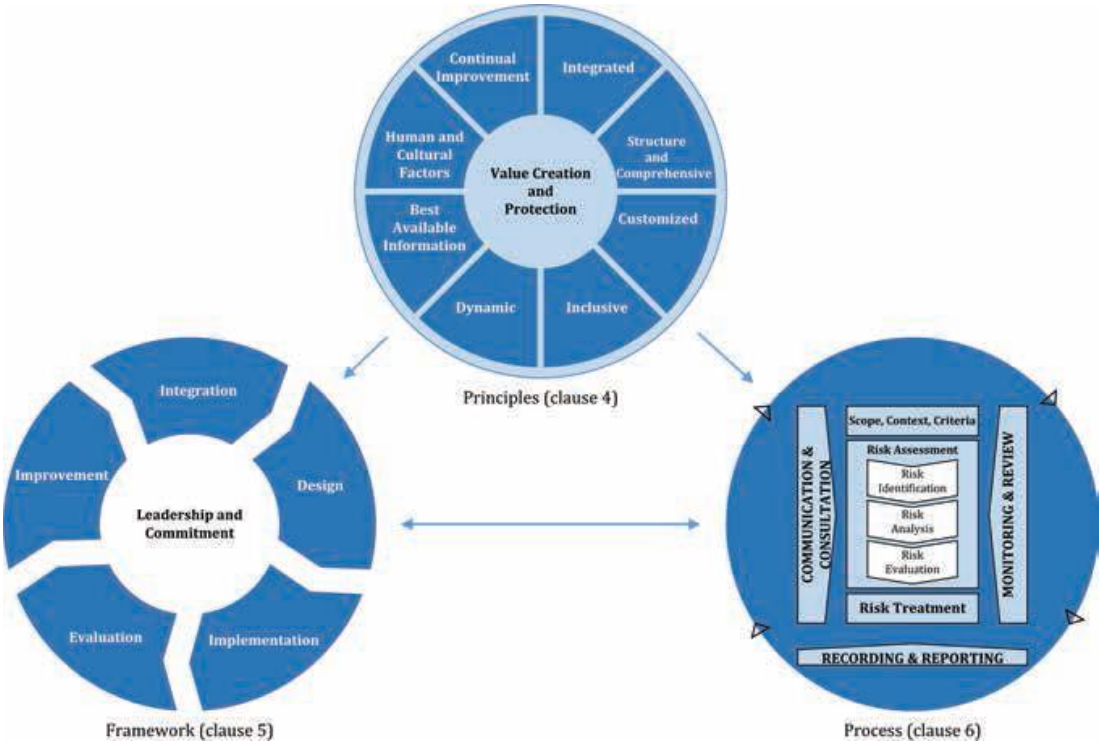
Section 3 - Principles of Risk Management

Managing Risk (Aligned with ISO 31000)

Managing risk is part of good governance and is fundamental to how an organisation is managed at all levels. Managing risk is part of all activities associated with an organisation and includes interaction with stakeholders; consideration of the external and internal context of the organisation, including behaviour and cultural factors.

ISO 31000: 2018 has three components for managing risk. These relate to (i) the identification of core **principles of risk management** with the intention that these will be addressed by (ii) the development of a **risk management framework.** In turn, the framework assists in managing risk through the (iii) **risk management processes** as outlined in the ISO 31000 standard. These are illustrated in diagrammatic format at Figure 1 below.

Figure 1 – Principles, Framework and Processes for Risk Management[1]



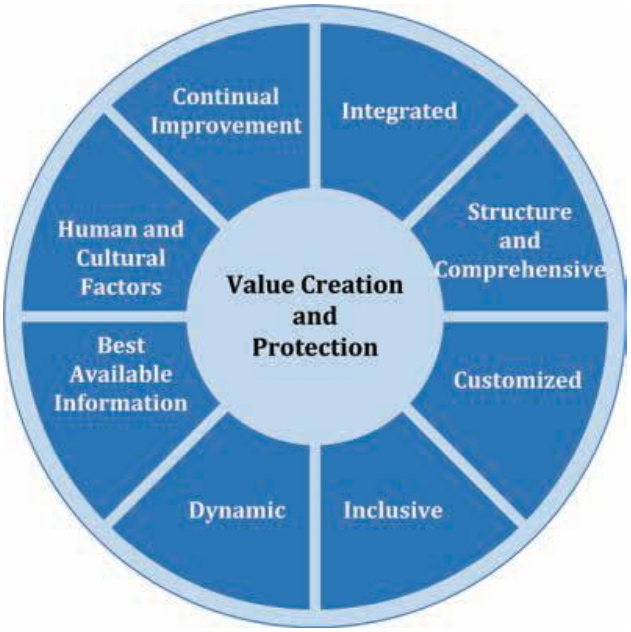
Principles of Risk Management

To be fully effective any risk management process must satisfy a minimum set of principles or characteristics. ISO 31000 includes a section (Clause 4) on these principles and these are shown in diagrammatic format in Figure 2 below. The

[1] Source – BSI ISO 31000:2018 – Risk Management Guidelines

principles are the foundation for managing risk and should be considered when establishing the organisation's risk management framework and processes and will help the organisation manage the effects of uncertainty on its objectives.

Figure 2 - Principles of Risk Management[2]



The principles are further explained in a short narrative format below:-

Component	Description
Integrated	Risk management should be integrated within all organisational activities.
Structured and comprehensive	A structured and comprehensive approach to risk management contributes to assurances in the Governance Statement.
Customised	The risk management framework and process should be customised and proportionate to the organisation's external and internal context related to its objectives.
Inclusive	Appropriate and timely involvement of stakeholders needs to be considered. This will better inform the organisation's risk management system.
Dynamic	Risks can emerge, change or disappear as an organisation's external and internal context changes. The risk management system needs to respond to these changes in a timely manner.
Best available information	Information should be timely, clear and available to relevant stakeholders.
Human and cultural factors	Human and cultural factors significantly influence all aspects of risk management.
Continual improvement	Risk management is continually improved through learning and experience and will feed into the organisation's quality improvement framework/systems.

[2] Source – BSI ISO 31000:2018 – Risk Management Guidelines

Section 4 - Risk Management Framework

Figure 3 below illustrates the elements of the second component - Risk Management Framework that is proposed to be adopted. Whilst each item is self-explanatory a short narrative about each is listed below.

Figure 3 – Components of a Risk Management Framework[3]

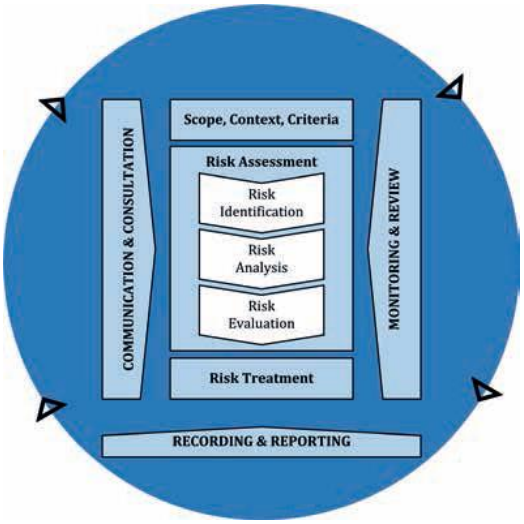
Component	Description
Leadership and Commitment	Management needs to ensure that risk management is integrated into all organisational activities and demonstrate leadership and commitment by implementing all components of the framework. This in turn will help align risk management with its objectives, strategy and culture.
Integration	Integrating risk management relies on an understanding of organisational structures and context. Risk is managed in every part of the organisation's structure. Everyone in an organisation has responsibility for managing risk.
Design	The organisation should examine and understand its external and internal context when designing its risk management framework.
Implementation	Successful implementation of the framework requires the awareness of all staff within the organisation.
Evaluation	The organisation should periodically measure its risk management framework against its purpose, implementation plans, risk management key performance indicators and expected behaviour. This will ensure it remains fit for purpose.
Improvement	The organisation should continually review, monitor and update its risk management framework to ensure it is fit for purpose.

[3] Source – BSI ISO 31000:2018 – Risk Management Guidelines

Section 5 - Risk Management Process

The third component – Risk Management Process is outlined in diagrammatic format in Figure 4 below with short descriptors of each item.

Figure 4 – Risk Management Process[4]



Communication and consultation

Communication and consultation with appropriate external and internal stakeholders should take place within and throughout all steps of the risk management process.

Scope, context and criteria

Scope, context and criteria involve defining the scope of the process, and understanding the external and internal context.

Risk Assessment

Component	Description
Risk identification	Risk identification should be a formal, structured process that considers sources of risk, areas of impact, and potential events and their causes and consequences.

[4] Source – BSI ISO 31000:2018 – Risk Management Guidelines

Risk Analysis	Risks should be analysed by considering the consequences/severity of the risk and the likelihood/frequency that those consequences may occur. The risk criteria contained within the regionally agreed Risk Rating Matrix and Impact Assessment Table will provide a guide for analysis.
Risk Evaluation	Risk evaluation involves making a decision about the level of risk and the priority for attention through the application of the criteria developed when the context was established. This stage of the risk assessment process determines whether the risks are acceptable or unacceptable. Acceptable risks are those as outlined in the organisation's Risk Management Strategy i.e. its risk appetite.

Risk Treatment

The purpose of risk treatment is to select and implement options for addressing risk. Risk treatment involves an iterative process of:

- Formulating and selecting risk treatment options;
- Planning and implementing risk treatment;
- Assessing the effectiveness of that treatment;
- Deciding whether the remaining risk is acceptable;
- If not acceptable, take further treatment/action.

Monitoring and Review

Monitoring and review should take place in all stages of the process. Monitoring and review includes planning, gathering and analysing information, recording results and providing feedback. The results of monitoring and review should be incorporated throughout the organisation's performance management, measurement and reporting activities.

Recording and Reporting

The risk management process and its outcomes should be documented and reported through appropriate mechanisms

Risk Registers

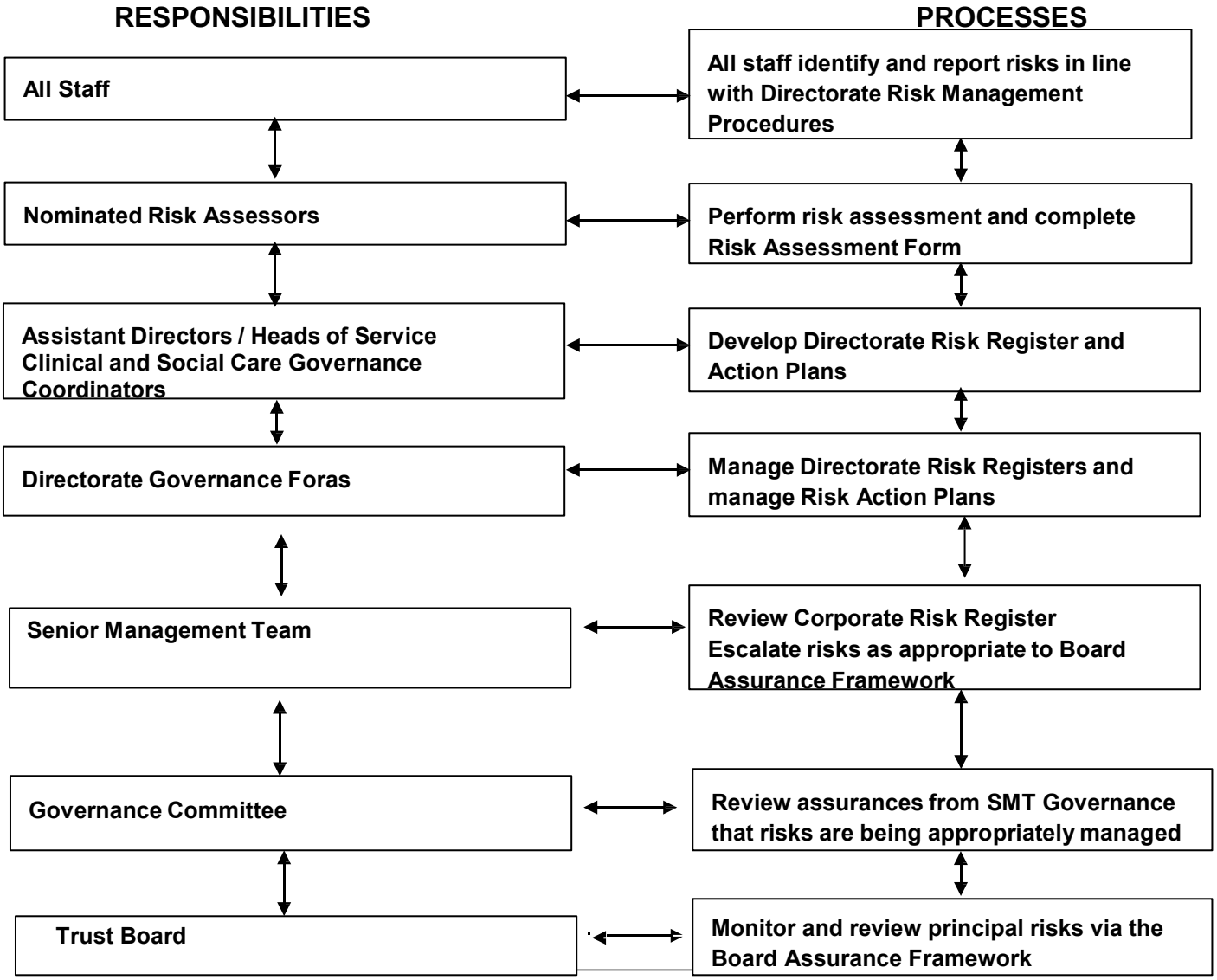
In order to develop and be aware of its risk profile and to identify the key areas for investment in risk reduction/management, the Trust has developed a framework for risk registers. This comprises both Corporate and Directorate risks. The Risk Registers will enable the Trust to identify the totality of its risk and quantify those that are deemed as acceptable or present significant risks that may affect the objectives of the Trust.

A Risk Register is a log of significant risks (clinical, non-clinical, financial etc.) that threaten the Trust's success in achieving its aims and objectives. It is populated through the various risk assessments undertaken within the organisation, together with external reviews and reports. This enables risk to be quantified and ranked to inform the Trust Board and aid decision-making and resource allocation processes.

Section 6 - Governance Arrangements in place to manage risk in the Trust

The specific governance arrangements relating to the Risk Management Strategy are described in the sub-sections which follow. A summary of the responsibilities and processes associated with risk management in the Trust is illustrated in Figure 5.

Figure 5 - Governance Arrangements in place to manage risk in the Trust



Trust Board

Within the context of this Strategy the Trust Board has a specific role in reviewing principal risks and significant gaps in control and assurance via the Board Assurance Framework, and ensuring that where gaps have been identified, corrective actions are taken.

The Trust Board is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to HSC organisations. This includes reviewing the effectiveness of internal controls - financial, organisational, clinical and social care governance and risk management. In the context of this Strategy the Trust Board will:

- Demonstrate its commitment to risk management through the endorsement of the Risk Management Strategy
- Ensure, through the Chief Executive, that the responsibilities and structure for risk management outlined in this document are fully introduced
- Oversee risk assurance processes
- Consider strategic and corporate level risks, including agreeing the related risk control measures and monitoring implementation of same
- Ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management
- Ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation

Governance Committee

The remit of the Governance Committee is to ensure that:

- There are effectively and regularly reviewed structures in place to support the effective implementation and development of integrated governance across the Trust
- Risk management is a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective
- Principal risks and significant gaps in controls and assurances are considered by the Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.

Both the Governance and Audit Committees separately review the adequacy of all governance and risk management and control related disclosure statements (the Governance Statement).

Within the context of this Strategy the Governance Committee will receive assurances from the Trust Senior Management Team (SMT) that risks are being effectively managed.

Senior Management Team (SMT)

It is the remit of the Senior Management Team to:

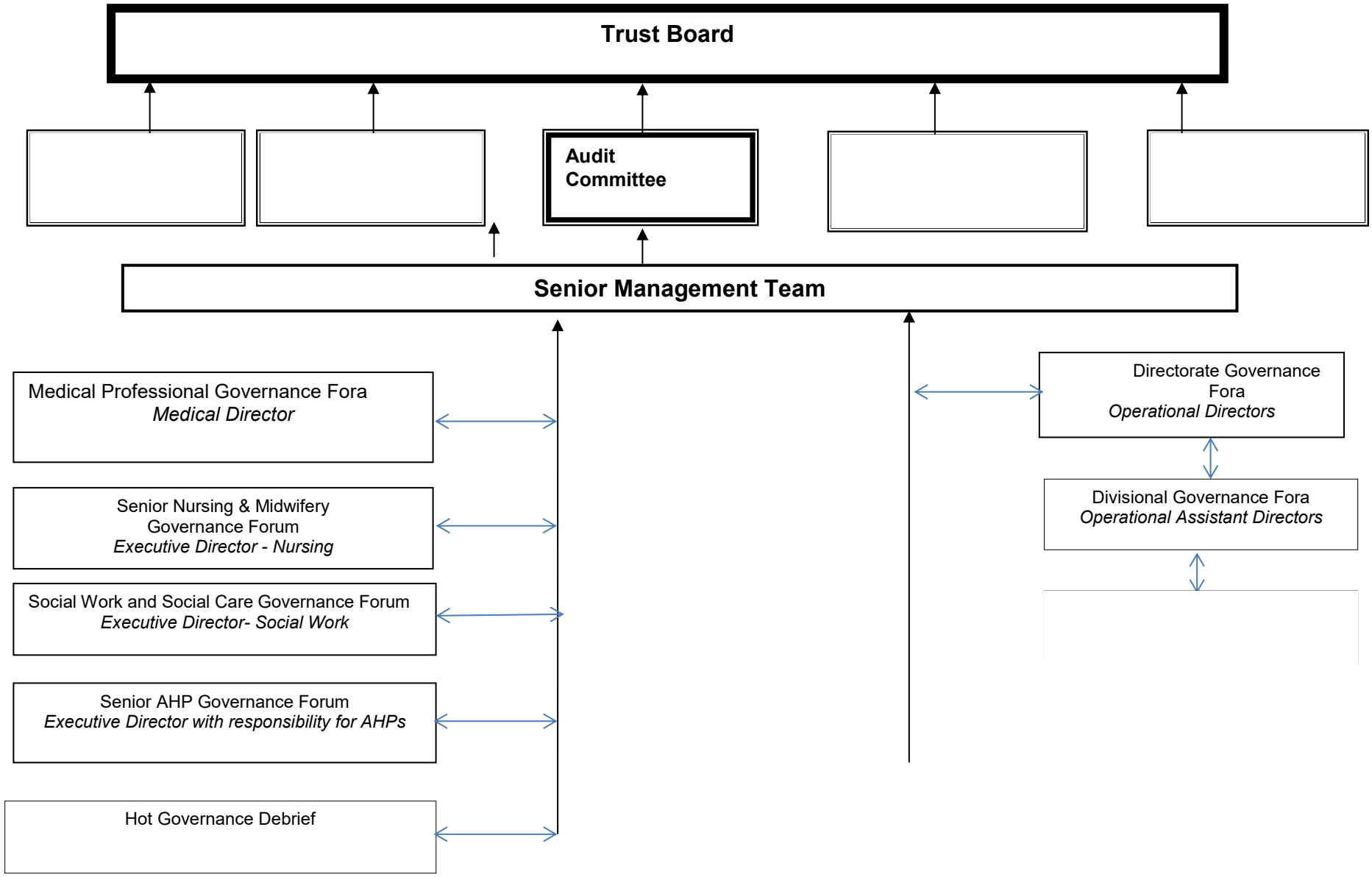
- Ensure that the Trust has an effective Corporate Risk Register
- Review the Corporate Risk Register and ensure and that risks are escalated to the Board Assurance Framework as appropriate
- Receive completed investigation reports of serious adverse events
- Receive completed reports of findings of Root Cause and Systems Analysis
- Implement and keep under review the Integrated Governance Framework
- Receive assurance of the
    - adequacy of systems for quality assurance,
    - managing risk / risk management strategies/ interventions
    - control of the environment
- Receive assurance regarding the implementation of activities associated with action plans for the
    - Controls Assurance programme,
    - HPSS Quality Standards
    - RQIA Recommendations etc.
- Accept and review reports and strategy documents pertaining to risk management and governance for endorsement by the Governance Committee
- Assess the adequacy of the Governance Sub Committees to provide accountability and assurance that governance arrangements are effective

The SMT is constituted from the following membership:

- Chief Executive (Chair)
- Executive Medical Director
- Interim Executive Director of Nursing , Midwifery and AHPs
- Executive Director of Social Work / Director of Children
- Director of Human Resources and Organisational Development
- Executive Director of Finance, Procurement and Estate
- Director of Performance and Reform
- Director of Mental Health & Disability
- Director of Acute Services
- Director of Older People & Primary Care
- Director of Children & Young People/Executive Director of Social Work

Other senior staff members will be required to attend meetings as the SMT considers necessary.

High Level Governance Structure



Operational Directorate Governance Foras

Operational Directorate Governance Foras are responsible for reviewing and managing Directorate Risk Registers. Directorates will be supported in this function by the Clinical and Social Care Governance (CSCG) Co-coordinators and Governance Officers aligned to each of the directorates. Directorate Governance Foras meet monthly and are reflective of all speciality interests/service areas across Directorates/Divisions.

Membership of Directorate Governance Foras should be drawn from (though not limited to) Associate Medical Directors, Clinical Directors, Assistant Directors, Heads of Service and the Clinical and Social Care Governance (CSCG) Coordinators and Governance Officers aligned to the Directorates of Acute, Children & Young People, Older People & Primary Care and Mental Health & Disability, as appropriate.

Within the context of this strategy, the Directorate Governance Foras manage the processes associated with developing, assessing and evaluating risk and developing Risk Registers within the Directorates as outlined in Section 3 of this Risk Management Strategy.

The Directorate Governance Foras through the appropriate Director present those risks which cannot be managed at Directorate level and/or may require consideration in respect of addition to the Corporate Risk Register to the Senior Management Team.

The processes associated with developing, assessing and evaluating risk and developing Risk Registers is documented in Section 4 of this Risk Management Strategy.

Section 7 - Roles and Responsibilities

Chief Executive

The Chief Executive is the Accounting Officer of the Trust and has overall responsibility for the effective and efficient management of the Trust and for the quality of health and social care provided. This responsibility encompasses the financial arrangements within the Trust and for the statutory duty of quality, as well as the governance, risk management and controls assurance arrangements. Whilst this overall responsibility is maintained, responsibilities for some aspects of governance have been delegated to executive directors as outlined below

Medical Director

The Medical Director is the Executive Director with delegated responsibility for risk management and clinical and social care governance.

This role encompasses:

- The effective co-ordination of clinical and social care risk and governance – specifically this relates to the functional areas of patient/service user safety, patient/service user liaison, litigation, effectiveness and evaluation, risk management and multi-disciplinary research.
- The provision of risk management support to Trust Directors via the clinical and social care governance structures of the medical directorate.
- Clinical and social care governance support for clinicians, nursing staff, social workers and allied health professionals.
- Regional/national initiatives related to clinical and social care governance are addressed and brought to the attention of appropriate staff.
- Regular clinical and social care governance reports/information are brought to the Governance committee (in line with the Governance reporting framework) and the Trust Board.

The Executive Medical Director is supported by the **Assistant Director for Clinical and Social Care Governance and the Medical Directorate** who are responsible for the development of systems and processes for clinical and social care governance and risk management. This includes the development of the strategic approach to patient client safety initiatives, patient service user liaison (this includes management of complaints and users' views), litigation, effectiveness and evaluation (this includes standards, guidelines and audit) and risk management.

Executive Directors of Nursing & AHP and Social Work

The Executive Directors of Nursing & AHP and Social Work with accountability for professional governance are responsible for ensuring effective risk management and

governance arrangements are in place across the Trust in respect of their professional group. The Directors will be supported by professional governance leads in ensuring that professional standards of care and practice are maintained

Directors

Whilst the Chief Executive has overall responsibility for Risk Management, Trust Directors are required to ensure that the Risk Management processes outlined in this Strategy are applied and working effectively in their own relevant areas. With the support of Assistant Director of Clinical and Social Care Governance and the Clinical and Social Care Governance Coordinators' aligned to Directorates, Trust Directors are required to:

- Ensure local Risk Management procedures are established for their area of responsibility based on the Trust-wide strategy including Risk Assessment, adverse incident reporting and Risk Registers
- Ensure that risk identification, reduction and management is a standing agenda item at team meetings
- Ensure there is a system for monitoring the application of risk management within the Directorates and that risks are actioned in accordance with the risk grading action guidance
- Provide reports that contribute to the Trust-wide monitoring and auditing of risk
- Ensure staff attend relevant mandatory and local training programmes and training in risk management
- Ensure there is a system in place to facilitate feedback to staff on risk management issues and the outcome of adverse incident reporting
- Ensure the specific responsibilities of managers and staff in relation to risk management and controls assurance are identified within the job descriptions of posts and that objectives are reflected in the individual performance review/staff appraisal process

Managers

Managers at all levels in the Trust must encourage, support and facilitate staff in the application of good risk management practice and ensure staff are provided with the education and training to allow them to do so.

Managers must be fully conversant with the Trust's approach to risk management and where applicable Controls Assurance and the Quality Standards for Health and Social Care. Managers will be supported in this role by the Clinical and Social Care Governance Co-ordinators and Governance Officers aligned to their directorates.

All Staff

All staff of the Trust are responsible for providing each patient/service user with the highest possible quality of care/services and for taking all appropriate action to promote patient and staff safety by minimising risk where possible.

Issues of concern should be highlighted through existing professional and or line management lines of accountability and expect timely feedback on what has been done to address their concerns. Where individual staff continue to have specific concerns of risks which may impact on the delivery of safe and effective care, they have a duty to highlight them through the Trust's Whistle Blowing Policy and to expect timely feedback on what has happened as a result.

All members of staff should:

- Demonstrate and awareness of risk/patient safety and its consequences at all times
- Consider the risks to patient/staff safety involved in what they do and minimise those risks where possible to an agreed acceptable level
- Practice in accordance with their professional Codes of Conduct
- Comply with the Risk Management Strategy and associated procedures for example The Incident Management Procedure
- Notify line managers of any hazard or risk identified in their area of work which cannot be managed and requires attention
- Participate in the Trusts Risk Management training and education programmes
- Accept personal and collective responsibility for maintaining a safe working environment

Clinical and Social Care Governance Co-ordinators'

The Key role of the CSCG Co-ordinator is to, on behalf of the Director, ensure that there are processes in place to support the implementation of this strategy and they must challenge and support the Directorate in the regular review of:

- Directorate/department Risk Registers
- Support the Assistant Directors and Heads of Service Directorate in preparation of actions plans to manage and minimise risk
- To monitor the progress of action plans and escalate barriers to progress to the appropriate directorate and Governance Fora
- Support and assist the Directorates in reviewing adverse incident trends
- Co-ordinate investigations into serious adverse incidents, medium to extreme incidents
- Support and monitor the Directorates in implementing recommendations arising from investigations on behalf of the Director
- Ensure that there are systems and processes in place to provide feedback to staff reporting risks and adverse incidents
- Report through the Assistant Director for Clinical and Social Care Governance to the Medical Director and Senior Management Team using weekly Governance Debrief using an agreed proforma.

Board Assurance Manager

On the delegated authority of the Chair (the Chief Executive) of SMT, the Board Assurance Manager is responsible for maintaining the Corporate Risk Register and Board Assurance Framework and supporting the Governance Committee and Trust Board in ensuring the provision of regular risk reporting and monitoring information and assurances.

Internal Audit

The internal audit function is responsible for providing independent advice and assurance to the Trust Board that risk management systems are in place, fit for purpose and meeting Trust objectives of improving Patient Quality Care and Safety.

Patients, Service Users and the Public

The Trust welcomes the value of risk reporting from patients and or members of the public, and assumes a positive approach to the complaints or comments from which potential risks are identified. The Trust is an open and learning organisation and will ensure that learning from the investigation of complaints, compliments and comments is shared to improve patient/service user quality care and safety.

External Providers, Contractors and Agency Staff

It is essential that External Providers, Contractors and agency staff are advised of their responsibilities to work safely within the Trust and acknowledge that the management of risk is an individual as well as a collective responsibility.

They should be informed of the reporting mechanisms in the local area they are working in for reporting any hazards, risks and incidents whether they impact upon the contractor, agency staff, patient, client, staff or visitor. All Service Level Agreements and Contracts will include a section on Risk Management.

Section 8 – SHSCT Trust Risk Management Procedure

The Trust's Risk Management Model is based on the ISO 31000 Standard as adopted by all regional HSC Trusts.

Establish the Scope, Context and Criteria

The following risk impact assessment criteria have been derived from the risk management objectives and will be used for the assessment of risks as part of the impact grading in the Trust's Risk Grading Matrix:

- Risks to people (impact physical/psychological on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)
- Risks to quality and professional standards/guidelines (Meeting quality/professional standards/statutory functions/responsibilities and Audit Inspections)
- Risks to reputation (Adverse publicity, enquiries from public representatives/media Legal/Statutory requirements)
- Risks to Finance, Information and Assets (Protect assets of the organisation and avoid loss)
- Risks to resources (Service and business interruption, problems with service provision, including staffing (number and competence), premises and equipment)
- Risks to the environment (air, land, water, waste management)

Risk Identification/Safety Management

There are several aspects to risk identification, all of which need to be present in an effective risk management system. Risks should be assessed anytime when there is the potential for unexplored and unidentified issues diverting the organizational resources from its objectives and goals. The risk management process should be applied to business planning at all levels and risk management issues should be communicated to key stakeholders where necessary.

Adverse incident reporting, legal claims, complaints, and user views, internal and external e.g. RQIA audit reports provide robust data but by definition are retrospective. Internal and external assessment are less quantifiable than adverse incident information but are critical in identifying key risks which have the potential to impact on the Trust.

The key elements for risk identification are detailed below:-

External Scrutiny and Inspection	Occurrences	Internal Assessments
Prospective	**Retrospective**	**Prospective**
Internal Audit Reports External Audit Reports Accreditation Bodies Report RQIA reports Reports from Professional Bodies Health and Safety Executive Reports/Visits Environmental Health Reports Independent Reviews Coroner's Reports Contract management meeting reports from external providers Contract management meeting reports from external contractors All internal C&SCG data e.g. safety thermometer, waiting time report etc. NCEPOD enquiries/reports	Adverse Incident Reporting User Views Complaints Locally resolved expressions of dissatisfaction Legal Claims Patient and Client Satisfaction Measures Employee Satisfaction Measures Measures of psychological safety Sickness and Absence Records Staff Turnover Levels of Agency Utilisation Medical Device and Equipment Alerts Introduction of new Standards and Guidelines Outcome of Audit	Controls Assurance – Self Assessments Performance reporting Specialist Committees e.g. Infection Control Health & Safety etc. Risk Assessments (including H&S; business/project planning e.g. new activities, services; referrals) Management of relationship risk – i.e., service partners/key suppliers taking into account the behaviour and risk priorities of those partners Networking – use of media reports and information from other Trusts Other self-assessment tools - Health and Social Care Quality Standards Audit Commission.

Directorates are required to develop appropriate systems and mechanisms to support the identification of risk. Some potential mechanisms are:

- Data review – review of adverse incidents, complaints, lessons learned from investigations, user views, claims data, and patient safety data.
- Workplace Risk Assessment – review of current risk assessments to identify trends and recurrent risks across the organisation e.g. staff shortages, psychological safety, engagement
- External Review(s) – examine review reports to identify risks identified by the external review team e.g. coroners investigations, RQIA, Internal Audit, Standards & Guidelines, College & Professional Body Reports, National and Confidential Enquiries.
- Contract management meeting reports from external providers & contractors

Using the above identification methods risks should be identified and recorded in Risk Registers.

A risk assessment form (Appendix 1) should be applied to this risk assessment process.

Risk Analysis and Evaluation

For each risk identified an assessment will be made of the **likelihood** of the risk occurring and the consequence or **impact** if this were to happen. The assessment will be made taking into account the effectiveness of controls that are already in place to mitigate the risk.

Once identified, risks will be analysed and actioned following the steps below:

i) Step 1 - Determining Risk Likelihood

In assessing **likelihood** it is important to consider the nature of the risk being assessed. On the one hand, risk may be scored in relation to **probability of future occurrence**. However, in using **likelihood scores** reactively, for example, when reviewing adverse incidents a more appropriate perspective might be 'How likely is this to occur again? / How frequently has this occurred?'

Figure 4 should be used to assign a descriptor for this perceived risk. This should be determined by **either** frequency or **likelihood.**

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

ii) Step 2 – Determining the Risk Impact/Consequence

The risk impact/consequence table at Figure 5 (known as the 5x5 matrix) provides guidance on applying the impact criteria. In determining the risk impact/consequence the following question should be asked:

If harm occurred, what are the likely consequences to the Trust achieving its objectives?

All risks should be assessed **across each** of the 5 consequence / impact categories. The highest value attained against any one of the categories will be the impact / consequence grade will be used to indicate the level of risk.

HSC Regional Impact Table – with effect from April 2013 (updated June 2016 & August 2018)

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

iii) Step 3 – Determining the Risk Rating

Following the identification of the level of likelihood and impact/consequence of the identified risk, a risk rating will be calculated using the matrix in Figure 6. This rating will prioritise and inform the further management of the risk identified.

Figure 6

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

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

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

iv) Step 4 - Risk Action Planning

As part of the process, those carrying out the risk assessment exercise should also develop proposals for management of the risks identified. This should be documented in the risk action plan. All options should be considered including accepting a higher level of risk if doing so increases the quality of life for a patient/client. It is unlikely that proposals to completely eliminate all risks impacting on the organisation will always be feasible. Proposals should strike a balance between improving the risk situation, the level of resource input required and a realistic timescale in which to bring the risk faced to an acceptable level.

All action plans should clearly set out the action required to manage the identified risk. The Trust recognises it is not always possible to eliminate or reduce risks to the lowest level of rating and that some risks will have to be accepted at a high level. The process for acceptance of these risks is outlined in the Risk Acceptance Framework, Section 5.

In developing risk action plans consideration should be given where: -

- There are no control measures at all;
- Current control measures are ineffective; or
- Additional control measures are required to the existing effective controls in place.

1. An individual with explicit responsibility must be identified for ensuring the action is taken.
2. The name of this person together with a target date for completion of the action must be recorded against the proposed action in the plan.
3. A planned date for the first review of the risk assessment, to assess progress initially, should be agreed and recorded in the action plan.
4. This date should be determined by the initial risk rating.

A **predicted** risk rating once all control measures are implemented should be determined.

If there are anticipated resource implications associated with the action plan, details and costs should be recorded.

The relevant Trust manager should sign off each action plan and ensure the risk is managed according to the process outlined in the Risk Acceptance Framework.

The management of the risk must then be reviewed on an ongoing basis to:

- Monitor whether the risk profile is changing; and
- Gain assurance that the risk action plan is effective and to identify when further action is necessary.

Details of subsequent reviews should be recorded in the action plan, including the date of the review, a summary of the current position and a re-assessment of the risk rating. The risk rating may change as actions are completed and this should be recorded.