

Donna Britton

From: serious incidents
Sent: 21 March 2017 12:23
To: Joanne McClean
Subject: Final RCA Report: Trust Ref: SHSCT SAI [Personal Information] / HSCB Ref: [Personal Information]
Attachments: Position Report [Personal Information].pdf; RCA Report [Personal Information].pdf

Please find attached the RCA Report from the **SHSCT** in relation to:

Trust Ref: **SHSCT SAI** [Personal Information]

HSCB Ref: [Personal Information]

Also attached is a SAI position report detailing all activity in relation to this incident. Please advise if any action is required or if you would like this SAI listed for the next Acute Review Team Meeting for discussion/closure.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Information] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Information]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient] [Personal Information] SAI Report

Dear Colleague

Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team

Directorate of Acute Services

The Maples

Craigavon Area Hosptial

Personal Information redacted by
the USI

Donna Britton

From: serious incidents
Sent: 26 April 2017 12:11
To: Joanne McClean
Subject: 1st Reminder - Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]
Attachments: Position Report [Personal Inform].pdf; RCA Report [Personal Inform].pdf
Importance: High

Joanne,

Please see email below, in relation to the above SAI.

Can you please advise if there is any further action required or if you would like this SAI listed for discussion/closure at the next Acute Review Team Meeting?

Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 21 March 2017 12:23
To: Joanne McClean
Subject: Final RCA Report: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Please find attached the RCA Report from the **SHSCT** in relation to:

Trust Ref: **SHSCT SA** [Personal Information]

HSCB Ref: [Personal Information]

Also attached is a SAI position report detailing all activity in relation to this incident. Please advise if any action is required or if you would like this SAI listed for the next Acute Review Team Meeting for discussion/closure.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager

Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

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From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]

Sent: 16 March 2017 11:49

To: serious incidents

Cc: ClientLiaison, AcutePatient

Subject: Encryption SAI Reports And Checklist ID [Personal Inform] Level 2

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Eileen Conlon
Corporate Governance

From: Farrell, Roisin

Sent: 16 March 2017 09:22

To: Corporate.Governance

Subject: SAI [Patient] [Personal Inform] SAI Report

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Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

Donna Britton

From: Joanne McClean
Sent: 28 April 2017 15:45
To: serious incidents
Subject: RE: 1st Reminder - Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]
Categories: Work in progress

Roisin,
Please list for next meeting
Joanne

From: serious incidents
Sent: 26 April 2017 12:11
To: Joanne McClean
Subject: 1st Reminder - Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]
Importance: High

Joanne,

Please see email below, in relation to the above SAI.

Can you please advise if there is any further action required or if you would like this SAI listed for discussion/closure at the next Acute Review Team Meeting?

Many Thanks

Roisin

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 21 March 2017 12:23
To: Joanne McClean
Subject: Final RCA Report: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Please find attached the RCA Report from the **SHSCT** in relation to:

Trust Ref: **SHSCT SAI** [Personal Inform]

HSCB Ref: [Personal Inform]

Also attached is a SAI position report detailing all activity in relation to this incident. Please advise if any action is required or if you would like this SAI listed for the next Acute Review Team Meeting for discussion/closure.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]
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From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 16 March 2017 11:49
To: serious incidents
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Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient 140] [Personal Inform] SAI Report

Dear Colleague
Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell
Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hosptial
[Personal Information redacted by the USI]

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 MAY 2017**Date:** 10 MAY 2017**Lead Officers:** Dr Brid Farrell, Siobhan Donnell, Dr McMaster, Eleanor Ross**Apologies:** Dr Louise Herron, Dr Miriam McCarthy, Dr Joanne McClean**In attendance:** Mareth Campbell, Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|--------------|------------------|-------------------|---------------------------|--|---|
| 4a | Personal Information redacted by the USI | | Dr J McClean | Closure Proposed | Y | Y plan to share report | <u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 | Review at meeting 9 June 2017 |
| 4b | | | S Donald | Closure Proposed | Y | Y | <u>First Review 10 May 2017:</u> CLOSE based on the information provided including the engagement checklist. No regional learning identified. Mary McElroy advised that all falls related SAIs are reviewed by the Regional Falls Group. DRO will forward completed Remedial Causes and Learning Lessons template in relation to this SAI to Elaine Hamilton | CLOSE Considered by Regional Falls Group Referred to Regional SAI Review Team Meeting |

| | | | | | | | | | |
|----|--|--|--|--------------|--|---|---|--|--|
| | | | | | | | | | |
| | | | | | | | Refer to the Regional SAI Review Team meeting to note referral to Regional Falls Group. Action: Governance Team / Siobhan Donald (DRO) | | |
| | Personal Information redacted by the USI | | | | | | | | |
| 4c | | | | Dr J McClean | Closure proposed | Y | Y plan to share report | <u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 | Review at meeting 9 June 2017 |
| 4d | | | | Dr J McClean | SAI deescalated to level one. Proposed closure | Y | Y plan to share report | <u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 | Review at meeting 9 June 2017 |
| 4e | | | | Dr J McClean | Proposed Closure | Y | Y plan to share report | <u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 | Review at meeting 9 June 2017 |
| 4f | | | | Dr J McCall | | Y | Y | <u>First Review 10 May 2017: Further Information Required.</u> • Dr McCall (DRO) advised SET are considering development of | Review at meeting July 2017 SAI to be |

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|--|----------|-----------|-----|------------------|-------------------|--------|---|--|
| | | | | | | | <p>a Jump Policy. Dr McCall will request a copy when it's completed.</p> <ul style="list-style-type: none"> • Dr McCall to share report with Catherine Coyle in respect of transfers to interventional radiology. • Dr McCall to request protocol for contingency plan for interventional radiologist in SET • Dr McCall to request guidelines from Radiology Network on timing of CTPA investigations in diagnosis of PE • Dr Farrell to Share Stroke Thrombectomy pathway with Dr McCall <p>It was agreed there are a number of regional learning points from this incident to be considered:</p> <ul style="list-style-type: none"> • Quicker recognition of patient bleeding and resuscitation | considered for a future SAI Learning Event |

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| | | | | | | | <ul style="list-style-type: none"> Learning from Human factors <p>This SAI will be considered for SAI learning Event in the future.</p> <p>Action: Dr McCall / Dr Farrell / Governance Team</p> <p>Review July 2017</p> | |
| 6a | Personal Information redacted by the USI | | Dr M McCarthy | SAI has not been received. Does DRO require further information? | n/a | n/a | <p><u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> | Review at meeting 9 June 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 APRIL 2017

Date: 19 April 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Dr Muhammad Sartaj, Mrs Eleanor Ross

Apologies: Mrs Mary McElroy, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|---------------|------------------|-------------------|--------|---|--|
| 4a | Personal Information redacted by the USI | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 19 April 2017 – Include in Scoping Exercise – Following review it was agreed there is regional learning around delayed diagnosis with the learning highlighting high level messages that are applicable. It was agreed to include this SAI in the scoping exercise to be undertaken by Dr McCall in relation to delayed diagnosis. Following the scoping exercise, Dr McCall and Dr McCarthy to meet to review.</p> <p>Action Dr McCall / Dr McCarthy</p> <p>Review June 2017</p> | <p>Review June 2017</p> <p>To be included in in delayed diagnosis scoping exercise</p> |
| 4d | | | S Donald | | Y | Y | <p>FIRST REVIEW 19 April 2017 – Further Professional Advice Required – It was agreed to share the SEA report and all related correspondence with Dr Sartaj to review and provide a medical opinion.</p> <p>Review June 2017</p> <p>Action: M Campbell</p> | <p>Review June 2017</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|---------------|---|-------------------|--------|--|--------------------------------|
| | Personal Information redacted by the USI | | | | | | | |
| 4g | | | Dr C McMaster | Trust notified SAI as a level 1. This was followed up by an amended notification form advising that the SAI had changed to a level 2. As the Trust hadn't provided a rationale for changing the level, the DRO asked that the SAI be listed for discussion. | N | N | <p>FIRST REVIEW 19 April 2017: Change of Level of Review – M Campbell advised that she had contacted the NHSCT asking that they advise of the reason for changing the level of investigation. A response is awaited.</p> <p>Members referenced the Thematic Review on Choking currently being undertaken by Mary McElroy and asked that this SAI is considered in the review.</p> <p>Action: M Campbell</p> <p>Review May 2017</p> <p>Update 10 May 2017: This SAI won't be included in the Choking Thematic Review as the Report hasn't been received but it will be considered in terms of themes for the review.</p> <p>The DRO had a telephone conversation with Trust Governance staff as the cause of the incident was not included in the TOR but DRO was advised the Report has been completed and will be</p> | Review when Report is received |

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|---|----------|--|---------------|---|-------------------|--------|--|------------------|
| | | | | | | | shared with HSCB/PHA in the near future. Therefore the DRO feels approval of TOR is not required/appropriate. | |
| | | Personal Information redacted by the USI | | | | | Review when report is received. | |
| 6 | | | Dr C McMaster | Listed for discussion to determine if there is learning | | | <p>Early Alert is linked to Personal Information redacted by the USI which was closed on 10 April 2014. The Early Alert received was advising that the case had been listed for hearing for two days on 23 and 24 February 2017.</p> <p>M Campbell to check if any learning was disseminated in 2014 and in particular around the European Guidelines referenced in the Coroner's report.</p> <p>Action: M Campbell</p> <p>Update 10 May 2017: The Trust has submitted an updated Action Plan (November 2016). The action plan refers to a Policy 'Ascites Management Guidelines for Liver Cirrhosis NHSCT/13/658' which is in place and used.</p> | Review June 2017 |

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| | | | | | | | <p>The Trusts Governance Department are currently carrying out a piece of work around learning and themes from inquests that were before the Coroner in the first quarter of this year - this case is included. These workings are due to be discussed at their Clinical Governance Steering Group meeting on 11 May 2017 and an update will be provided following the meeting.</p> <p>Trust Governance Department will confirm if any learning was disseminated in 2014.</p> <p>Action: Elaine Hamilton</p> <p>Review June 2017</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 MARCH 2017

Date: 20 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster, Dr Muhammad Sartaj, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|---------------|------------------|-------------------|--------|---|---|
| | Personal Information redacted by the USI | | | | | | | |
| 3a | | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017 – Further Information Required - The summary of events doesn't indicate the likely reason for the cardiac arrest. BHSCT to be asked to provide more information on any factors relating to anaesthetic and/or medications administered which may have been a contributory factor.</p> <p>BHSCT also to be asked to provide further detail on why they haven't shared the SEA Report with the family to date.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 – DRO query has been forwarded to the Trust. Governance Team to follow up and SAI to be reviewed at a future meeting when response is received.</p> <p>Action: Governance Team</p> | REVIEW AT A FUTURE MEETING WHEN RESPONSE IS RECEIVED FROM TRUST |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|--|---------------|------------------|-------------------|--------|---|---|
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr M McCarthy | | | | <p>FIRST REVIEW 20 March 2017 - CLOSE based on the information provided including the engagement checklist, with <u>Regional Learning identified</u>.</p> <p>Action: Governance Team</p> <p>Refer to SAI Sub-Group to note an article in Learning Matters newsletter</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p><u>Postscript:</u> There is a similar SAI (Personal Information redacted by the USI) in the Older People programme of care and the learning from both SAIs should be linked. David Petticrew to be contacted.</p> <p>Action: M Campbell</p> <p>Members also considered the Shared Learning proforma from BHSC in relation to loose fitting dentures. It was agreed there is regional learning</p> | <p>Pending Closure – view from Michael Donaldson</p> <p>Refer to SAI Review Sub-Group</p> |

Comment [EH1]: Is this on both agendas? I will take to the next meeting

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| | | | | | | | <p>as outlined above (article in Learning Matters). The group disagreed with the learning point that the Commissioner should consider making all dentures radio opaque. Michael Donaldson to be contacted for an opinion.</p> <p>Action: M Campbell</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 1.2, 1.3 and 1.4 Action: Governance Team Learning Lessons Categorisation – 1 Action: M Campbell | |
| | | Personal Information redacted by the USI | Dr M McCarthy | | | | <p>FIRST REVIEW 20 March 2017– Further Information Required – Trust to be asked to forward</p> <ul style="list-style-type: none"> A copy of Standardised Operating Procedure (SOP) for validation process A copy of Standardised Operating Procedure (SOP) for monitoring and tracking of investigations. An update on recommendation 5 – the reference to cease 'green | Review June 2017 |

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| | | | | | | | notes' system. Action: Governance Team Review June 2017 | |
| 3b | Personal Information redacted by the USI | | Dr J McClean | | Y | Y | FIRST REVIEW 20 March 2017– DRO not present. Defer to next meeting. However it was noted there are significant nursing issues. Relist for April meeting. Update 19 April 2017 - SEA report has been shared with Eleanor Ross for nursing view. DRO not present – defer to next meeting. Review May 2017 Update 10 May 2017: Further Professional Input Required. Dr McClean (DRO) will liaise with Siobhan Donald and Angela Carrington as regional learning was identified in respect of omitted medicines and delay in medicines in nursing/pharmacy. | Review July 2017 |

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|----|--|-----------|--------------|------------------|-------------------|--------|--|--------------------|
| | | | | | | | Review July 2017 Action: Dr McClean (DRO), Siobhan Donald and Angela Carrington | |
| | Personal Information redacted by the USI | | | | | | | |
| 3c | | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – Dr McCall to highlight this SAI to Sepsis Collaborative run by Safety Forum.</p> <p>Action: Dr McCall</p> <p>DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting.</p> <p>Update 10 May 2017: Dr McCall has highlighted this SAI to the Safety Forum. It was agreed there is regional learning from this SAI – possibly a learning matters article but will be discussed further when DRO is present.</p> <p>Relist for June Meeting</p> | Review 9 June 2017 |

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| | Personal Information redacted by the USI | | | | | | | |
| 3d | | | Dr J McClean | | Y | Y | FIRST REVIEW 20 March 2017 – DRO not present. Defer to next meeting. Relist for April meeting. Review 19 April 2017 - DRO not present – defer to next meeting. Update 10 May 2017: DEFERRED DRO not present. Defer to next meeting. Review 9 June 2017 | Review 9 June 2017 |
| 3e | | | Dr J McClean | | Y | Y | FIRST REVIEW 20 March 2017 – DRO not present. Defer to next meeting. Relist for April meeting. Review 19 April 2017 - DRO not present – defer to next meeting. Update 10 May 2017: DEFERRED DRO not present. Defer to next meeting. Review 9 June 2017 | Review 9 June 2017 |
| | | | Dr J McCall | | Y | Y | FIRST REVIEW 20 March 2017 – <u>Further Input</u> - Patient lost to follow up. DRO | Review June 2017 |

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| | | | | | | | <p>referenced a similar SAI where the patient wasn't followed up in a timely manner. Both SAIs to be highlighted to the LCG but in the first instance, DRO to speak to Lisa McWilliams (PMSI) regarding endoscopy waiting lists and patients not being prioritised appropriately. A search to be undertaken on Datix for linked cases to look at demand/capacity gap. Review in 3 months.</p> <p>Action: Dr McCall/M Campbell</p> <p>Review June 2017</p> | |
| | | Personal Information redacted by the USI | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017 - CLOSE based on the information provided including the engagement checklist, with <u>Regional Learning identified</u> around the correct use of anticoagulants, lack of co-ordination of care and the need for early referral to multi-specialist team/service. Mary McElroy to refer SAI to Geraldine Teague for consideration of regional learning by the Diabetic Foot Team.</p> | <p>Awaiting feedback from Diabetic Foot Team prior to closure</p> <p>Refer to SA Review Sub-Group</p> |

Comment [EH2]: Is this on both agendas

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| | | | | | | | <p>Action: Governance Team Mary McElroy</p> <p>Refer to SAI Review Sub-Group to note referral to Improving Management of Warfarin, NOACs and Antiplatelets Action Group led by Lynne Charlton, the Diabetic Foot Team and to note an article for Learning Matters (Dr McCall agreed to prepare the article when required).</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 3.3 Action: Governance Team Learning Lessons Categorisation – 1 and 5 Action: M Campbell | |
| 5a | Personal Information redacted by the USI | | Dr M McCarthy | Shared Learning linked to <small>Personal Inform</small> | N | N | FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting. | REVIEW SHARED LEARNING WHEN SEA REPORT IS RECEIVED |

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| | | | | | | | <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Members noted the SEA report had not been received and agreed to consider the shared learning when the SEA Report is received.</p> <p>Review Shared Learning at a future meeting when SEA Report is received.</p> | |
| | | Personal Information redacted by the USI | | | | | | |
| 5b | | | Dr M McCarthy | Shared Learning linked to <small>Personal Information</small> closed on 21 September 2015. | | | <p>FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Members noted this issue had been addressed by Medical Directors and agreed no further action was required.</p> <p>Post Script – On review of the Datix record, Shared Learning SL9933 related to tests being requested from another healthcare provider/service. The issue</p> | Review June meeting |

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| | | | | | | | <p>addressed by Medical Directors related to Employment of New/Locum Medical Staff (SL10497). BHSCT have confirmed that both Shared Learning reports are linked to SAI</p> <p>Personal Information redacted by the USI</p> <p>Review Shared Learning Proforma SL9933 at May meeting.</p> <p>Update 10 May 2017: Further Information Required: Governance Team to seek confirmation from Dr O'Brien (Integrated Care) if a LES for phlebotomy was in place in the GP practice?</p> <p>Action: Governance Team</p> <p>Review at June meeting.</p> | |
| 5c | | Personal Information redacted by the USI | Dr M McCarthy | Shared Learning linked to Personal Inform closed on 22 August 2016. | | | <p>FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> | Review June 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|---------------|------------------|-------------------|--------|--|--|
| | | | | | | | Update 19 April 2017 – Dr McCarthy to review RCA Report alongside Shared Learning proforma to determine if there is regional learning. As Dr McCarthy is not available for May meeting, review at June meeting. Review June meeting | |
| 3f | Personal Information redacted by the USI | | Dr M McCarthy | | | | FIRST REVIEW 20 March 2017: EARLY ALERT – DRO had listed Early Alert for discussion following response from Trust advising they were not intending to report this incident as a SAI. Following discussion, it was agreed to inform the Trust that the Acute SAI Review Team considered there may be wider learning including learning on central alerting systems and in that regard would be grateful if the Trust would submit a SAI Level 1. Action: Governance Team Review April 2017 Update 19 April 2017 – Trust have | REVIEW AT A FUTURE MEETING WHEN RESPONSE IS RECEIVED |

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| | | | | | | | <p>been requested to submit a SAI notification form. A response is awaited. Governance Team to follow up.</p> <p>Action: Governance Team</p> <p>Review at a future meeting when response is received from BHSCT.</p> | |

| Date | Agenda Item | Action Agreed | Person Responsible |
|---------------|-------------|---|-------------------------------------|
| 20 March 2017 | 9 3p | <p>Feedback from DRO Workshops – Discussion deferred to next meeting.</p> <p>Update 19 April 2017 - DRO Protocol – DROs to discuss DRO Protocol at a staff meeting. Dr Farrell to advise when to relist.</p> <p>Action: Dr Farrell</p> | DR FARRELL TO ADVISE WHEN TO RELIST |
| 20 March 2017 | 10 3q | <p>Acute SAI Review Team - Draft Terms of Reference – Deferred to next meeting.</p> <p>Update 19 April 2017 – Members to consider the Draft Terms of Reference at a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell</p> | DR FARRELL TO ADVISE WHEN TO RELIST |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Update 10 May 2017: Elaine Hamilton to remind Dr Farrell to add this item to a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell / Elaine Hamilton</p> | |

Date: 9 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall (until 9.30am), Dr Muhammad Sartaj (until 10.15am), Dr Christine McMaster, Mrs Mary McElroy (via teleconference)

Apologies: Dr Miriam McCarthy, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 3g | | | Dr M Sartaj | | Y | Y | <p>FIRST REVIEW 9 March 2017 – Further Information Required – Trust to be asked to advise what mechanisms they have put in place to call/recall to review patients diagnosed with conditions that can deteriorate.</p> <p>Action: Governance Team</p> <p>Dr Sartaj to commence discussions</p> | Review June 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>with clinicians and check NICE guidance for good practice.</p> <p>Action: Dr Sartaj</p> <p>Review 20 March 2016</p> <p>Update 20 March 2017 – DRO query to be forwarded to Trust for response. Review at April meeting.</p> <p>Action: Governance Team</p> <p>Update 19 April 2017 – Dr Sartaj advised that he had a discussion with Rose Sharkey, Clinical Lead in WHSCT. It was acknowledged there are ongoing pressures within outpatient clinics. Internally WHSCT have a process which prioritises patients who require urgent review, however it relies on administrative staff to identify slots and most of the time it is difficult to find a slot for review even urgent reviews.</p> <p>Following discussion it was agreed there is a potential for regional</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | learning. Dr Sartaj to scope the potential for any specific learning that can be taken forward at a regional level. To be reviewed at June meeting. Action: Dr Sartaj | |
| | Personal Information redacted by the USI | | Dr M Sartaj | | Y | N | FIRST REVIEW 9 March 2017 – A completed Checklist remains outstanding. Governance team to follow up with Trust. Action: Governance Team It was noted there is significant work being done on sepsis through the Safety Forum in the Sepsis Collaborative. SAI was highlighted to be considered for the SAI Learning Event. Discuss with Jackie McCall re unusual presentation of sepsis. Upon receipt of a completed checklist and approval by DRO it was agreed the SAI could be <u>CLOSED</u> based on the information provided. No new | CLOSE |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>regional learning identified.</p> <p>Action: Governance Team</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 1.3, 1.5, 3.1 and 6.2 <p>Action: Governance Team</p> <ul style="list-style-type: none"> Learning Lessons Categorisation – 1, 2 and 7 <p>Action: M Campbell</p> <p>Update 10 May 2017: <u>CLOSE</u> based on the information provided including the engagement checklist. No new regional learning identified.</p> | |
| | Personal Information redacted by the USI | | Dr M Sartaj | | Y | Y | <p>FIRST REVIEW 9 March 2017 – Further Information Required – A tracking and monitoring report clearly outlining the actions that have been taken in response to learning identified from the SAI remains outstanding. Governance Team to follow up with the Trust.</p> <p>Action: Governance Team</p> | <p>Review at a future meeting when tracking and monitoring report is received</p> <p>Refer to SAI</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | SAI to be further considered when tracking and monitoring report is received. At this stage it is felt there is Regional Learning. Refer to SAI Review-Sub-Group to note an article for Learning Matters on atypical presentation of stroke. It was noted the last article on atypical presentation of stroke was 18 months ago. Action: M Campbell/DRO (Dr M Sartaj) | Review Sub-Group to note |
| 3i | | Personal Information redacted by the USI | R McHugh | | Y | Y | FIRST REVIEW 9 March 2017 – FURTHER PROFESSIONAL INPUT REQUIRED - Report to be shared with Dr McClean to seek a medical opinion in relation to page 3 of the report where it states that the x-ray request form did not have any clinical information which resulted in the x-ray not being completed for 9 hours. Action: Mary McElroy to share report with Dr McClean The engagement checklist states that there is a plan to share the final review report at a later date and further | CLOSE |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>engagement is planned. DRO (Rose McHugh) to be informed when this takes place.</p> <p>Action: Governance Team</p> <p>Review 20 March 2017 – Report has been shared with Dr McClean and a response is awaited. Review April meeting.</p> <p>Update 19 April 2017 – Report has been shared with Dr McClean. As Dr McClean is not present, list for review at May meeting.</p> <p>Review May 2017</p> <p>Update 10 May 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning identified.</p> <p>Report was shared with Dr McClean and it was noted there is no regional learning applicable in this case as issues can be dealt with on a local basis.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Mary McElroy will forward completed Remedial Causes and Learning Lessons template to Elaine Hamilton</p> <p>Action: Mary McElroy / Elaine Hamilton / Governance Team</p> | |
| | | Personal Information redacted by the USI | | | | | | |
| 3h | | | Dr C McMaster | | Y | Y | <p>FIRST REVIEW 9 March 2017- FURTHER INFORMATION REQUIRED - NHSCT to be asked for reassurance that both the ED triage mechanism in Causeway and the pathway for suspected pneumothorax follow existing guidance for pleuritic chest pain.</p> <p>Action: Governance Team</p> <p>Dr Sartaj to check what guidance is available for management of pleuritic chest pain.</p> <p>Review April 2017</p> <p>Update 19 April 2017 – DRO query has been forwarded to Trust. A response is awaited. Governance Team to follow up.</p> | <p>CLOSE</p> <p>SAI Listed for SAI Learning Event 23 May 2017</p> |

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| 9 March 2017 3r | | <p>Medicated Related SAls – It was agreed to review medicated related SAls at the next meeting and also the input of Angela Carrington, Northern Ireland Medicines Governance Team Leader for secondary care at future meetings.</p> <p>Update 20 March 2017 – Angela Carrington to be invited to join the Acute SAI Review Sub-Group. Review April 2017.</p> <p>Update 19 April 2017 - Angela has been contacted regarding joining the Group. Angela is very keen to be part of the group, however, due to her current working pattern Angela will be unable to attend most of the meetings as she doesn't work Monday afternoons. Dr Farrell asked that for the foreseeable future, DROs continue to liaise directly with Angela as they have been doing. Mareth Campbell to circulate Angela's contact details to the Group.</p> <p>Action: Mareth Campbell</p> <p>Update 10 May 2017: It was agreed Dr Farrell will write to Head of Pharmacy BHSC to confirm Angela Carrington's attendance and work role at the Acute SAI Review Team. This item can be removed from the action log.</p> <p>Action: Dr Farrell</p> | <p>Review May 2017</p> <p>M Campbell</p> <p>M Campbell</p> <p>Dr Farrell</p> |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 JANUARY 2017

Date: 16 January 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy

Apologies: Dr Miriam McCarthy

In attendance: Mrs Eleanor Ross (for item 5b), Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 16 January 2017 3j | 9 | <p>Any Other Business</p> <ul style="list-style-type: none"> <div>Personal Info</div> – SHSCT SAI Members considered the position report in respect of <div>Personal Info</div>. <u>Further information required</u> – Governance Team to ask Southern Trust to forward a copy of their Protocol detailing how lab results are filed following a procedure. The response should also describe how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately. Action: Governance Team Review February 2017 Update 20 March 2017 – DRO not present. Defer to next meeting. Review April 2017 Update 19 April 2017 – It was noted SHSCT submitted Swab Protocol – this was not the Protocol requested. Trust has been asked to submit Lab Result Protocol. Review SAI when correct Protocol is received from Trust. | REVIEW AT A FUTURE MEETING WHEN PROTOCOL IS RECEIVED FROM TRUST |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 DECEMBER 2016

Date: 19 December 2016

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Dr Joanne McClean (via teleconference)

Apologies: Dr Muhammad Sartaj, Mrs Mary McElroy

In attendance: Mrs Siobhan Donald (for item 3b), Mrs Eleanor Ross (for items 4e and 4f), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 NOVEMBER 2016

Date: 21 November 2016

Lead Officers: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster

In attendance: Mrs Eleanor Ross (for item 4m), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | Personal Information redacted by the USI | | | | | | |
| 3l | | | Dr J McClean | | Y | Y | FIRST REVIEW 21 November 2017 – Further professional input – Mary McElroy to discuss with Caroline | CLOSE Refer to |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>McGeary and Dr Lourda Geoghegan to ascertain if there is any regional learning around bundle management.</p> <p>Action: Mrs Mary McElroy</p> <p>Review December 2016</p> <p>Update 19 December 2016 – As Mary McElroy was not present and an update had not been provided in advance of the meeting, this SAI to be re-listed for the January meeting.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Mary McElroy advised she had spoken with Dr Geoghegan and had contacted the Trusts. From responses received to date (BT and WT is awaited), bundle insertion, which is national, is ongoing and appears to be strictly adhered to. It was noted that whilst ongoing care is done frequently, perhaps this should go on to maintenance of daily care.</p> <p>Dr McCall to check practice in England</p> | Regional SAI Review Group |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>and advise.</p> <p>Action: Dr McCall</p> <p>Review February 2017</p> <p>Update 20 March 2017 – Response has been received from NHS Improvement England and shared with Dr McClean who is to consider the format of regional learning – possibly an article for Learning Matters.</p> <p>Action: Dr McClean</p> <p>Review April 2017</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting</p> <p>Update 10 May 2017: CLOSE based on the information provided including the engagement checklist <u>with regional learning identified</u>. Dr McClean (DRO) in conjunction with Siobhan Donald and Mary McElroy will complete an article for Learning Matters in relation to ongoing care.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Dr McCall will liaise with Dr Lavery if the issues raised in this SAI are applicable in ICU and feedback to the Dr McClean.</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article.</p> <p>Dr McClean will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McClean (DRO), Mary McElroy, Siobhan Donald, Elaine Hamilton, Governance Team</p> | |
| | | Personal Information redacted by the USI | Dr J McClean | | Y | y | <p>FIRST REVIEW 21 November 2016– Further Information Required – Dr Farrell raised a number of queries which are to be forwarded to the Trust for response. Response when received from SHSCT it is to be shared with Dr Farrell and Dr McClean for review.</p> <p>Action: Governance Team</p> <p>Further Professional Input: M</p> | Review 9 June 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Campbell to follow up with Integrated Care (Dr M Dowds) regarding shared care scheme with GP.</p> <p>Action: M Campbell</p> <p>Review January 2017</p> <p>Update 16 January 2017 – A response from the Trust to queries raised remains outstanding. With regards to Dr Dowds query it was clarified the Shared Care Scheme refers to Lithium LES. M Campbell to advise Dr Dowds.</p> <p>Action: M Campbell</p> <p>Review February 2017</p> <p>Update 20 March 2017 – A response from the Trust to queries raised remains outstanding. Governance Team continue to follow up.</p> <p>Action: Governance Team</p> <p>With regards the prescribing of lithium via a Shared Care Scheme, the GP</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>practice has advised that this patient was not prescribed Lithium under a Shared Care Scheme.</p> <p>RCA report to be shared with Angela Carrington to consider.</p> <p>Southern Trust to be advised that this patient wasn't prescribed lithium under shared care scheme. This would imply the Trust was responsible for monitoring lithium – Trust to be asked to provide comment on this.</p> <p>Action: M Campbell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> | |
| | | Personal Information redacted by the USI | Dr J McClean | DRO has query with membership of Review Group | N | N | FIRST REVIEW 21 November 2016 REVIEW TEAM MEMBERSHIP – The DRO has requested that a Vascular Surgeon is involved in the Review Team. The Trust has advised that the | Review at a future meeting when RCA report is |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>SAI is in relation to an aortic aneurysm (arterial). The Trust has vascular surgeons but not arterial surgeons and feel it would not be appropriate to include them in the SAI Group.</p> <p>Governance Team to advise Trust the DRO is content with Terms of Reference and Team Membership.</p> <p>Action: Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives RCA report.</p> | received |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 21 November 2016 | 6 | <p>Never Events - Circular HSC (SQSD) 56/16</p> <p>Members noted the DoH had issued Circular HSC (SQSD) 56/16 – The Introduction of a Never Events list on 21 October 2016.</p> <p>With regards SAI B8532 which had been identified as a Never Event at the October</p> | |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | meeting, Mary McElroy undertook to seek clarity from SAI Review Sub-Group as to whether this SAI should be recorded as a Never Event. | Mary McElroy |
| 21 November 2016 | 9.3 | <p>SHSCT ED Related SAIs</p> <p>It was noted that three SAIs discussed earlier in the meeting related to patients attending SHSCT Emergency Departments with abdominal pain (Personal Information redacted b [redacted] and [redacted] Personal Inform[redacted]). It was agreed M Campbell would undertake a search on Datix to identify any other similar SAIs and put together a timeline for discussion between Dr McClean, Dr Farrell and SHSCT Medical Director at a meeting on 30 January 2017.</p> <p>Action: M Campbell</p> <p>Review February 2017</p> <p>Update 10 May 2017: DRO not present. Defer to June Meeting</p> | <p>Review at June meeting</p> <p>M Campbell</p> |

Comment [EH3]: What is happening with this action? Speak to Mary

Comment [EH4]: Bring to Meeting with Joanne/Brid

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 17 OCTOBER 2016

Date: 17 October 2016

Lead Officers: Dr Brid Farrell, Dr Christine McMaster, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies:

In attendance: Dr Ruth-Ann Thornbury (ADEPT Fellow, Safety Forum), Dr Judith Ewing (Public Health SpR), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr J McCall | | Y | Y | <p>FIRST REVIEW 17 October 2016– DRO advised that this SAI had been listed due to the inadequate SEA report received. It is not clear from the SEA report the main and underlying reasons contributing to why the event happened.</p> <p>DRO to draft an email for HSCB Governance Team to forward to SET advising Acute Review Team not happy with the report and requesting an amended SEA report.</p> <p>Action: Dr J McCall and Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives amended</p> | <p>Review at 19 June Meeting</p> <p>Included in Delayed Diagnosis Scoping Exercise</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>SEA report.</p> <p>Update 10 May 2017: FURTHER ADVICE REQUIRED. Dr McCall will liaise with Lisa McWilliams PMSI in relation to the recommendations.</p> <p>This SAI will be included in the Scoping Exercise on delayed diagnosis.</p> <p>Action: Dr McCall</p> <p>Review at 19 June meeting</p> | |

Date: 23 September 2016

Lead Officers: Dr Brid Farrell, Dr Christine McMaster, Dr Muhammad Sartaj, Siobhan Donald (on behalf of Mary McElroy)

Apologies: Dr Joanne McClean, Dr Jackie McCall, Mrs Mary McElroy, Dr Miriam McCarthy

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | Dr J McClean | For discussion | Y | Y | FIRST REVIEW 23 September 2016 – DRO not present but an update had | Review June 2017 |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3m | | | | | | <p>been provided. However in light of further comments received from Dr O'Hagan today, it was agreed the DRO should be given a chance to consider these and the SAI would be re-listed for review at the next meeting.</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Further professional input required – SEA Report to be shared with the Mental Health SAI Review Team to review and consider any regional learning.</p> <p>Action: Governance Team</p> <p>Review November 2016</p> <p>Update 21 November 2016 – The SEA report has been shared with the Mental Health Review Team and will be considered at their next meeting in January 2017.</p> <p>Review February 2017</p> <p>Update 20 March 2017 – Governance Team to follow up with DRO to</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>ascertain if any further information is required from Mental Health Team. DRO not present. Defer to next meeting.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED DRO not present – defer to next meeting</p> <p>Review June 2017</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 AUGUST 2016

Date: 22 August 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Jackie McCall, Dr Christine McMaster, Mrs Mary McElroy

Apologies: Dr Joanne McClean, Dr Muhammad Sartaj

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Personal Information redacted by the USI | | | | | | | |
| | | Dr J McCall | | Y | Y | <p>FIRST REVIEW 22 August 2016– Further information requested – Governance Team to ask Trust to advise on the outcome of Coroner’s review of the RCA report and whether an inquest will be held in respect of this case.</p> <p>Action: Governance Team</p> <p>Review November 2016</p> <p>Update 21 November 2016 – SET have advised that the Coroner’s office have confirmed that this case was closed in August 2016 without an Inquest.</p> <p>DRO to speak to Angela Carrington about the issue of needing to adjust paracetamol dose for patients of low weight and to see if this learning has already been circulated in Medsafe newsletter or if there are plans to do so.</p> <p>Action: Dr J McCall</p> <p>Review December 2016 - Dr McCall advised that she had discussed the SAI</p> | <p>CLOSE</p> <p>Reminder of Best Practice Letter</p> <p>SAI Learning Event</p> <p>Refer to Regional SAI Review Team Meeting</p> |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>with Angela Carrington. It was felt there was Regional Learning in respect of IV paracetamol. Angela Carrington to review AIs and SAs reported to determine the learning points – upon initial review there is potential for a learning letter requesting action and seeking assurances.</p> <p>Action: Dr J McCall/Angela Carrington</p> <p>It was noted that family raised concerns about staff attitude to patient – similar issues reported in Personal Information re</p> <p>This SAI was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – It was noted that NHS England will not be issuing a PSA about IV Paracetamol but there are changes being made to BNF about weight and documentation. Discussions are ongoing regarding the Regional Learning.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Review April 2017</p> <p>Update 19 April 2017 – Dr McCall to speak to Angela Carrington. Defer to 10 May meeting.</p> <p>Action: Dr McCall</p> <p>Review May meeting</p> <p>Update 10 May 2017: CLOSE based on the information provided including the engagement checklist <u>with regional learning identified.</u></p> <p>DRO (Dr McCall) discussed the SAI with Angela Carrington and they recommended a reminder of best practice letter on all IV paracetamol incidents.</p> <p>This SAI will be brought to the SAI Learning Event 23 May 2017</p> <p>DRO will forward completed Remedial Causes and Learning Lessons template in relation to this SAI to Elaine Hamilton</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | Refer to Regional SAI Review Team Meeting to note Reminder of Best Practice Letter Action: Dr McCall | |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 22 August 2016 | | <p>(iii) Key Words With regards the surveillance of SAIs to identify patterns/clusters/trends, it was agreed to consider the identification of key words. Mary to provide a list of key words for discussion at the October meeting.</p> <p>Action: Mary McElroy</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Mary McElroy advised she had obtained a list of key words compiled and used by Mental Health and Learning Disability Teams and undertook to share with the group. Mary and Mareth to produce a list of key words identified to date by the Acute Team and circulate for review at the November meeting. Dr McCall to check with other countries if they have a list of key words.</p> <p>Review November 2016</p> | <p>Review November 2016</p> <p>Mary McElroy</p> <p>Mary McElroy</p> <p>Mary McElroy/Mareth Campbell</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Update 21 November 2016 – Members considered the list of key words identified by the Acute Team since April 2016 along with the key words identified and used by the Mental Health and Learning Disability Teams. To be further reviewed at the December meeting when list of key words from NHS England is available.</p> <p>Review December 2016</p> <p>Update 19 December 2016 – Members considered the list of incident types provided by NHS England Clinical Incident review process circulated with the papers. Dr McCall is awaiting a further list from Julian Johnston which is used at Mortality and Morbidity reviews in Trusts. It was agreed a few officers would meet to consider all lists with a view to compiling a list of key words for the acute team.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Members considered the list of learning lesson categorisations used at Mortality and Morbidity meetings. Dr McCall advised she would share the list with Lynne Charlton, Mary McElroy and Jacqui Burns. She is meeting with them to review this and NHS England classification and identify key words which in turn could be used to identify key themes.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – It has been agreed that in order to ‘theme SAls’ the Acute SAI Group would consider the Learning Lessons and DATIX remedial causes categorisations when closing SAls. This will run as a pilot.</p> | <p>Review December 2016</p> <p>Review February 2017</p> <p>Review September 2017</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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Date: 18 July 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy (via teleconference)

Apologies: Dr Jackie McCall

In attendance: Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
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All Actions completed from 18 July 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 JUNE 2016

Date: 20 June 2016

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Christine McMaster

Apologies: Dr Joanne McClean

In attendance: Jenny Keane, Mareth Campbell

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 23 MAY 2016

Date: 23 May 2016

Lead Officers: Dr Janet Little, Dr Jackie McCall, Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Paul Darragh, Mrs Mary McElroy, Dr Brid Farrell

Apologies: Siobhan McIntyre

In attendance: Mrs Eleanor Ross, Mrs Siobhan Donald, Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 APRIL 2016

Date: 18 April 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Jackie McCall, Dr Muhammad Sartaj

Apologies: Dr Janet Little

In attendance: Mrs Elaine Hamilton, Mrs Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Date | Agenda Item | Action Agreed | Person Responsible | Status |
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| 18 April 2016 | 7 | <p>Any Other Business</p> <p>(i) Safety Forum – Learning Event Jackie McCall advised members the Safety Forum are commencing plans for the next regional Learning Event for 2016/17. Jackie requested for DROs to highlight any suitable SAIs that could be used for learning at the event. 'Good Standard of Report' is a key word which is captured on Datix and it was agreed DROs will use this if they deem an SAI appropriate for use at the event. This item will be added onto the agenda for each Acute meeting to remind DROs.</p> <p>Update 23 May 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 20 June 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 18 July 2016 - Members agreed to identify three anticoagulant drug related SAIs to showcase at the Learning Event. It was agreed these could be identified during the review being undertaken by Dr Jackie McCall.</p> <p>Update 22 August 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 23 September 2016 – SAI SHSCT SAI [Personal Information redacted by] was highlighted as a SAI that could be used at the learning event.</p> <p>Update 17 October 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 21 November 2016 – SAI [Personal Inform] – SHSCT SAI [Personal Inform] was</p> | <p>All members/Mareth Campbell</p> <p>Dr Jackie McCall</p> | <p>To be a reviewed at each meeting of Acute SAI Review Team</p> |
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| | | <p>highlighted as a SAI that could be considered for the Regional Learning Event.</p> <p>Update 19 December 2016 - SAI (Personal Information redacted by the USI) was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Update 16 January 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) – showing patient journey ○ SHSCT SAI (Personal Information redacted by the USI) <p>Update 9 March 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) ○ (Personal Information redacted by the USI) <p>Update 20 March 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 19 April 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 10 May 2017: (Personal Information redacted by the USI) will be considered for a future SAI Learning Event.</p> | | |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 MARCH 2016

Date: 21 March 2016

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Paul Darragh (Via teleconference)

Apologies: Dr Jackie McCall, Mrs Mary McElroy

In attendance: Mrs Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 15 FEBRUARY 2016

Date: 15 February 2016

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Paul Darragh, Mrs Mary McElroy (via teleconference)

Apologies: Dr Muhammad Sartaj, Dr Jackie McCall

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 14 JANUARY 2016

Date: 14 January 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Muhammad Sartaj, Mrs Mary McElroy (via teleconference)

Apologies: Dr Janet Little, Dr Jackie McCall

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 14 January 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 DECEMBER 2015

Date: 22 December 2015

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Jackie McCall

Apologies: Dr Muhammad Sartaj, Dr Paul Darragh,

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 22 December 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 24 NOVEMBER 2015

Date: 24 November 2015

Lead Officers: Dr Janet Little (Chair), Dr Muhammad Sartaj, Dr Miriam McCarthy

Apologies: Dr Paul Darragh, Mrs Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Jackie McCall, Paul Kavanagh

In attendance: Elaine Hamilton

All Actions completed from 19 October 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 September 2015

Date: 21 September 2015

Lead Officers: Dr Paul Darragh (Chair), Dr Catherine Coyle, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Jackie McCall, Dr Louise Herron
(Personal Information redacted by the USI))

Apologies: Janet Little, Miriam McCarthy

In attendance: Paul Kavanagh, Elaine Hamilton

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 September 2015

Date: 21 September 2015

Lead Officers: Dr Paul Darragh (Chair), Dr Catherine Coyle, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Jackie McCall, Dr Louise Herron
 (Personal Information redacted by the USI))

Apologies: Janet Little, Miriam McCarthy

In attendance: Paul Kavanagh, Elaine Hamilton

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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 August 2015

Date: 18 August 2015

Lead Officers: Dr Paul Darragh (Chair), Mrs Mary McElroy (via teleconference), Dr Muhammad Sartaj, Dr Louise Herron (for SA [irrelevant information] Dr

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 18 August 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 JULY 2015

Date: 21 JULY 2015

Lead Officers: Dr Janet Little (Chair), Dr Paul Darragh, Mrs Mary McElroy (via teleconference),

Apologies: Dr Muhammad Sartaj, Dr Louise Herron, Dr Jackie McCall, Dr Miriam McCarthy

In attendance: Margaret McNally obo Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 21 July 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 15 JUNE 2015

Date: 15 June 2015

Lead Officers: Dr Janet Little (Chair), Dr Paul Darragh, Dr Muhammad Sartaj, Mrs Mary McElroy (via teleconference), Dr Louise Herron, Dr Jackie McCall

Apologies: Dr Miriam McCarthy

In attendance: Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – 21 MAY 2015 – ALL ACTION COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – 22 APRIL 2015- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – 16 MARCH 2015- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 FEBRUARY 2015

Date: 16 FEBRUARY 2015

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Paul Darragh, Mary McElroy

Apologies: Louise Herron, Muhammad Sartaj, Jackie McCall

In attendance: Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 16 February 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING - 12 JANUARY 2015 - ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING - : 07 November 2014- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 28 OCTOBER 2014

Date: 28 October 2014

Lead Officers: Dr Miriam McCarthy, Dr Paul Darragh, Dr Louise Herron, Dr Muhammad Sartaj, Mrs Mary McElroy

Apologies: Dr Janet Little, Mrs Jacqui Burns

In attendance: Mrs Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Personal Information redacted by the USI | | Dr B Farrell | The inquest into this case opened on 28th January and was adjourned by the Coroner The Coroner has asked the Trust to undertake a number of actions and Trust are currently working through these and updating the action plan as part | y | n/a | FIRST REVIEW 28 October 2014: Further Information: The family and DRO were not content with the first report and an amended report has now been received from WHSCT and they have advised 4 independent reports from experts reviewing the aspects of care will be submitted as appendices to the report. Two of these reports have been received. | Review June 2017 |
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| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | of that process and the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner. | | | <p>DRO is awaiting the final two reports and input from the coroner in Manchester</p> <p>It was noted there is a delay due to difficulty obtaining an independent report regarding the GP and Community Nursing aspect.</p> <p>It was agreed Governance Team will request two remaining reports from Western Trust and copy email to DRO.</p> <p>Relist for December meeting</p> <p>Action: Governance Team / E Hamilton</p> <p>Ask trust to ensure we get two additional reports!</p> <p>UPDATE 12 JANUARY 2015:</p> <p>FURTHER INFORMATION REQUIRED: There was a delay with the GP report but DRO advised GP and Intensive Care Report will be issued in the near future. There is still no date agreed for Coroner to proceed with the inquest.</p> <p>DRO will request recommendations in the investigation report to be reviewed following submission of all reports.</p> <p>It was agreed this item will remain on the agenda for review.</p> <p>ACTION: GOVERNANCE TEAM</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p><i>Review at February meeting</i></p> <p>Update 16 February 2015: FURTHER INFORMATION REQUIRED Still awaiting a report on intensive care treatment. GP report is imminent and will soon be with Trust.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Relist for March meeting</i></p> <p>Update 16 March 2015: The GP report is currently being compiled. ICU report has been submitted.</p> <p>It was agreed due to the complexities of this SAI Paul will provide an update to Dr Carolyn Harper.</p> <p>Relist for April meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 21 May 2015: DRO has been liaising with Dr McKinney Medical Director in the Trust regarding this SAI. DRO Will provide an update to Dr Harper.</p> <p>Relist for June meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 15 June 2015: DRO has received a verbal update from Therese Brown WHSCT. Dr Harper has been advised.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Relist for July meeting</p> <p>ACTION: Governance Team</p> <p>Update 21 July 2015: It was noted a Coroner's Report from Manchester was awaited. The status of this would be reviewed at the next meeting.</p> <p>ACTION: Governance Team</p> <p>Update 18 August 2015: : <u>FURTHER INFORMATION REQUIRED</u> – Members agreed an email would be sent from the HSCB Governance Team to the Trust for the attention of the Medical Director on behalf of the DRO stating the following:</p> <p><i>'Can the Trust please provide an updated final report by 30 October 2015 to incorporate the findings of the original review and the independent reports commissioned over recent months.</i></p> <p><i>The updated report would be expected to provide the findings, recommendations and a tracking and monitoring report on the actions taken to address the recommendations of the various reports.'</i></p> <p>ACTION: Governance Team</p> <p><u>Update 24 November 2015:</u> DRO had a telecom with Dr A McKinney and T Brown with Lourda Geoghegan and Mary McElroy to discuss progress.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Trust action plan has been reviewed and a series of responses have been prepared in respect of all the products of the original report and the speciality reports. DRO awaiting the comments back from Lourda and Mary to our combined response. Once agreed DRO will issue to Trust (via SAls) our overall comments. It is understood this case will be considered by the Manchester Coroner within the next few months.</p> <p>ACTION: DRO (Paul Darragh)</p> <p>Review December Meeting</p> <p>Update 22 December 2015: <u>DEFERRED</u>. DRO not present at meeting.</p> <p>Relist January Meeting</p> <p>Action: Governance Team</p> <p>Update 14 January 2016: <u>FURTHER INFORMATION REQUIRED</u> This SAI was discussed at a recent SHSCG meeting at DHSSPS. Therese Brown advised at the meeting this SAI may be used in the upcoming SAI Event. DRO noted no date has been set for the Manchester Coroner to review the case.</p> <p>Relist for March 2016</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Action: Governance Team</p> <p>Update 21 March 2016: <u>FURTHER INFORMATION REQUIRED</u> The inquest into this case opened on 28th January and was adjourned by the Coroner.</p> <p>The Coroner has asked the Trust to undertake a number of actions and the Trust is currently working through these and updating the action plan and as part of that process the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner.</p> <p>Governance Team to ascertain if there is a timeframe for the response to be submitted to the Coroner? If no timeframe has been specified the response to outstanding HSCB queries should be requested within a two month timeframe.</p> <p>Relist for May 2016</p> <p>Action: Governance Team</p> <p>Update 23 May 2016: A response from the Trust regarding the timeframe to respond to the Coroner remains outstanding. However, it was noted the Coroner's Inquest shouldn't delay any learning. DRO advised Dr L Geoghegan continues to be involved with Mary McElroy concerning issues around cross infection, nursing and community</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>nursing. Dr Geoghegan and Mary McElroy to meet with Dr Farrell to discuss. Dr Farrell to share feedback with the Trust.</p> <p>Action: Dr B Farrell</p> <p>Relist for August 2016</p> <p>Update 18 July 2016 – Dr Farrell to arrange a further meeting with Mary McElroy and Dr Geoghegan.</p> <p>Action: Dr B Farrell</p> <p>Review September 2016</p> <p>Update 23 September 2016 - Dr Farrell advised that she had met with Mary McElroy and Dr Geoghegan. An updated Action Plan was received from the Trust on 22 August 2016. DRO content with Action Plan, however wishes to clarify access to community microbiology advice as the RCA report is ambiguous about this. Dr Farrell undertook to raise this with the Pathology Network.</p> <p>Review November meeting.</p> <p>Update 19 December 2016 – Dr Farrell to raise this with the Pathology Network.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Review January 2017</p> <p>Update 16 January 2017 – Defer to February 2017 meeting.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – Defer to 20 March 2017 meeting.</p> <p>Review March 2017</p> <p>Update 20 March 2017 – Dr Farrell advised a response has been received from the Pathology Network and undertook to share the response with Mary McElroy. However, the response doesn't accurately address the query therefore a revised query is to be submitted to the Pathology Network.</p> <p>Action: Dr Farrell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED. SAI Deferred to next meeting</p> <p>Review June 2017</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING - 16 SEPTEMBER 2014- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 5 AUGUST 2014

Date: 5 August 2014

Lead Officers: Janet Little, Louise Heron, Paul Darragh, Miriam McCarthy, Paul Darragh, Caroline McGeary (for item Personal Information redacted by the USI),
Muhammad Sartaj

In attendance: Jacqui Burns

ACUTE SERVICES SAI REVIEW TEAM MEETING – 8 JULY 2014 ALL ACTIONS COMPLETED

ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 6 JUNE 2017

Date: 6 MAY 2017

Lead Officers: Dr Brid Farrell (chair), Dr Joanne McClean

Apologies:

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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No new agenda items were discussed at this meeting

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 MAY 2017

Date: 10 MAY 2017

Lead Officers: Dr Brid Farrell (chair), Siobhan Donnell, Dr McMaster, Eleanor Ross, Dr Jackie McCall, Mary McElroy (via teleconference)

Apologies: Dr Louise Herron, Dr Miriam McCarthy, Dr Joanne McClean

In attendance: Mareth Campbell, Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 4a | Personal Information redacted by the USI | | Dr J McClean | | Y | Y plan to share report | First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting. | Review July 2017 |
| | | | | | | | Review June 2017 | |
| | | | | | | | Update 6 June 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Dr McClean has requested input/comments from Dr Corrigan. Dr Farrell will raise the issue of seeking clinical advice on SAIs at a staff meeting. | |
| | | | | | | | Review July 2017 | |
| | Personal Information redacted by the USI | | | | | | Action: Dr Farrell / Dr McClean | |
| 4c | Personal Information redacted by the USI | | Dr J McClean | | Y | Y plan to share report | First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points: <ul style="list-style-type: none">Request further clarification on | Review when response has been received from Trust |

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| | | | | | | | <p>who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.</p> <ul style="list-style-type: none"> The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> | |
| 4d | Personal Information redacted by the USI | | Dr J McClean | | Y | Y plan to share report | <p><u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> | Review when response received from Trust |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email SHSCT with the following points:</p> <ul style="list-style-type: none"> • Can the Trust advise what awareness sessions have been provided in relation to Sepsis following this incident. • Can the Trust advise on progress towards recommendation 3 – implementing the 'Sepsis 6 Bundle' • Seek clarification from the Trust on what protocol is used for communicating positive blood cultures results. <p>DRO noted there was the following errors in this case:</p> <ul style="list-style-type: none"> • Failure to recognise sepsis. • Deteriorating patient not recognised. • Escalation of deteriorating | |

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| | | | | | | | <p>patient.</p> <ul style="list-style-type: none"> Recording error of information from lab and conveying of information. Results were mixed up. <p>Dr McClean will liaise with Dr McCall on the regional work which is ongoing with Sepsis</p> <p>Action: Governance Team / Dr McClean</p> <p>Review when response received from Trust</p> | |
| 4f | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | <p><u>First Review 10 May 2017: Further Information Required.</u></p> <ul style="list-style-type: none"> Dr McCall (DRO) advised SET are considering development of a Jump Policy. Dr McCall will request a copy when it's completed. Dr McCall to share report with Catherine Coyle in respect of transfers to interventional | <p>Review at meeting July 2017</p> <p>SAI to be considered for a future SAI Learning Event</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>radiology.</p> <ul style="list-style-type: none"> • Dr McCall to request protocol for contingency plan for interventional radiologist in SET • Dr McCall to request guidelines from Radiology Network on timing of CTPA investigations in diagnosis of PE • Dr Farrell to Share Stroke Thrombectomy pathway with Dr McCall <p>It was agreed there are a number of regional learning points from this incident to be considered:</p> <ul style="list-style-type: none"> • Quicker recognition of patient bleeding and resuscitation • Learning from Human factors <p>This SAI will be considered for SAI learning Event in the future.</p> <p>Action: Dr McCall / Dr Farrell / Governance Team</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | Review July 2017 | |
| 6a | Personal Information redacted by the USI | | Dr M McCarthy | SAI has not been received. Does DRO require further information? | n/a | n/a | First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 | Review at meeting 9 June 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 APRIL 2017

Date: 19 April 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Dr Muhammad Sartaj, Mrs Eleanor Ross

Apologies: Mrs Mary McElroy, Dr Joanne McClean, Dr Louise Herron

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 4a | | | Dr M McCarthy | | Y | Y | FIRST REVIEW 19 April 2017 – Include in Scoping Exercise – Following review it was agreed there is regional learning around delayed diagnosis with the learning highlighting high level messages that are applicable. It was agreed to include this SAI in the | Review June 2017 To be included in in delayed diagnosis |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | scoping exercise to be undertaken by Dr McCall in relation to delayed diagnosis. Following the scoping exercise, Dr McCall and Dr McCarthy to meet to review. Action Dr McCall / Dr McCarthy Review June 2017 | scoping exercise |
| | Personal Information redacted by the USI | | | | | | | |
| 4d | | | S Donald | | Y | Y | FIRST REVIEW 19 April 2017 – Further Professional Advice Required – It was agreed to share the SEA report and all related correspondence with Dr Sartaj to review and provide a medical opinion. Review June 2017 Action: M Campbell | Review June 2017 |
| | Personal Information redacted by the USI | | | | | | | |
| 4g | | | Dr C McMaster | Trust notified SAI as a level 1. This was followed up by an amended notification form advising that the SAI had changed to a level 2. As the Trust | N | N | FIRST REVIEW 19 April 2017: Change of Level of Review – M Campbell advised that she had contacted the NHSCT asking that they advise of the reason for changing the level of investigation. A response is awaited. | Review when Report is received |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | hadn't provided a rationale for changing the level, the DRO asked that the SAI be listed for discussion. | | | <p>Members referenced the Thematic Review on Choking currently being undertaken by Mary McElroy and asked that this SAI is considered in the review.</p> <p>Action: M Campbell</p> <p>Review May 2017</p> <p>Update 10 May 2017: This SAI won't be included in the Choking Thematic Review as the Report hasn't been received but it will be considered in terms of themes for the review.</p> <p>The DRO had a telephone conversation with Trust Governance staff as the cause of the incident was not included in the TOR but DRO was advised the Report has been completed and will be shared with HSCB/PHA in the near future. Therefore the DRO feels approval of TOR is not required/appropriate.</p> <p>Review when report is received.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 6 | | | Dr C McMaster | Listed for discussion to determine if there is learning | | | <p>Early Alert is linked to Personal Information redacted by the USI which was closed on 10 April 2014. The Early Alert received was advising that the case had been listed for hearing for two days on 23 and 24 February 2017.</p> <p>M Campbell to check if any learning was disseminated in 2014 and in particular around the European Guidelines referenced in the Coroner's report.</p> <p>Action: M Campbell</p> <p>Update 10 May 2017: The Trust has submitted an updated Action Plan (November 2016). The action plan refers to a Policy 'Ascites Management Guidelines for Liver Cirrhosis' Personal Information redacted by the USI which is in place and used.</p> <p>The Trusts Governance Department are currently carrying out a piece of work around learning and themes from inquests that were before the Coroner in the first quarter of this year - this</p> | Review June 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>case is included. These workings are due to be discussed at their Clinical Governance Steering Group meeting on 11 May 2017 and an update will be provided following the meeting.</p> <p>Trust Governance Department will confirm if any learning was disseminated in 2014.</p> <p>Action: Elaine Hamilton</p> <p>Review June 2017</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 MARCH 2017

Date: 20 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster, Dr Muhammad Sartaj, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

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| | Personal Information redacted by the USI | | | | | | | |
| 3a | | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017 – Further Information Required - The summary of events doesn't indicate the likely reason for the cardiac arrest. BHSCT to be asked to provide more information on any factors relating to anaesthetic and/or medications administered which may have been a contributory factor.</p> <p>BHSCT also to be asked to provide further detail on why they haven't shared the SEA Report with the family to date.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 – DRO query has been forwarded to the Trust. Governance Team to follow up and SAI to be reviewed at a future meeting when response is received.</p> <p>Action: Governance Team</p> | REVIEW AT A FUTURE MEETING WHEN RESPONSE IS RECEIVED FROM TRUST |
| | Personal Information redacted by the USI | | Dr M McCarthy | | | | FIRST REVIEW 20 March 2017 - CLOSE based on the information provided | Pending Closure – |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>including the engagement checklist, with <u>Regional Learning identified</u>.</p> <p>Action: Governance Team</p> <p>Refer to SAI Sub-Group to note an article in Learning Matters newsletter</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p><u>Postscript:</u> There is a similar SAI (Personal Information redacted by the USI) in the Older People programme of care and the learning from both SAIs should be linked. David Petticrew to be contacted.</p> <p>Action: M Campbell</p> <p>Members also considered the Shared Learning proforma from BHSCT in relation to loose fitting dentures. It was agreed there is regional learning as outlined above (article in Learning Matters). The group disagreed with the learning point that the Commissioner should consider making</p> | <p>view from Michael Donaldson</p> <p>Refer to SAI Review Sub-Group</p> |

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| | | | | | | | <p>all dentures radio opaque. Michael Donaldson to be contacted for an opinion.</p> <p>Action: M Campbell</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 1.2, 1.3 and 1.4 Action: Governance Team Learning Lessons Categorisation – 1 Action: M Campbell | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr M McCarthy | | | | <p>FIRST REVIEW 20 March 2017– Further Information Required – Trust to be asked to forward</p> <ul style="list-style-type: none"> A copy of Standardised Operating Procedure (SOP) for validation process A copy of Standardised Operating Procedure (SOP) for monitoring and tracking of investigations. An update on recommendation 5 – the reference to cease ‘green notes’ system. <p>Action: Governance Team</p> | Review June 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | Review June 2017 | |
| 3b | | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017– DRO not present. Defer to next meeting. However it was noted there are significant nursing issues.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 - SEA report has been shared with Eleanor Ross for nursing view. DRO not present – defer to next meeting.</p> <p>Review May 2017</p> <p>Update 10 May 2017: Further Professional Input Required. Dr McClean (DRO) will liaise with Siobhan Donald and Angela Carrington as regional learning was identified in respect of omitted medicines and delay in medicines in nursing/pharmacy.</p> <p>Review July 2017</p> <p>Action: Dr McClean (DRO), Siobhan Donald and Angela Carrington</p> | <p>Review July 2017</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article</p> |

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| | | | | | | | <p>Update 6 June 2017: Dr McClean will compile an article for Learning Matters. E Hamilton to seek views from Siobhan Donald and Angela Carrington if they have any additional action to be taken in relation to prescribing and nursing issues.</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article</p> <p>Action Dr McClean / Elaine Hamilton</p> <p>Review July 2017</p> | |
| 3c | Personal Information redacted by the USI | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – Dr McCall to highlight this SAI to Sepsis Collaborative run by Safety Forum.</p> <p>Action: Dr McCall</p> <p>DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting.</p> | Review July 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Update 10 May 2017: Dr McCall has highlighted this SAI to the Safety Forum. It was agreed there is regional learning from this SAI – possibly a learning matters article but will be discussed further when DRO is present.</p> <p>Relist for June Meeting</p> <p>Update 6 June 2017: It was agreed a learning matters article is not appropriate for this incident as there is more work required on a regional basis regarding Sepsis.</p> <p>It was agreed Dr McClean will liaise with Dr McCall regarding regional work for sepsis – possibly introduction of sepsis bundles. More work needs to be carried out in relation to early recognition and management of sepsis.</p> <p>It was noted there is NICE sepsis guidance.</p> <p>Action Dr McClean Review July 2017</p> | |

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| 3d | | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Review 19 April 2017 - DRO not present – defer to next meeting.</p> <p>Update 10 May 2017: DEFERRED DRO not present. Defer to next meeting.</p> <p>Review 9 June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. DRO requested Governance Team to email the Trust with the following point:</p> <ul style="list-style-type: none"> Trust to give consideration of an electronic referral form preferably the white board system to be available on all wards, between specialities and in ED rather than paper based systems. <p>DRO noted the following concerns: Failure to recognise the deteriorating</p> | Review July 2017 |

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| | | | | | | | <p>patient and failure to escalate</p> <p>Action: Governance Team</p> <p>Review July 2017</p> | |
| | Personal Information redacted by the USI | | | | | | | |
| 3e | | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Review 19 April 2017 - DRO not present – defer to next meeting.</p> <p>Update 10 May 2017: DEFERRED DRO not present. Defer to next meeting.</p> <p>Review 9 June 2017</p> <p>Update 6 June 2017: CLOSE based on the information provided including the engagement checklist. No regional learning identified. Refer to Regional SAI Review Group to note referral to Radiology Network</p> <p>Dr McClean will forward remedial causes and learning lessons template</p> | <p>CLOSE</p> <p>Refer to Regional SAI Review Group to note referral to Radiology Network</p> |

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| | | | | | | | to Elaine Hamilton. Action: Dr McClean / E Hamilton | |
| | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | FIRST REVIEW 20 March 2017 – <u>Further Input</u> - Patient lost to follow up. DRO referenced a similar SAI where the patient wasn't followed up in a timely manner. Both SAIs to be highlighted to the LCG but in the first instance, DRO to speak to Lisa McWilliams (PMSI) regarding endoscopy waiting lists and patients not being prioritised appropriately. A search to be undertaken on Datix for linked cases to look at demand/capacity gap. Review in 3 months. Action: Dr McCall/M Campbell Review June 2017 | Review June 2017 |
| | Personal Information redacted by the USI | | Dr M McCarthy | | Y | Y | FIRST REVIEW 20 March 2017 - CLOSE based on the information provided including the engagement checklist, with <u>Regional Learning identified</u> around the correct use of | Awaiting feedback from Diabetic Foot Team |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>anticoagulants, lack of co-ordination of care and the need for early referral to multi-specialist team/service. Mary McElroy to refer SAI to Geraldine Teague for consideration of regional learning by the Diabetic Foot Team.</p> <p>Action: Governance Team Mary McElroy</p> <p>Refer to SAI Review Sub-Group to note referral to Improving Management of Warfarin, NOACs and Antiplatelets Action Group led by Lynne Charlton, the Diabetic Foot Team and to note an article for Learning Matters (Dr McCall agreed to prepare the article when required).</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 3.3 Action: Governance Team Learning Lessons Categorisation – 1 and 5 Action: M Campbell | <p>prior to closure</p> <p>Refer to SAI Review Sub-Group</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 5a | Personal Information redacted by the USI | | Dr M McCarthy | Shared Learning linked to Personal Informa | N | N | <p>FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Members noted the SEA report had not been received and agreed to consider the shared learning when the SEA Report is received.</p> <p>Review Shared Learning at a future meeting when SEA Report is received.</p> | REVIEW SHARED LEARNING WHEN SEA REPORT IS RECEIVED |
| 5b | | | | | | | <p>FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Members noted this issue had been addressed</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>by Medical Directors and agreed no further action was required.</p> <p>Post Script – On review of the Datix record, Shared Learning SL [irrelevant info] related to tests being requested from another healthcare provider/service. The issue addressed by Medical Directors related to Employment of New/Locum Medical Staff (SL [irrelevant info]). BHSCT have confirmed that both Shared Learning reports are linked to SAI Personal Information redacted by the USI</p> <p>Review Shared Learning Proforma SL9933 at May meeting.</p> <p>Update 10 May 2017: Further Information Required: Governance Team to seek confirmation from Dr O'Brien (Integrated Care) if a LES for phlebotomy was in place in the GP practice?</p> <p>Action: Governance Team</p> <p>Review at June meeting.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 5c | Personal Information redacted by the USI | | Dr M McCarthy | Shared Learning linked to <small>Personal Information</small> closed on 22 August 2016. | | | <p>FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Dr McCarthy to review RCA Report alongside Shared Learning proforma to determine if there is regional learning. As Dr McCarthy is not available for May meeting, review at June meeting.</p> <p>Review June meeting</p> | Review June 2017 |
| 3f | Personal Information redacted by the USI | | Dr M McCarthy | | | | <p>FIRST REVIEW 20 March 2017: EARLY ALERT – DRO had listed Early Alert for discussion following response from Trust advising they were not intending to report this incident as a SAI. Following discussion, it was agreed to inform the Trust that the Acute SAI Review Team considered there may be wider learning including learning on central alerting systems and in that regard would be grateful if the Trust</p> | REVIEW AT A FUTURE MEETING WHEN RESPONSE IS RECEIVED |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>would submit a SAI Level 1.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 – Trust have been requested to submit a SAI notification form. A response is awaited. Governance Team to follow up.</p> <p>Action: Governance Team</p> <p>Review at a future meeting when response is received from BHSCT.</p> | |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 20 March 2017 | 9 3p | <p>Feedback from DRO Workshops – Discussion deferred to next meeting.</p> <p>Update 19 April 2017 - DRO Protocol – DROs to discuss DRO Protocol at a staff meeting. Dr Farrell to advise when to relist.</p> <p>Action: Dr Farrell</p> | DR FARRELL TO ADVISE WHEN TO RELIST |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 20 March 2017 | 10 3q | <p>Acute SAI Review Team - Draft Terms of Reference – Deferred to next meeting.</p> <p>Update 19 April 2017 – Members to consider the Draft Terms of Reference at a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell</p> <p>Update 10 May 2017: Elaine Hamilton to remind Dr Farrell to add this item to a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell / Elaine Hamilton</p> | DR FARRELL TO ADVISE WHEN TO RELIST |

Date: 9 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall (until 9.30am), Dr Muhammad Sartaj (until 10.15am), Dr Christine McMaster, Mrs Mary McElroy (via teleconference)

Apologies: Dr Miriam McCarthy, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 3g | | | Dr M Sartaj | | Y | Y | FIRST REVIEW 9 March 2017 – Further Information Required – Trust to be asked to advise what mechanisms they | Review June 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>have put in place to call/recall to review patients diagnosed with conditions that can deteriorate.</p> <p>Action: Governance Team</p> <p>Dr Sartaj to commence discussions with clinicians and check NICE guidance for good practice.</p> <p>Action: Dr Sartaj</p> <p>Review 20 Mach 2016</p> <p>Update 20 March 2017 – DRO query to be forwarded to Trust for response. Review at April meeting.</p> <p>Action: Governance Team</p> <p>Update 19 April 2017 – Dr Sartaj advised that he had a discussion with Rose Sharkey, Clinical Lead in WHSCT. It was acknowledged there are ongoing pressures within outpatient clinics. Internally WHSCT have a process which prioritises patients who require urgent review, however it</p> | |

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| | | | | | | | <p>relies on administrative staff to identify slots and most of the time it is difficult to find a slot for review even urgent reviews.</p> <p>Following discussion it was agreed there is a potential for regional learning. Dr Sartaj to scope the potential for any specific learning that can be taken forward at a regional level. To be reviewed at June meeting.</p> <p>Action: Dr Sartaj</p> | |
| | Personal Information redacted by the USI | | Dr M Sartaj | | Y | Y | <p>FIRST REVIEW 9 March 2017 – Further Information Required – A tracking and monitoring report clearly outlining the actions that have been taken in response to learning identified from the SAI remains outstanding. Governance Team to follow up with the Trust.</p> <p>Action: Governance Team</p> <p>SAI to be further considered when tracking and monitoring report is received. At this stage it is felt there is</p> | <p>Review at a future meeting when tracking and monitoring report is received</p> <p>Refer to SAI Review Sub-Group to note</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Regional Learning. Refer to SAI Review-Sub-Group to note an article for Learning Matters on atypical presentation of stroke. It was noted the last article on atypical presentation of stroke was 18 months ago.</p> <p>Action: M Campbell/DRO (Dr M Sartaj)</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 JANUARY 2017

Date: 16 January 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy

Apologies: Dr Miriam McCarthy

In attendance: Mrs Eleanor Ross (for item 5b), Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
|---------------------------|-------------|---|---|
| 16 January 2017 3j | 9 | <p>Any Other Business</p> <ul style="list-style-type: none"> <div>Personal Inform</div> – SHSCT SAI Members considered the position report in respect of <div>Personal Inform</div> <u>Further information required</u> – Governance Team to ask Southern Trust to forward a copy of their Protocol detailing how lab results are filed following a procedure. The response should also describe how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately. Action: Governance Team Review February 2017 Update 20 March 2017 – DRO not present. Defer to next meeting. Review April 2017 Update 19 April 2017 – It was noted SHSCT submitted Swab Protocol – this was not the Protocol requested. Trust has been asked to submit Lab Result Protocol. Review SAI when correct Protocol is received from Trust. | REVIEW AT A FUTURE MEETING WHEN PROTOCOL IS RECEIVED FROM TRUST |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 DECEMBER 2016

Date: 19 December 2016

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Dr Joanne McClean (via teleconference)

Apologies: Dr Muhammad Sartaj, Mrs Mary McElroy

In attendance: Mrs Siobhan Donald (for item 3b), Mrs Eleanor Ross (for items 4e and 4f), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 NOVEMBER 2016

Date: 21 November 2016

Lead Officers: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster

In attendance: Mrs Eleanor Ross (for item 4m), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| 3I | | | Dr J McClean | | Y | Y | FIRST REVIEW 21 November 2017 – Further professional input – Mary McElroy to discuss with Caroline | Was previously closed. Not |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>McGeary and Dr Lourda Geoghegan to ascertain if there is any regional learning around bundle management.</p> <p>Action: Mrs Mary McElroy</p> <p>Review December 2016</p> <p>Update 19 December 2016 – As Mary McElroy was not present and an update had not been provided in advance of the meeting, this SAI to be re-listed for the January meeting.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Mary McElroy advised she had spoken with Dr Geoghegan and had contacted the Trusts. From responses received to date (BT and WT is awaited), bundle insertion, which is national, is ongoing and appears to be strictly adhered to. It was noted that whilst ongoing care is done frequently, perhaps this should go on to maintenance of daily care.</p> <p>Dr McCall to check practice in England</p> | to be reopened but will remain on agenda until 19 June meeting. |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>and advise.</p> <p>Action: Dr McCall</p> <p>Review February 2017</p> <p>Update 20 March 2017 – Response has been received from NHS Improvement England and shared with Dr McClean who is to consider the format of regional learning – possibly an article for Learning Matters.</p> <p>Action: Dr McClean</p> <p>Review April 2017</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting</p> <p>Update 10 May 2017: CLOSE based on the information provided including the engagement checklist <u>with regional learning identified</u>. Dr McClean (DRO) in conjunction with Siobhan Donald and Mary McElroy will complete an article for Learning Matters in relation to ongoing care.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Dr McCall will liaise with Dr Lavery if the issues raised in this SAI are applicable in ICU and feedback to the Dr McClean.</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article.</p> <p>Dr McClean will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McClean (DRO), Mary McElroy, Siobhan Donald, Elaine Hamilton, Governance Team</p> <p>Update 6 June 2017: FURTHER ADVICE REQUIRED. Dr McClean will liaise with Mary McElroy to ensure all lumens are capped or clamped and ensure this is added to the point of care intervention bundle when it is reprinted.</p> <p>Dr McClean will forward remedial causes and learning lessons template to Elaine Hamilton.</p> | |

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| | Personal Information redacted by the USI | | | | | | Action: Dr McClean / Mary McElroy | |
| | | | Dr J McClean | | Y | y | <p>FIRST REVIEW 21 November 2016– Further Information Required – Dr Farrell raised a number of queries which are to be forwarded to the Trust for response. Response when received from SHSCT it is to be shared with Dr Farrell and Dr McClean for review.</p> <p>Action: Governance Team</p> <p>Further Professional Input: M Campbell to follow up with Integrated Care (Dr M Dowds) regarding shared care scheme with GP.</p> <p>Action: M Campbell</p> <p>Review January 2017</p> <p>Update 16 January 2017 – A response from the Trust to queries raised remains outstanding. With regards to Dr Dowds query it was clarified the Shared Care Scheme refers to Lithium LES. M Campbell to advise Dr Dowds.</p> | Review when response is received from Trust |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Action: M Campbell</p> <p>Review February 2017</p> <p>Update 20 March 2017 – A response from the Trust to queries raised remains outstanding. Governance Team continue to follow up.</p> <p>Action: Governance Team</p> <p>With regards the prescribing of lithium via a Shared Care Scheme, the GP practice has advised that this patient was not prescribed Lithium under a Shared Care Scheme.</p> <p>RCA report to be shared with Angela Carrington to consider.</p> <p>Southern Trust to be advised that this patient wasn't prescribed lithium under shared care scheme. This would imply the Trust was responsible for monitoring lithium – Trust to be asked to provide comment on this.</p> <p>Action: M Campbell</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: AWAITING FURTHER INFORMATION: DRO awaiting a response to queries. Governance Team will continue to liaise with the Trust.</p> <p>Action: Governance Team</p> <p>Review when response received from Trust</p> | |
| | Personal Information redacted by the USI | | Dr J McClean | DRO has query with membership of Review Group | N | N | <p>FIRST REVIEW 21 November 2016</p> <p>REVIEW TEAM MEMBERSHIP – The DRO has requested that a Vascular Surgeon is involved in the Review Team. The Trust has advised that the SAI is in relation to an aortic aneurysm (arterial). The Trust has vascular surgeons but not arterial surgeons and feel it would not be appropriate to</p> | Review at a future meeting when RCA report is received |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>include them in the SAI Group.</p> <p>Governance Team to advise Trust the DRO is content with Terms of Reference and Team Membership.</p> <p>Action: Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives RCA report.</p> | |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 21 November 2016 | 6 | <p>Never Events - Circular HSC (SQSD) 56/16</p> <p>Members noted the DoH had issued Circular HSC (SQSD) 56/16 – The Introduction of a Never Events list on 21 October 2016.</p> <p>With regards SAI B8532 which had been identified as a Never Event at the October meeting, Mary McElroy undertook to seek clarity from SAI Review Sub-Group as to whether this SAI should be recorded as a Never Event.</p> | Mary McElroy |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 21 November 2016 | 9.3 | <p>SHSCT ED Related SAIs</p> <p>It was noted that three SAIs discussed earlier in the meeting related to patients attending SHSCT Emergency Departments with abdominal pain [Personal Information redacted by the U] and [Personal Information]. It was agreed M Campbell would undertake a search on Datix to identify any other similar SAIs and put together a timeline for discussion between Dr McClean, Dr Farrell and SHSCT Medical Director at a meeting on 30 January 2017.</p> <p>Action: M Campbell</p> <p>Review February 2017</p> <p>Update 10 May 2017: DRO not present. Defer to June Meeting</p> <p>Update 6 June 2017: Meeting took place with Medical Director and Dean Sullivan, Dr Farrell and Dr McClean. Trust was made aware of concerns and issues by HSCB.</p> | <p>CLOSE</p> <p>M Campbell</p> |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 17 OCTOBER 2016

Date: 17 October 2016

Lead Officers: Dr Brid Farrell, Dr Christine McMaster, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies:

In attendance: Dr Ruth-Ann Thornbury (ADEPT Fellow, Safety Forum), Dr Judith Ewing (Public Health SpR), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr J McCall | | Y | Y | <p>FIRST REVIEW 17 October 2016– DRO advised that this SAI had been listed due to the inadequate SEA report received. It is not clear from the SEA report the main and underlying reasons contributing to why the event happened.</p> <p>DRO to draft an email for HSCB Governance Team to forward to SET advising Acute Review Team not happy with the report and requesting an amended SEA report.</p> <p>Action: Dr J McCall and Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives amended</p> | <p>Review at 19 June Meeting</p> <p>Included in Delayed Diagnosis Scoping Exercise</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>SEA report.</p> <p>Update 10 May 2017: FURTHER ADVICE REQUIRED. Dr McCall will liaise with Lisa McWilliams PMSI in relation to the recommendations.</p> <p>This SAI will be included in the Scoping Exercise on delayed diagnosis.</p> <p>Action: Dr McCall</p> <p>Review at 19 June meeting</p> | |

Date: 23 September 2016

Lead Officers: Dr Brid Farrell, Dr Christine McMaster, Dr Muhammad Sartaj, Siobhan Donald (on behalf of Mary McElroy)

Apologies: Dr Joanne McClean, Dr Jackie McCall, Mrs Mary McElroy, Dr Miriam McCarthy

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | Dr J McClean | For discussion | Y | Y | FIRST REVIEW 23 September 2016 – DRO not present but an update had | CLOSE |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3m | | | | | | <p>been provided. However in light of further comments received from Dr O'Hagan today, it was agreed the DRO should be given a chance to consider these and the SAI would be re-listed for review at the next meeting.</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Further professional input required – SEA Report to be shared with the Mental Health SAI Review Team to review and consider any regional learning.</p> <p>Action: Governance Team</p> <p>Review November 2016</p> <p>Update 21 November 2016 – The SEA report has been shared with the Mental Health Review Team and will be considered at their next meeting in January 2017.</p> <p>Review February 2017</p> <p>Update 20 March 2017 – Governance Team to follow up with DRO to</p> | <p>Referred to Mental Health to take forward recommendations</p> <p>Refer to Regional SAI Review Group to note actions</p> |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>ascertain if any further information is required from Mental Health Team. DRO not present. Defer to next meeting.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED DRO not present – defer to next meeting</p> <p>Review June 2017</p> <p>Update 6 June 2017: CLOSE based on the information provided including the engagement checklist <u>with regional learning identified from Mental Health Team Recommendations.</u> Denise O'Hagan (MHT) suggested a number of recommendations.</p> <p>The Acute Team would be unable to</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>take forward the recommendations highlighted as they relate to Mental Health. Elaine Hamilton to liaise with Jacqui Burns to ascertain if the Mental Health Team can take forward the recommendations outlined by Denise.</p> <p>Dr McClean will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Refer to Regional SAI Review Team to note onward referral to Mental Health Team to take forward recommendations.</p> <p>Actions: Elaine Hamilton / Dr McClean</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 AUGUST 2016

Date: 22 August 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Jackie McCall, Dr Christine McMaster, Mrs Mary McElroy

Apologies: Dr Joanne McClean, Dr Muhammad Sartaj

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 22 August 2016 | | <p>(iii) Key Words With regards the surveillance of SAIs to identify patterns/clusters/trends, it was agreed to consider the identification of key words. Mary to provide a list of key words for discussion at the October meeting.</p> <p>Action: Mary McElroy</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Mary McElroy advised she had obtained a list of key words compiled and used by Mental Health and Learning Disability Teams and undertook to share with the group. Mary and Mareth to produce a list of key words identified to date by the Acute Team and circulate for review at the November meeting. Dr McCall to check with other countries if they have a list of key words.</p> <p>Review November 2016</p> <p>Update 21 November 2016 – Members considered the list of key words identified by the Acute Team since April 2016 along with the key words identified and used by the Mental Health and Learning Disability Teams. To be further reviewed at the December meeting when list of key words from NHS England is available.</p> | <p>Review November 2016</p> <p>Mary McElroy</p> <p>Mary McElroy</p> <p>Mary McElroy/Mareth Campbell</p> <p>Review December 2016</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Review December 2016</p> <p>Update 19 December 2016 – Members considered the list of incident types provided by NHS England Clinical Incident review process circulated with the papers. Dr McCall is awaiting a further list from Julian Johnston which is used at Mortality and Morbidity reviews in Trusts. It was agreed a few officers would meet to consider all lists with a view to compiling a list of key words for the acute team.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Members considered the list of learning lesson categorisations used at Mortality and Morbidity meetings. Dr McCall advised she would share the list with Lynne Charlton, Mary McElroy and Jacqui Burns. She is meeting with them to review this and NHS England classification and identify key words which in turn could be used to identify key themes.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – It has been agreed that in order to ‘theme SAls’ the Acute SAI Group would consider the Learning Lessons and DATIX remedial causes categorisations when closing SAls. This will run as a pilot.</p> | <p>Review February 2017</p> <p>Review September 2017</p> |

Date: 18 July 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy (via teleconference)

Apologies: Dr Jackie McCall

In attendance: Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
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All Actions completed from 18 July 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 JUNE 2016

Date: 20 June 2016

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Christine McMaster

Apologies: Dr Joanne McClean

In attendance: Jenny Keane, Mareth Campbell

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 23 MAY 2016

Date: 23 May 2016

Lead Officers: Dr Janet Little, Dr Jackie McCall, Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Paul Darragh, Mrs Mary McElroy, Dr Brid Farrell

Apologies: Siobhan McIntyre

In attendance: Mrs Eleanor Ross, Mrs Siobhan Donald, Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 APRIL 2016

Date: 18 April 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Jackie McCall, Dr Muhammad Sartaj

Apologies: Dr Janet Little

In attendance: Mrs Elaine Hamilton, Mrs Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Date | Agenda Item | Action Agreed | Person Responsible | Status |
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| 18 April 2016 | 7 | Any Other Business (i) Safety Forum – Learning Event Jackie McCall advised members the Safety Forum are commencing plans for the next regional Learning Event for 2016/17. Jackie requested for DROs to highlight any suitable SAIs that could be used for learning at the event. ‘Good Standard of Report’ is a key word which is captured on Datix and it was agreed DROs will use this if they | All members/Mareth Campbell | To be a reviewed at each meeting of Acute SAI Review |

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| | | <p>deem an SAI appropriate for use at the event. This item will be added onto the agenda for each Acute meeting to remind DROs.</p> <p>Update 23 May 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 20 June 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 18 July 2016 - Members agreed to identify three anticoagulant drug related SAIs to showcase at the Learning Event. It was agreed these could be identified during the review being undertaken by Dr Jackie McCall.</p> <p>Update 22 August 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 23 September 2016 – SAI SHSCT SAI (Personal Information redacted by the) was highlighted as a SAI that could be used at the learning event.</p> <p>Update 17 October 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 21 November 2016 – SAI (Personal Informa – SHSCT SAI (Personal Informa was highlighted as a SAI that could be considered for the Regional Learning Event.</p> <p>Update 19 December 2016 - SAI (Personal Information redacted by the USI) was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Update 16 January 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> | Dr Jackie McCall | Team |
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| | | <ul style="list-style-type: none"> ○ Personal Information redacted by the USI – showing patient journey ○ SHSCT SAI Personal Information redacted by the USI <p>Update 9 March 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ Personal Information redacted by the USI ○ SAI Personal Information redacted by the USI <p>Update 20 March 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 19 April 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 10 May 2017: Personal Information redacted by the USI will be considered for a future SAI Learning Event.</p> | | |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 MARCH 2016

Date: 21 March 2016

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Paul Darragh (Via teleconference)

Apologies: Dr Jackie McCall, Mrs Mary McElroy

In attendance: Mrs Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 15 FEBRUARY 2016

Date: 15 February 2016

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Paul Darragh, Mrs Mary McElroy (via teleconference)

Apologies: Dr Muhammad Sartaj, Dr Jackie McCall

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 14 JANUARY 2016

Date: 14 January 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Muhammad Sartaj, Mrs Mary McElroy (via teleconference)

Apologies: Dr Janet Little, Dr Jackie McCall

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 14 January 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 DECEMBER 2015

Date: 22 December 2015

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Jackie McCall

Apologies: Dr Muhammad Sartaj, Dr Paul Darragh,

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 22 December 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 24 NOVEMBER 2015

Date: 24 November 2015

Lead Officers: Dr Janet Little (Chair), Dr Muhammad Sartaj, Dr Miriam McCarthy

Apologies: Dr Paul Darragh, Mrs Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Jackie McCall, Paul Kavanagh

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 24 November 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 OCTOBER 2015

Date: 19 October 2015

Lead Officers: Dr Paul Darragh (Chair), Dr Muhammad Sartaj, Dr Jackie McCall

Apologies: Dr Janet Little, Dr Miriam McCarthy, Mrs Mary McElroy, Siobhan Donald, Siobhan McIntyre

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 19 October 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 September 2015

Date: 21 September 2015

Lead Officers: Dr Paul Darragh (Chair), Dr Catherine Coyle, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Jackie McCall, Dr Louise Herron

(Personal Information redacted by the USI))

Apologies: Janet Little, Miriam McCarthy

In attendance: Paul Kavanagh, Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 21 September 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 August 2015

Date: 18 August 2015

Lead Officers: Dr Paul Darragh (Chair), Mrs Mary McElroy (via teleconference), Dr Muhammad Sartaj, Dr Louise Herron (for SAI (Personal Information)), Dr Miriam McCarthy

Apologies: Dr Janet Little Dr Jackie McCall

In attendance: Margaret McNally obo Elaine Hamilton, Dr Catherine Coyle

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 18 August 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 JULY 2015

Date: 21 JULY 2015

Lead Officers: Dr Janet Little (Chair), Dr Paul Darragh, Mrs Mary McElroy (via teleconference),

Apologies: Dr Muhammad Sartaj, Dr Louise Herron, Dr Jackie McCall, Dr Miriam McCarthy

In attendance: Margaret McNally obo Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 21 July 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 15 JUNE 2015

Date: 15 June 2015

Lead Officers: Dr Janet Little (Chair), Dr Paul Darragh, Dr Muhammad Sartaj, Mrs Mary McElroy (via teleconference), Dr Louise Herron, Dr Jackie McCall

Apologies: Dr Miriam McCarthy

In attendance: Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – 21 MAY 2015 – ALL ACTION COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – 22 APRIL 2015- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – 16 MARCH 2015- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 FEBRUARY 2015

Date: 16 FEBRUARY 2015

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Paul Darragh, Mary McElroy

Apologies: Louise Herron, Muhammad Sartaj, Jackie McCall

In attendance: Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 16 February 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING - 12 JANUARY 2015 - ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING - : 07 November 2014- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 28 OCTOBER 2014

Date: 28 October 2014

Lead Officers: Dr Miriam McCarthy, Dr Paul Darragh, Dr Louise Herron, Dr Muhammad Sartaj, Mrs Mary McElroy

Apologies: Dr Janet Little, Mrs Jacqui Burns

In attendance: Mrs Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Personal Information redacted by the USI | | Dr B Farrell | The inquest into this case opened on 28th January and was adjourned by the Coroner. The Coroner has asked the Trust to undertake a number of actions and Trust are currently working through these and updating the action plan as part of that process and the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner. | y | n/a | <p>FIRST REVIEW 28 October 2014: Further Information: The family and DRO were not content with the first report and an amended report has now been received from WHSCT and they have advised 4 independent reports from experts reviewing the aspects of care will be submitted as appendices to the report. Two of these reports have been received.</p> <p>DRO is awaiting the final two reports and input from the coroner in Manchester</p> <p>It was noted there is a delay due to difficulty obtaining an independent report regarding the GP and Community Nursing aspect.</p> <p>It was agreed Governance Team will request two remaining reports from Western Trust and copy email to DRO.</p> <p>Relist for December meeting</p> <p>Action: Governance Team / E Hamilton</p> <p>Ask trust to ensure we get two additional reports!</p> <p>UPDATE 12 JANUARY 2015:</p> | Review June 2017 |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|--|--------|
| | | | | | | <p>FURTHER INFORMATION REQUIRED: There was a delay with the GP report but DRO advised GP and Intensive Care Report will be issued in the near future. There is still no date agreed for Coroner to proceed with the inquest.</p> <p>DRO will request recommendations in the investigation report to be reviewed following submission of all reports.</p> <p>It was agreed this item will remain on the agenda for review.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Review at February meeting</i></p> <p>Update 16 February 2015: FURTHER INFORMATION REQUIRED Still awaiting a report on intensive care treatment. GP report is imminent and will soon be with Trust.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Relist for March meeting</i></p> <p>Update 16 March 2015: The GP report is currently being compiled. ICU report has been submitted.</p> <p>It was agreed due to the complexities of this SAI Paul will provide an update to Dr Carolyn Harper.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Relist for April meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 21 May 2015: DRO has been liaising with Dr McKinney Medical Director in the Trust regarding this SAI. DRO Will provide an update to Dr Harper.</p> <p>Relist for June meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 15 June 2015: DRO has received a verbal update from Therese Brown WHSCT. Dr Harper has been advised.</p> <p>Relist for July meeting</p> <p>ACTION: Governance Team</p> <p>Update 21 July 2015: It was noted a Coroner's Report from Manchester was awaited. The status of this would be reviewed at the next meeting.</p> <p>ACTION: Governance Team</p> <p>Update 18 August 2015: : <u>FURTHER INFORMATION REQUIRED</u> – Members agreed an email would be sent from the HSCB Governance Team to the Trust for the attention of the Medical Director on behalf of the DRO stating the following:</p> <p><i>'Can the Trust please provide an updated final</i></p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p><i>report by 30 October 2015 to incorporate the findings of the original review and the independent reports commissioned over recent months.</i></p> <p><i>The updated report would be expected to provide the findings, recommendations and a tracking and monitoring report on the actions taken to address the recommendations of the various reports.'</i></p> <p>ACTION: Governance Team</p> <p><u>Update 24 November 2015:</u> DRO had a telecom with Dr A McKinney and T Brown with Lourda Geoghegan and Mary McElroy to discuss progress. Trust action plan has been reviewed and a series of responses have been prepared in respect of all the products of the original report and the speciality reports. DRO awaiting the comments back from Lourda and Mary to our combined response. Once agreed DRO will issue to Trust (via SAls) our overall comments. It is understood this case will be considered by the Manchester Coroner within the next few months.</p> <p>ACTION: DRO (Paul Darragh)</p> <p>Review December Meeting</p> <p>Update 22 December 2015: <u>DEFERRED</u>. DRO not present at meeting.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Relist January Meeting</p> <p>Action: Governance Team</p> <p>Update 14 January 2016: <u>FURTHER INFORMATION REQUIRED</u> This SAI was discussed at a recent SHSCG meeting at DHSSPS. Therese Brown advised at the meeting this SAI may be used in the upcoming SAI Event. DRO noted no date has been set for the Manchester Coroner to review the case.</p> <p>Relist for March 2016</p> <p>Action: Governance Team</p> <p>Update 21 March 2016: <u>FURTHER INFORMATION REQUIRED</u> The inquest into this case opened on 28th January and was adjourned by the Coroner. The Coroner has asked the Trust to undertake a number of actions and the Trust is currently working through these and updating the action plan and as part of that process the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner.</p> <p>Governance Team to ascertain if there is a timeframe for the response to be submitted to the Coroner? If no timeframe has been specified the</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|---|--------|
| | | | | | | <p>response to outstanding HSCB queries should be requested within a two month timeframe.</p> <p>Relist for May 2016</p> <p>Action: Governance Team</p> <p>Update 23 May 2016: A response from the Trust regarding the timeframe to respond to the Coroner remains outstanding. However, it was noted the Coroner's Inquest shouldn't delay any learning. DRO advised Dr L Geoghegan continues to be involved with Mary McElroy concerning issues around cross infection, nursing and community nursing. Dr Geoghegan and Mary McElroy to meet with Dr Farrell to discuss. Dr Farrell to share feedback with the Trust.</p> <p>Action: Dr B Farrell</p> <p>Relist for August 2016</p> <p>Update 18 July 2016 – Dr Farrell to arrange a further meeting with Mary McElroy and Dr Geoghegan.</p> <p>Action: Dr B Farrell</p> <p>Review September 2016</p> <p>Update 23 September 2016 - Dr Farrell advised that she</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|--|--------|
| | | | | | | <p>had met with Mary McElroy and Dr Geoghegan. An updated Action Plan was received from the Trust on 22 August 2016. DRO content with Action Plan, however wishes to clarify access to community microbiology advice as the RCA report is ambiguous about this. Dr Farrell undertook to raise this with the Pathology Network.</p> <p>Review November meeting.</p> <p>Update 19 December 2016 – Dr Farrell to raise this with the Pathology Network.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Defer to February 2017 meeting.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – Defer to 20 March 2017 meeting.</p> <p>Review March 2017</p> <p>Update 20 March 2017 – Dr Farrell advised a response has been received from the Pathology Network and undertook to share the response with Mary McElroy. However, the response doesn't accurately address the</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>query therefore a revised query is to be submitted to the Pathology Network.</p> <p>Action: Dr Farrell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED. SAI Deferred to next meeting</p> <p>Review June 2017</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING - 16 SEPTEMBER 2014- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 5 AUGUST 2014

Date: 5 August 2014

Lead Officers: Janet Little, Louise Heron, Paul Darragh, Miriam McCarthy, Paul Darragh, Caroline McGeary (for item BHSC) Irrelevant information redacted by [REDACTED]
Muhammad Sartaj

In attendance: Jacqui Burns

ACUTE SERVICES SAI REVIEW TEAM MEETING – 8 JULY 2014 ALL ACTIONS COMPLETED

Donna Britton

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID [Personal Information] Level 2 / HSCB Ref: [Personal Information]

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

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

www.hscboard.hscni.net

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Information] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Information]

Regards

Eileen Conlon

Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI Personal Information SAI Report

Dear Colleague

Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hosptial

Personal Information redacted by the USI

ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 JUNE 2017

Date: 19 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Muhammad Sartaj, Dr Miriam McCarthy, Dr Jackie McCall, Dr Joanne McClean (by Teleconference), Mrs Mary McElroy (by Teleconference), Mrs Angela Carrington (by Teleconference).

Apologies: Dr Christine McMaster, Ms Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|-------------|-------------------|--------|--|---|
| 2d | Personal Information redacted by the USI | | Dr M Sartaj | y | y | <p>First Review 19 June 2017: CLOSE based on the information provided including the engagement checklist. <u>Regional Learning was identified.</u> DRO will complete an article for Learning Matters as this is a rare event.</p> <p>Refer to Regional SAI Sub-Group to note Learning Matters Article</p> <p>Action: Dr Sartaj</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 1.2, 1.4 Action: Governance Team Learning Lessons Categorisation - 1 Action: E Hamilton | <p>CLOSE</p> <p>Refer to SAI Sub-Group to note Learning</p> |

| | | | | | | | |
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| 2e | Personal Information redacted by the USI | | S McIntyre | y | y | <p>First Review 19 June 2017: <u>CLOSE</u> based on the information provided including the engagement checklist. DRO requested Mary McElroy to review the SAI. Mary noted learning regarding removal of equipment, positive urinalysis not acted on and documentation. The learning from this SAI has been included in the feedback to the Regional Falls In-patient Group.</p> <p>Refer to Regional SAI Review Sub Group to note learning identified and referred to Regional Falls In-patient Group.</p> <p>Siobhan McIntyre will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Mary McElroy, Siobhan McIntyre, Elaine Hamilton</p> | <p>CLOSE</p> <p>Refer to SAI Sub-Group to note Learning</p> |
| 2f | Personal Information redacted by the USI | | Dr M Sartaj | y | y | <p>First Review 19 June 2017: FURTHER INFORMATION REQUIRED. Dr Sartaj to discuss both this SAI and <small>Personal Information</small> with Louise O'Dalaigh (WHSCT – Ophthalmology and Optometry) to request further information / clarity on these SAIs.</p> <p>Action: Dr Sartaj</p> <p>Review 3 July 2017</p> | <p>Review 3 July 2017</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 2g | | | Dr J McCall | y | y | <p>First Review 19 June 2017: FURTHER INFORMATION REQUIRED. It was agreed there is regional learning and Dr McCall and Dr McCarthy will compile a Reminder of Best Practice Letter re Acute Oncology Guidelines.</p> <p>Refer to Regional SAI Review Sub-Group for approval of Reminder of Best Practice Letter.</p> <p>Elaine Hamilton to run a report on Datix searching for SAls relating to chemotherapy and diarrhoea.</p> <p>Action: Dr McCall, Dr McCarthy and Elaine Hamilton</p> <p>Review 17 July 2017</p> | <p>Review 17 July 2017</p> <p>Refer to Regional SAI Review Sub Group</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|-------------|-------------------|--------|---|--------------------|
| 2h | Personal Information redacted by the USI | | Dr M Sartaj | | | <p>First Review 19 June 2017: CLOSE based on the information provided including the engagement checklist with no new regional learning identified.</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 1.2, 2.1, 5.4 Action: Governance Team Learning Lessons Categorisation – 1 and 3 Action: E Hamilton | CLOSE |
| 2i | Personal Information redacted by the USI | | Dr M Sartaj | | | <p>First Review 19 June 2017: FURTHER INFORMATION REQUIRED. Dr Sartaj to discuss both this SAI and W [Personal info] with Louise O'Dalaigh (WHSC – Ophthalmology and Optometry) to request further information / clarity.</p> <p>Action: Dr Sartaj</p> <p>Review 3 July 2017</p> | Review 3 July 2017 |

ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 9 JUNE 2017

Date: 9 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Christine McMaster, Dr Muhammad Sartaj, Eleanor Ross

Apologies: Dr Joanne McClean, Dr Jackie McCall, Dr Louise Herron, Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Miriam McCarthy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3a | | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning identified.</p> <p>Dr McCarthy will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCarthy / Elaine Hamilton</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|---------------|-------------------|--------|--|---|
| 3b | Personal Information redacted by the USI | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE based on the information provided including the engagement checklist. Dr McCarthy will ask Catherine Coyle to raise this SAI with CCANI for consideration of further action.</p> <p>Refer to Regional SAI Review Team meeting to note referral to CCANI for consideration.</p> <p>Dr McCarthy will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCarthy</p> | <p>CLOSE</p> <p>Refer to Regional SAI Review Team Meeting</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3d | | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED. Dr McCarthy to draft an email for Governance Team to BHSCT Vascular Service requesting confirmation of care pathway for carotid surgery. Dr McCarthy to share report with Vascular Network for their consideration.</p> <p>Refer to Regional SAI Group to note referral to Vascular Network.</p> <p>Action Dr McCarthy / Governance Team</p> | <p>Review August 2017</p> <p>Refer to Regional SAI Group</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3e | | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED Dr McCarthy to draft an email for Governance Team to issue to BHSCT seeking further clarity on the clinical rationale for decision making for the five patients.</p> <p>Action: Dr McCarthy / Governance Team</p> <p>Review when response received from Trust</p> | Review when response received from Trust |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3f | Personal Information redacted by the USI | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED. Dr McCarthy to draft an email for Governance Team to issue to BHSCT seeking confirmation on responsibility for post op monitoring of epidurals and request copy of Trust Epidural Policy.</p> <p>Action: Dr McCarthy / Governance Team</p> <p>Review when response received from Trust</p> | Review when response received from Trust |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3g | Personal Information redacted by the USI | | Dr Sartaj | Y | Y | <p>FIRST REVIEW 9 June 2017: PENDING CLOSURE. Close pending receipt of monitoring and tracking report and based on the information provided including the engagement checklist. No regional learning identified.</p> <p>Refer to SAI Sub-Group to note an onward referral to Judith Ewing for SAI to be considered in the review of Oral Anticoagulants.</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 2.1, 3.3 and 5.1 Action: Governance Team Learning Lessons Categorisation – 3 & 5 Action: E Hamilton <p>SAI not required to be reviewed. Will be noted at Group when monitoring and tracking report is received for formal closure</p> | <p>SAI not required to be reviewed will be noted at Group when monitoring and tracking report is received for formal closure.</p> <p>Refer to Regional SAI Review Group</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|------------|-------------------------|-----------|--|--------|
| 3h | Personal Information redacted by the USI | | S McIntyre | Y | Y | <p>FIRST REVIEW 9 June 2017: FURTHER INFORMATION REQUIRED: Dr Sartaj will provide his medical opinion and advise Siobhan McIntyre.</p> <p>Action: Dr Sartaj / Siobhan McIntyre</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE based on advice from Dr Sartaj, and the information provided including the engagement checklist. No new regional learning identified.</p> <p>Siobhan McIntyre will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCarthy</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3i | | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED. Governance team to seek clarification from BHSC Trust in relation the criteria for discharge home for the patient when they presented to ED on 1 October.</p> <p>Action: Governance Team</p> <p>Review when response received from Trust</p> | Review when response received from Trust |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3j | Personal Information redacted by the USI | | Dr M Sartaj | Y | Y | <p>FIRST REVIEW 9 June 2017: FURTHER INFORMATION REQUIRED Dr Sartaj will refer this SAI to Dr Corrigan for consideration by the Trauma Network.</p> <p>Refer to Regional SAI Review Group to note referral to Trauma Network for consideration.</p> <p>Governance Team to request the corners report from Western HSC Trust.</p> <p>Action: Governance Team / Dr Sartaj</p> <p>Review when Coroners Report Received</p> | <p>Review when Coroners Report received</p> <p>Refer to Regional SAI Review Team Meeting</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3j | | | Dr Sartaj | Y | Y | <p>First Review 9 June 2017: FURTHER INFORMATION REQUIRED. This SAI involved a rare complication of nasogastric insertion causing a pneumothorax. Governance Team to email Jackie McCall requesting information on how many of these cases have been reported nationally and advise DRO.</p> <p>Eleanor Ross agreed to research protocols around chest x-ray following nasogastric insertion and report back to DRO via serious incidents.</p> <p>It was agreed there is regional learning and Dr Sartaj would complete a newsletter article highlighting complications of a common procedures.</p> <p>Elaine Hamilton will ask Jackie McCall if this can be considered for the SAI learning Event 2018.</p> <p>Refer to Regional SAI Review Team to note Learning Matters newsletter article.</p> <p>Actions: Dr Sartaj, Eleanor Ross, Elaine Hamilton, Governance Team Review June 2017</p> | <p>Review July 2017</p> <p>Refer to Regional SAI Review Team Meeting</p> <p>SAI Learning Event 2018</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3L | | | Dr McMaster | Y | Y | <p>First Review 9 June 2017: FURTHER INFORMATION REQUIRED BEFORE CLOSURE. Dr McMaster to clarify with Maria Wright re provision of out of hours MRI availability in all five Trusts. Subject to clarification SAI can be closed at next meeting.</p> <p>Action: Dr McMaster</p> <p>Review 19 June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED Dr McMaster to seek further assurance from Maria Wright re access to MRI out of hours in all five Trusts e.g. how is a suspected acute cauda equina diagnosed out of hours outside of Belfast?</p> <p>Action: Dr McMaster</p> <p>Review 17 July 2017</p> | Review 17 July 2017 |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 4a | | | Dr McCarthy | n/a | n/a | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED. Copy of SAI report in relation to this Shared Learning will be forwarded to Angela Carrington.</p> <p>Action: Angela Carrington / Elaine Hamilton</p> <p>Review 17 July 2017</p> | Review 17 July 2017 |
| 4c | | | Dr M McCarthy | n/a | n/a | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: Governance Team to advise BHSCT this was considered by the Acute SAI Review Team and will not be issued as Regional Learning.</p> | CLOSE |

| | | | | | | | |
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| 6a | Personal Information redacted by the USI | | Dr M McCarthy | n/a | n/a | FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting. Review June 2017 Update 19 June 2017: Early Alert to be resent to DRO to identify any issues in relation to sepsis. Dr McCall to be advised if any issues relating to sepsis identified. Action: Governance Team Review 17 July 2017 | Review 17 July 2017 |
| 6b | | | Dr M Sartaj | n/a | n/a | FIRST REVIEW 19 June 2017:CLOSE Early Alert can be closed – No further action required. | CLOSE |

| | | | |
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| 9c | Longest outliers | <p>Elaine Hamilton referred to a paper which highlighted the longest outliers with the Trusts in the Acute POC. DROs acknowledged there was an issue receiving reports/requested information etc from Trusts in a timely manner. There was a brief discussion and it was felt this could possibly be addressed through a performance management route and the issue should be raised at SMT.</p> <p>Elaine Hamilton will forward the longest outliers to the individual DROs for their comment/advice.</p> <p><i>Additional Note following the meeting: This issue has been discussed at the QSE Group and it has been agreed Mary Hinds will raise with Valerie Watts before listing this item at the Chief Executive Forum Meeting.</i></p> | Review 17 July 2017 |
|----|------------------|---|---------------------|

ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 6 JUNE 2017

Date: 6 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Joanne McClean

Apologies:

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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No new agenda items were discussed at this meeting

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 MAY 2017

Date: 10 MAY 2017

Lead Officers: Dr Brid Farrell (chair), Siobhan Donnell, Dr McMaster, Eleanor Ross, Dr Jackie McCall, Mary McElroy (via teleconference)

Apologies: Dr Louise Herron, Dr Miriam McCarthy, Dr Joanne McClean

In attendance: Mareth Campbell, Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 4a | | | Dr J McClean | | Y | Y plan to share report | <u>First Review 10 May 2017: DEFERRED</u> DRO not present. SAI to be relisted for next meeting. Review June 2017 Update 6 June 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Dr McClean has requested input/comments from Dr Corrigan. Dr | Review July 2017 |

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| | | | | | | | Farrell will raise the issue of seeking clinical advice on SAls at a staff meeting. Review July 2017 Action: Dr Farrell / Dr McClean | |
| 4c | Personal Information redacted by the USI | | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is | Review when response has been received from Trust |

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| | | | | | | | <p>unacceptable. Can the Trust advise this how this has been addressed?</p> <ul style="list-style-type: none"> Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> | |
| 4d | Personal Information redacted by the USI | | Dr J McClean | | Y | Y plan to share report | <p><u>First Review 10 May 2017: DEFERRED</u> DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email SHSCT with the following points:</p> <ul style="list-style-type: none"> Can the Trust advise what awareness sessions have been provided in relation to Sepsis following this incident. Can the Trust advise on | Review when response received from Trust |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>progress towards recommendation 3 – implementing the ‘Sepsis 6 Bundle’</p> <ul style="list-style-type: none"> • Seek clarification from the Trust on what protocol is used for communicating positive blood cultures results. <p>DRO noted there was the following errors in this case:</p> <ul style="list-style-type: none"> • Failure to recognise sepsis. • Deteriorating patient not recognised. • Escalation of deteriorating patient. • Recording error of information from lab and conveying of information. • Results were mixed up. <p>Dr McClean will liaise with Dr McCall on the regional work which is ongoing with Sepsis</p> <p>Action: Governance Team / Dr</p> | |

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| | | | | | | | Review when response received from Trust | |
| 4f | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | <p><u>First Review 10 May 2017: Further Information Required.</u></p> <ul style="list-style-type: none"> • Dr McCall (DRO) advised SET are considering development of a Jump Policy. Dr McCall will request a copy when it's completed. • Dr McCall to share report with Catherine Coyle in respect of transfers to interventional radiology. • Dr McCall to request protocol for contingency plan for interventional radiologist in SET • Dr McCall to request guidelines from Radiology Network on timing of CTPA investigations in diagnosis of PE | <p>Review at meeting July 2017</p> <p>SAI to be considered for a future SAI Learning Event</p> |

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| | | | | | | | <ul style="list-style-type: none"> • Dr Farrell to Share Stroke Thrombectomy pathway with Dr McCall <p>It was agreed there are a number of regional learning points from this incident to be considered:</p> <ul style="list-style-type: none"> • Quicker recognition of patient bleeding and resuscitation • Learning from Human factors <p>This SAI will be considered for SAI learning Event in the future.</p> <p>Action: Dr McCall / Dr Farrell / Governance Team</p> <p>Review July 2017</p> | |
| 6a | Personal Information redacted by the USI | | Dr M McCarthy | | n/a | n/a | <p><u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 9 June 2017: DEFERRED BHSCT advised they will not be submitting an</p> | CLOSE |

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| | | | | | | | SAI. DRO to consider response. DRO not present. SAI to be relisted for next meeting. Review 19 June 2017 Update 19 June 2017: CLOSE DRO is content with response submitted from BHSCT and agrees the SAI does not meet the criteria for an SAI. | |
| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr J McClean | Proposed Closure | Y | Y plan to share report | <u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting. Review July 2017 | Review at meeting July 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 APRIL 2017

Date: 19 April 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Dr Muhammad Sartaj, Mrs Eleanor Ross

Apologies: Mrs Mary McElroy, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

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| 4a | | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 19 April 2017 – Include in Scoping Exercise – Following review it was agreed there is regional learning around delayed diagnosis with the learning highlighting high level messages that are applicable. It was agreed to include this SAI in the scoping exercise to be undertaken by Dr McCall in relation to delayed diagnosis. Following the scoping exercise, Dr McCall and Dr McCarthy to meet to review.</p> <p>Action Dr McCall / Dr McCarthy</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE based on the information provided including the engagement checklist. No regional learning identified.</p> <p>Dr McCarthy will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCarthy</p> | CLOSE |

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| 6 | | | Dr C McMaster | | | | <p>Early Alert is linked to <small>Personal Information redacted by the USI</small> which was closed on 10 April 2014. The Early Alert received was advising that the case had been listed for hearing for two days on 23 and 24 February 2017.</p> <p>M Campbell to check if any learning was disseminated in 2014 and in particular around the European Guidelines referenced in the Coroner's report.</p> <p>Action: M Campbell</p> <p>Update 10 May 2017: The Trust has submitted an updated Action Plan (November 2016). The action plan refers to a Policy 'Ascites Management Guidelines for Liver Cirrhosis NHSCT/13/658' which is in place and used.</p> <p>The Trusts Governance Department are currently carrying out a piece of work around learning and themes from inquests that were before the Coroner in the first quarter of this year - this</p> | Review when response received from Trust |

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| | | | | | | | <p>case is included. These workings are due to be discussed at their Clinical Governance Steering Group meeting on 11 May 2017 and an update will be provided following the meeting.</p> <p>Trust Governance Department will confirm if any learning was disseminated in 2014.</p> <p>Action: Elaine Hamilton</p> <p>Review June 2017</p> <p>Update 9 June 2017: FURTHER INFORMATION REQUIRED. Northern Trust advised the Clinical Governance Steering Group meeting scheduled for 11 May was cancelled and this item should discussed at the Clinical Council meeting on 9 June 2017. Trust has yet to confirm if any learning was disseminated. Elaine Hamilton will continue to follow up with the Trust.</p> <p>Action: Elaine Hamilton</p> <p>Review when response received from</p> | |

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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 MARCH 2017

Date: 20 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster, Dr Muhammad Sartaj, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3a | | | Dr M McCarthy | | Y | Y | FIRST REVIEW 20 March 2017 – Further Information Required - The summary of events doesn't indicate the likely reason for the cardiac arrest. BHSCT to be asked to provide more information on any factors relating to anaesthetic and/or medications administered which may have been a contributory factor. | CLOSE |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>BHSCT also to be asked to provide further detail on why they haven't shared the SEA Report with the family to date.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 – DRO query has been forwarded to the Trust. Governance Team to follow up and SAI to be reviewed at a future meeting when response is received.</p> <p>Action: Governance Team</p> <p>Update 9 June 2017: DEFERRED. DRO not present SAI deferred to next meeting. It was noted a response to DRO queries has been received.</p> <p>Review at next meeting</p> <p>Update 19 June 2017: CLOSE based on the information provided including the engagement checklist – no new</p> | |

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| | | | | | | | <p>regional learning identified.</p> <p>Dr McCarthy will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCarthy</p> | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017– Further Information Required – Trust to be asked to forward</p> <ul style="list-style-type: none"> • A copy of Standardised Operating Procedure (SOP) for validation process • A copy of Standardised Operating Procedure (SOP) for monitoring and tracking of investigations. • An update on recommendation 5 – the reference to cease ‘green notes’ system. <p>Action: Governance Team</p> <p>Review June 2017</p> <p>Update 9 June 2017: DEFERRED. DRO not present. Will be discussed at the</p> | CLOSE |

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| | | | | | | | <p>next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE based on the information provided including the engagement checklist – no new regional learning identified.</p> <p>Dr McCarthy will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCarthy</p> | |
| 3b | Personal Information redacted by the USI | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017– DRO not present. Defer to next meeting. However it was noted there are significant nursing issues.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 - SEA report has been shared with Eleanor Ross for nursing view. DRO not present – defer to next meeting.</p> <p>Review May 2017</p> | <p>Review July 2017</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article</p> |


| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Update 10 May 2017: Further Professional Input Required. Dr McClean (DRO) will liaise with Siobhan Donald and Angela Carrington as regional learning was identified in respect of omitted medicines and delay in medicines in nursing/pharmacy.</p> <p>Review July 2017</p> <p>Action: Dr McClean (DRO), Siobhan Donald and Angela Carrington</p> <p>Update 6 June 2017: Dr McClean will compile an article for Learning Matters. E Hamilton to seek views from Siobhan Donald and Angela Carrington if they have any additional action to be taken in relation to prescribing and nursing issues.</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article</p> <p>Action Dr McClean / Elaine Hamilton</p> | |

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| | Personal Information redacted by the USI | | | | | | Review July 2017 | |
| 3c | | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – Dr McCall to highlight this SAI to Sepsis Collaborative run by Safety Forum.</p> <p>Action: Dr McCall</p> <p>DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting.</p> <p>Update 10 May 2017: Dr McCall has highlighted this SAI to the Safety Forum. It was agreed there is regional learning from this SAI – possibly a learning matters article but will be discussed further when DRO is present.</p> <p>Relist for June Meeting</p> <p>Update 6 June 2017: It was agreed a learning matters article is not appropriate for this incident as there is more work required on a regional basis</p> | Review July 2017 |

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| | | | | | | | <p>regarding Sepsis.</p> <p>It was agreed Dr McClean will liaise with Dr McCall regarding regional work for sepsis – possibly introduction of sepsis bundles. More work needs to be carried out in relation to early recognition and management of sepsis.</p> <p>It was noted there is NICE sepsis guidance.</p> <p>Action Dr McClean Review July 2017</p> | |
| 3d | Personal Information redacted by the USI | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Review 19 April 2017 - DRO not present – defer to next meeting.</p> <p>Update 10 May 2017: DEFERRED DRO not present. Defer to next meeting.</p> <p>Review 9 June 2017</p> <p>Update 6 June 2017: FURTHER</p> | Review July 2017 |

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| | | | | | | | <p>INFORMATION REQUIRED. DRO requested Governance Team to email the Trust with the following point:</p> <ul style="list-style-type: none"> Trust to give consideration of an electronic referral form preferably the white board system to be available on all wards, between specialities and in ED rather than paper based systems. <p>DRO noted the following concerns: Failure to recognise the deteriorating patient and failure to escalate</p> <p>Action: Governance Team</p> <p>Review July 2017</p> | |
| | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | <p>FIRST REVIEW 20 March 2017 – <u>Further Input</u> - Patient lost to follow up. DRO referenced a similar SAI where the patient wasn't followed up in a timely manner. Both SAIs to be highlighted to the LCG but in the first instance, DRO to speak to Lisa McWilliams (PMSI) regarding endoscopy waiting lists and patients not being prioritised</p> | Review July 2017 |

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| | | | | | | | <p>appropriately. A search to be undertaken on Datix for linked cases to look at demand/capacity gap. Review in 3 months.</p> <p>Action: Dr McCall/M Campbell</p> <p>Review June 2017</p> <p>Update 9 June 2017: FURTHER INFORMATION REQUIRED. DRO was not present. DRO will undertake analysis of delayed diagnosis of other cancer cases. DRO has met with Lisa McWilliams and Laura Malloy and provide an update at the next meeting.</p> <p>Action: Dr McCall</p> <p>Review July 2017</p> | |
| | | Personal Information redacted by the USI | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017 - CLOSE based on the information provided including the engagement checklist, with <u>Regional Learning identified</u> around the correct use of anticoagulants, lack of co-ordination of care and the need for early referral to multi-specialist team/service. Mary</p> | Awaiting feedback from Diabetic Foot Team prior to closure |

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| | | | | | | | <p>McElroy to refer SAI to Geraldine Teague for consideration of regional learning by the Diabetic Foot Team.</p> <p>Action: Governance Team Mary McElroy</p> <p>Refer to SAI Review Sub-Group to note referral to Improving Management of Warfarin, NOACs and Antiplatelets Action Group led by Lynne Charlton, the Diabetic Foot Team and to note an article for Learning Matters (Dr McCall agreed to prepare the article when required).</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 3.3 Action: Governance Team Learning Lessons Categorisation – 1 and 5 Action: M Campbell | Refer to SAI Review Sub-Group |
| 5a | Personal Information redacted by the USI | | Dr M McCarthy | Shared Learning linked to  | N | N | FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the | CLOSE |

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| | | | | | | | <p>Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Members noted the SEA report had not been received and agreed to consider the shared learning when the SEA Report is received.</p> <p>Review Shared Learning at a future meeting when SEA Report is received.</p> <p>Update 9 June 2017: DEFERRED. SEA report has been received and shared with DRO. DRO not present deferred to next meeting.</p> <p>Update 19 June 2017: CLOSE Shared Learning was discussed at the Acute Group and it was agreed the shared learning will not be issued regionally. Governance Team to advise BHSCT.</p> <p>Action: Governance Team</p> | |
| 5b | Personal Information redacted by the USI | | Dr M | Shared Learning linked | | | FIRST REVIEW 20 March 2017: SHARED | CLOSE |

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| | | Personal Information redacted by the USI | McCarthy | to Personal Informatic closed on 21 September 2015. | | | <p>LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Members noted this issue had been addressed by Medical Directors and agreed no further action was required.</p> <p>Post Script – On review of the Datix record, Shared Learning S Irrelevant inform related to tests being requested from another healthcare provider/service. The issue addressed by Medical Directors related to Employment of New/Locum Medical Staff (Irrelevant information redad BHSCT have confirmed that both Shared Learning reports are linked to SAI</p> <p>Personal Information redacted by the USI</p> <p>Review Shared Learning Proforma SL9933 at May meeting.</p> <p>Update 10 May 2017: Further Information Required: Governance</p> | |

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| | | | | | | | <p>Team to seek confirmation from Dr O'Brien (Integrated Care) if a LES for phlebotomy was in place in the GP practice?</p> <p>Action: Governance Team</p> <p>Review at June meeting.</p> <p>Update 9 June 2017: DEFERRED. Awaiting response from Trust. DRO not present. SAI deferred to next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE</p> <p>LES for phlebotomy was not in place in the GP practice.</p> <p>Shared Learning was discussed at the Acute Group and it was agreed the shared learning will not be issued regionally. Governance Team to advise BHSCT.</p> <p>Action: Governance Team</p> | |

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| 5c | | | Dr M McCarthy | Shared Learning linked to Personal Informa closed on 22 August 2016. | | | <p>FIRST REVIEW 20 March 2017: SHARED LEARNING - Due to time constraints the Group were unable to review the Shared Learning. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Update 19 April 2017 – Dr McCarthy to review RCA Report alongside Shared Learning proforma to determine if there is regional learning. As Dr McCarthy is not available for May meeting, review at June meeting.</p> <p>Review June meeting</p> <p>Update 9 June 2017: DEFERRED. DRO not present. SAI deferred to next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: CLOSE Shared Learning was discussed at the Acute Group and it was agreed the shared learning will not be issued regionally.</p> | CLOSE |

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| | | | | | | | Governance Team to advise BHSCT. Action: Governance Team | |
| 3f | Personal Information redacted by the USI | | Dr M McCarthy | | | | <p>FIRST REVIEW 20 March 2017: EARLY ALERT – DRO had listed Early Alert for discussion following response from Trust advising they were not intending to report this incident as a SAI. Following discussion, it was agreed to inform the Trust that the Acute SAI Review Team considered there may be wider learning including learning on central alerting systems and in that regard would be grateful if the Trust would submit a SAI Level 1.</p> <p>Action: Governance Team</p> <p>Review April 2017</p> <p>Update 19 April 2017 – Trust have been requested to submit a SAI notification form. A response is awaited. Governance Team to follow up.</p> <p>Action: Governance Team</p> | REVIEW AT A FUTURE MEETING WHEN RESPONSE IS RECEIVED |

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| | | | | | | | Review at a future meeting when response is received from BHSCT. | |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 20 March 2017 | 9 3p | Feedback from DRO Workshops – Discussion deferred to next meeting. Update 19 April 2017 - DRO Protocol – DROs to discuss DRO Protocol at a staff meeting. Dr Farrell to advise when to relist. Action: Dr Farrell | DR FARRELL TO ADVISE WHEN TO RELIST |
| 20 March 2017 | 10 3q | Acute SAI Review Team - Draft Terms of Reference – Deferred to next meeting. Update 19 April 2017 – Members to consider the Draft Terms of Reference at a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion. Action: Dr Farrell Update 10 May 2017: Elaine Hamilton to remind Dr Farrell to add this item to a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion. Action: Dr Farrell / Elaine Hamilton | DR FARRELL TO ADVISE WHEN TO RELIST |

Date: 9 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall (until 9.30am), Dr Muhammad Sartaj (until 10.15am), Dr Christine McMaster, Mrs Mary McElroy (via teleconference)

Apologies: Dr Miriam McCarthy, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3g | | | Dr M Sartaj | | Y | Y | <p>FIRST REVIEW 9 March 2017 – Further Information Required – Trust to be asked to advise what mechanisms they have put in place to call/recall to review patients diagnosed with conditions that can deteriorate.</p> <p>Action: Governance Team</p> <p>Dr Sartaj to commence discussions with clinicians and check NICE guidance for good practice.</p> <p>Action: Dr Sartaj</p> <p>Review 20 Mach 2016</p> <p>Update 20 March 2017 – DRO query to be forwarded to Trust for response. Review at April meeting.</p> | Review July 2017 |

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| | | | | | | | <p>Action: Governance Team</p> <p>Update 19 April 2017 – Dr Sartaj advised that he had a discussion with Rose Sharkey, Clinical Lead in WHSCT. It was acknowledged there are ongoing pressures within outpatient clinics. Internally WHSCT have a process which prioritises patients who require urgent review, however it relies on administrative staff to identify slots and most of the time it is difficult to find a slot for review even urgent reviews.</p> <p>Following discussion it was agreed there is a potential for regional learning. Dr Sartaj to scope the potential for any specific learning that can be taken forward at a regional level. To be reviewed at June meeting.</p> <p>Action: Dr Sartaj</p> <p>Update 9 June 2017: FURTHER INFORMATION REQUIRED. Dr Farrell has raised the issue of Nurse Injectors</p> | |

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| | | | | | | | <p>with Lisa McWilliams and will request further advice from the SQAT team in respect of this and timely reviews of patient as an overall theme. Dr Farrell will also review the EIAP guidelines re follow up of patients with deteriorating conditions and provide feedback at the next meeting.</p> <p>It was noted the local issues has been identified and dealt with but there is regional learning around robust procedures being put in place for patients with deteriorating conditions to ensure they are followed up more urgently.</p> <p>Action: Dr Farrell / Elaine Hamilton</p> <p>Review July 2017.</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 JANUARY 2017

Date: 16 January 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy

Apologies: Dr Miriam McCarthy

In attendance: Mrs Eleanor Ross (for item 5b), Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 16 January 2017 3j | 9 | <p>Any Other Business</p> <ul style="list-style-type: none"> <div>Personal Inform</div> – SHSCT SAI Members considered the position report in respect of <div>Personal Inform</div> <u>Further information required</u> – Governance Team to ask Southern Trust to forward a copy of their Protocol detailing how lab results are filed following a procedure. The response should also describe how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately. Action: Governance Team Review February 2017 Update 20 March 2017 – DRO not present. Defer to next meeting. Review April 2017 Update 19 April 2017 – It was noted SHSCT submitted Swab Protocol – this was not the Protocol requested. Trust has been asked to submit Lab Result Protocol. Review SAI when correct Protocol is received from Trust. | REVIEW AT A FUTURE MEETING WHEN PROTOCOL IS RECEIVED FROM TRUST |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 DECEMBER 2016

Date: 19 December 2016

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Dr Joanne McClean (via teleconference)

Apologies: Dr Muhammad Sartaj, Mrs Mary McElroy

In attendance: Mrs Siobhan Donald (for item 3b), Mrs Eleanor Ross (for items 4e and 4f), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 NOVEMBER 2016

Date: 21 November 2016

Lead Officers: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster

In attendance: Mrs Eleanor Ross (for item 4m), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | Personal Information redacted by the USI | | | | | | |
| 3I | | | Dr J McClean | | Y | Y | FIRST REVIEW 21 November 2017 – Further professional input – Mary McElroy to discuss with Caroline | CLOSE |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>McGeary and Dr Lourda Geoghegan to ascertain if there is any regional learning around bundle management.</p> <p>Action: Mrs Mary McElroy</p> <p>Review December 2016</p> <p>Update 19 December 2016 – As Mary McElroy was not present and an update had not been provided in advance of the meeting, this SAI to be re-listed for the January meeting.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Mary McElroy advised she had spoken with Dr Geoghegan and had contacted the Trusts. From responses received to date (BT and WT is awaited), bundle insertion, which is national, is ongoing and appears to be strictly adhered to. It was noted that whilst ongoing care is done frequently, perhaps this should go on to maintenance of daily care.</p> <p>Dr McCall to check practice in England</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>and advise.</p> <p>Action: Dr McCall</p> <p>Review February 2017</p> <p>Update 20 March 2017 – Response has been received from NHS Improvement England and shared with Dr McClean who is to consider the format of regional learning – possibly an article for Learning Matters.</p> <p>Action: Dr McClean</p> <p>Review April 2017</p> <p>Update 19 April 2017 - DRO not present – defer to next meeting</p> <p>Update 10 May 2017: CLOSE based on the information provided including the engagement checklist <u>with regional learning identified</u>. Dr McClean (DRO) in conjunction with Siobhan Donald and Mary McElroy will complete an article for Learning Matters in relation to ongoing care.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Dr McCall will liaise with Dr Lavery if the issues raised in this SAI are applicable in ICU and feedback to the Dr McClean.</p> <p>Refer to Regional SAI Review Group to note Learning Matters Article.</p> <p>Dr McClean will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McClean (DRO), Mary McElroy, Siobhan Donald, Elaine Hamilton, Governance Team</p> <p>Update 6 June 2017: FURTHER ADVICE REQUIRED. Dr McClean will liaise with Mary McElroy to ensure all lumens are capped or clamped and ensure this is added to the point of care intervention bundle when it is reprinted.</p> <p>Dr McClean will forward remedial causes and learning lessons template to Elaine Hamilton.</p> | |

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| | | | | | | | <p>Action: Dr McClean / Mary McElroy</p> <p>Update 19 June 2017: All actions have been completed. This will now be removed from agenda</p> | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr J McClean | | Y | y | <p>FIRST REVIEW 21 November 2016– Further Information Required – Dr Farrell raised a number of queries which are to be forwarded to the Trust for response. Response when received from SHSCT it is to be shared with Dr Farrell and Dr McClean for review.</p> <p>Action: Governance Team</p> <p>Further Professional Input: M Campbell to follow up with Integrated Care (Dr M Dowds) regarding shared care scheme with GP.</p> <p>Action: M Campbell</p> <p>Review January 2017</p> <p>Update 16 January 2017 – A response</p> | Review when response is received from Trust |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>from the Trust to queries raised remains outstanding. With regards to Dr Dowds query it was clarified the Shared Care Scheme refers to Lithium LES. M Campbell to advise Dr Dowds.</p> <p>Action: M Campbell</p> <p>Review February 2017</p> <p>Update 20 March 2017 – A response from the Trust to queries raised remains outstanding. Governance Team continue to follow up.</p> <p>Action: Governance Team</p> <p>With regards the prescribing of lithium via a Shared Care Scheme, the GP practice has advised that this patient was not prescribed Lithium under a Shared Care Scheme.</p> <p>RCA report to be shared with Angela Carrington to consider.</p> <p>Southern Trust to be advised that this patient wasn't prescribed lithium</p> | |

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| | | | | | | | <p>under shared care scheme. This would imply the Trust was responsible for monitoring lithium – Trust to be asked to provide comment on this.</p> <p>Action: M Campbell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: AWAITING FURTHER INFORMATION: DRO awaiting a response to queries. Governance Team will continue to liaise with the Trust.</p> <p>Action: Governance Team</p> <p>Review when response received from Trust</p> | |
| | Personal Information redacted by the USI | | Dr J McClean | DRO has query with membership of Review Group | N | N | FIRST REVIEW 21 November 2016 REVIEW TEAM MEMBERSHIP – The DRO has requested that a Vascular | Review at a future meeting |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>Surgeon is involved in the Review Team. The Trust has advised that the SAI is in relation to an aortic aneurysm (arterial). The Trust has vascular surgeons but not arterial surgeons and feel it would not be appropriate to include them in the SAI Group.</p> <p>Governance Team to advise Trust the DRO is content with Terms of Reference and Team Membership.</p> <p>Action: Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives RCA report.</p> | when RCA report is received |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| 21 November 2016 | 6 | <p>Never Events - Circular HSC (SQSD) 56/16</p> <p>Members noted the DoH had issued Circular HSC (SQSD) 56/16 – The Introduction of a Never Events list on 21 October 2016.</p> | |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>With regards SAI [Personal Info] which had been identified as a Never Event at the October meeting, Mary McElroy undertook to seek clarity from SAI Review Sub-Group as to whether this SAI should be recorded as a Never Event.</p> <p>Update 9 June 2017: Elaine will confirm with Mary McElroy this action was taken forward.</p> <p>ACTION: Elaine Hamilton</p> <p>Update 19 June 2017: Never Events will remain as a standing agenda item at every meeting. Mary McElroy will discuss SAI B [Personal Info] which had been identified as a Never Event at the October meeting at the SAI Review Sub-Group on Wednesday 21 June 2017.</p> <p>ACTION: Mary McElroy</p> | Mary McElroy |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 17 OCTOBER 2016

Date: 17 October 2016

Lead Officers: Dr Brid Farrell, Dr Christine McMaster, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies:

In attendance: Dr Ruth-Ann Thornbury (ADEPT Fellow, Safety Forum), Dr Judith Ewing (Public Health SpR), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | Dr J McCall | | Y | Y | <p>FIRST REVIEW 17 October 2016– DRO advised that this SAI had been listed due to the inadequate SEA report received. It is not clear from the SEA report the main and underlying reasons contributing to why the event happened.</p> <p>DRO to draft an email for HSCB Governance Team to forward to SET advising Acute Review Team not happy with the report and requesting an amended SEA report.</p> <p>Action: Dr J McCall and Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives amended</p> | <p>CLOSE</p> <p>Refer to Regional SAI Review Team</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>SEA report.</p> <p>Update 10 May 2017: FURTHER ADVICE REQUIRED. Dr McCall will liaise with Lisa McWilliams PMSI in relation to the recommendations.</p> <p>This SAI will be included in the Scoping Exercise on delayed diagnosis.</p> <p>Action: Dr McCall</p> <p>Review at 19 June meeting</p> <p>Update 19 June 2017: CLOSE based on the information provided including the engagement checklist.</p> <p>Laura Molloy advised workshops will be held with the four Trusts to advise on how Belfast are managing planned patients for endoscopies more effectively/efficiently. In the meantime Laura has also contact SET to determine their current action for waiting lists.</p> <p>This SAI has also been included within</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>the Delayed Diagnosis Exercise.</p> <p>Dr McCall will forward remedial causes and learning lessons template to Elaine Hamilton.</p> <p>Action: Dr McCall</p> | |

Date: 23 September 2016

Lead Officers: Dr Brid Farrell, Dr Christine McMaster, Dr Muhammad Sartaj, Siobhan Donald (on behalf of Mary McElroy)

Apologies: Dr Joanne McClean, Dr Jackie McCall, Mrs Mary McElroy, Dr Miriam McCarthy

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 AUGUST 2016

Date: 22 August 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Jackie McCall, Dr Christine McMaster, Mrs Mary McElroy

Apologies: Dr Joanne McClean, Dr Muhammad Sartaj

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 22 August 2016 | | <p>(iii) Key Words With regards the surveillance of SAIs to identify patterns/clusters/trends, it was agreed to consider the identification of key words. Mary to provide a list of key words for discussion at the October meeting.</p> <p>Action: Mary McElroy</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Mary McElroy advised she had obtained a list of key words compiled and used by Mental Health and Learning Disability Teams and undertook to share with the group. Mary and Mareth to produce a list of key words identified to date by the Acute Team and circulate for review at the November meeting. Dr McCall to check with other countries if they have a list of key words.</p> <p>Review November 2016</p> <p>Update 21 November 2016 – Members considered the list of key words identified by the Acute Team since April 2016 along with the key words identified and used by the Mental Health and Learning Disability Teams. To be further reviewed at the</p> | <p>Review November 2016</p> <p>Mary McElroy</p> <p>Mary McElroy</p> <p>Mary McElroy/Mareth Campbell</p> <p>Review December 2016</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>December meeting when list of key words from NHS England is available.</p> <p>Review December 2016</p> <p>Update 19 December 2016 – Members considered the list of incident types provided by NHS England Clinical Incident review process circulated with the papers. Dr McCall is awaiting a further list from Julian Johnston which is used at Mortality and Morbidity reviews in Trusts. It was agreed a few officers would meet to consider all lists with a view to compiling a list of key words for the acute team.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Members considered the list of learning lesson categorisations used at Mortality and Morbidity meetings. Dr McCall advised she would share the list with Lynne Charlton, Mary McElroy and Jacqui Burns. She is meeting with them to review this and NHS England classification and identify key words which in turn could be used to identify key themes.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – It has been agreed that in order to ‘theme SAIs’ the Acute SAI Group would consider the Learning Lessons and DATIX remedial causes categorisations when closing SAIs. This will run as a pilot.</p> | <p>Review February 2017</p> <p>Review September 2017</p> |

Date: 18 July 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy (via teleconference)

Apologies: Dr Jackie McCall

In attendance: Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
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All Actions completed from 18 July 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 JUNE 2016

Date: 20 June 2016

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Christine McMaster

Apologies: Dr Joanne McClean

In attendance: Jenny Keane, Mareth Campbell

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 23 MAY 2016

Date: 23 May 2016

Lead Officers: Dr Janet Little, Dr Jackie McCall, Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Paul Darragh, Mrs Mary McElroy, Dr Brid Farrell

Apologies: Siobhan McIntyre

In attendance: Mrs Eleanor Ross, Mrs Siobhan Donald, Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All actions completed from 23 May 2016 meeting

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 APRIL 2016

Date: 18 April 2016

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 18 April 2016 | 7 | <p>Any Other Business</p> <p>(i) Safety Forum – Learning Event Jackie McCall advised members the Safety Forum are commencing plans for the next regional Learning Event for 2016/17. Jackie requested for DROs to highlight any suitable SAIs that could be used for learning at the event. 'Good Standard of Report' is a key word which is captured on Datix and it was agreed DROs will use this if they deem an SAI appropriate for use at the event. This item will be added</p> | All members/Mareth Campbell | To be a reviewed at each meeting of Acute SAI Review Team |

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| | | <p>onto the agenda for each Acute meeting to remind DROs.</p> <p>Update 23 May 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 20 June 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 18 July 2016 - Members agreed to identify three anticoagulant drug related SAIs to showcase at the Learning Event. It was agreed these could be identified during the review being undertaken by Dr Jackie McCall.</p> <p>Update 22 August 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 23 September 2016 – SAI SHSCT SAI (Personal Information redacted by the USI) was highlighted as a SAI that could be used at the learning event.</p> <p>Update 17 October 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 21 November 2016 – SAI (Personal Information redacted by the USI) – SHSCT SAI (Personal Information redacted by the USI) was highlighted as a SAI that could be considered for the Regional Learning Event.</p> <p>Update 19 December 2016 - SAI (Personal Information redacted by the USI) was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Update 16 January 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) – showing patient journey | Dr Jackie McCall | |
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| | | <ul style="list-style-type: none"> ○ SHSCT SAI <small>Personal Information redacted by the USI</small> <p>Update 9 March 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ <small>Personal Information redacted by the USI</small>) ○ <small>Personal Information redacted by the USI</small> <p>Update 20 March 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 19 April 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 10 May 2017: <small>Personal Information redacted by the USI</small> will be considered for a future SAI Learning Event.</p> <p>Update 9 June 2017: <small>Personal Information redacted by the USI</small> will be considered for a future learning event.</p> | | |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 MARCH 2016

Date: 21 March 2016

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Muhammad Sartaj, Dr Paul Darragh (Via teleconference)

Apologies: Dr Jackie McCall, Mrs Mary McElroy

In attendance: Mrs Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 21 March 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 15 FEBRUARY 2016

Date: 15 February 2016

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Paul Darragh, Mrs Mary McElroy (via teleconference)

Apologies: Dr Muhammad Sartaj, Dr Jackie McCall

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 15 February 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 14 JANUARY 2016

Date: 14 January 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Muhammad Sartaj, Mrs Mary McElroy (via teleconference)

Apologies: Dr Janet Little, Dr Jackie McCall

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 14 January 2016

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 DECEMBER 2015

Date: 22 December 2015

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Jackie McCall

Apologies: Dr Muhammad Sartaj, Dr Paul Darragh,

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 22 December 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 24 NOVEMBER 2015

Date: 24 November 2015

Lead Officers: Dr Janet Little (Chair), Dr Muhammad Sartaj, Dr Miriam McCarthy

Apologies: Dr Paul Darragh, Mrs Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Jackie McCall, Paul Kavanagh

In attendance: Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 24 November 2015

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 19 October 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 September 2015

Date: 21 September 2015

Lead Officers: Dr Paul Darragh (Chair), Dr Catherine Coyle, Dr Muhammad Sartaj, Mrs Mary McElroy, Dr Jackie McCall, Dr Louise Herron

(Personal Information redacted by the USI)

Apologies: Janet Little, Miriam McCarthy

In attendance: Paul Kavanagh, Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 21 September 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 August 2015

Date: 18 August 2015

Lead Officers: Dr Paul Darragh (Chair), Mrs Mary McElroy (via teleconference), Dr Muhammad Sartaj, Dr Louise Herron (for SAI Personal Information), Dr Miriam McCarthy

Apologies: Dr Janet Little Dr Jackie McCall

In attendance: Margaret McNally obo Elaine Hamilton, Dr Catherine Coyle

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 18 August 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 JULY 2015

Date: 21 JULY 2015

Lead Officers: Dr Janet Little (Chair), Dr Paul Darragh, Mrs Mary McElroy (via teleconference),

Apologies: Dr Muhammad Sartaj, Dr Louise Herron, Dr Jackie McCall, Dr Miriam McCarthy

In attendance: Margaret McNally obo Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 21 July 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 15 JUNE 2015

Date: 15 June 2015

Lead Officers: Dr Janet Little (Chair), Dr Paul Darragh, Dr Muhammad Sartaj, Mrs Mary McElroy (via teleconference), Dr Louise Herron, Dr Jackie McCall

Apologies: Dr Miriam McCarthy

In attendance: Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – 21 MAY 2015 – ALL ACTION COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – 22 APRIL 2015- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – 16 MARCH 2015- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 FEBRUARY 2015

Date: 16 FEBRUARY 2015

Lead Officers: Dr Janet Little (Chair), Dr Miriam McCarthy, Dr Paul Darragh, Mary McElroy

Apologies: Louise Herron, Muhammad Sartaj, Jackie McCall

In attendance: Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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All Actions completed from 16 February 2015

ACUTE SERVICES SAI REVIEW TEAM MEETING - 12 JANUARY 2015 - ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING - : 07 November 2014- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 28 OCTOBER 2014

Date: 28 October 2014

Lead Officers: Dr Miriam McCarthy, Dr Paul Darragh, Dr Louise Herron, Dr Muhammad Sartaj, Mrs Mary McElroy

Apologies: Dr Janet Little, Mrs Jacqui Burns

In attendance: Mrs Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|-----------|--------------|--|--------------------|--------|---|------------------|
| Personal Information redacted by the USI | | Dr B Farrell | The inquest into this case opened on 28th January and was adjourned by the Coroner. The Coroner has asked the Trust to undertake a number of actions and Trust are currently working through these and updating the action plan as part of that process and the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner. | y | n/a | <p>FIRST REVIEW 28 October 2014: Further Information: The family and DRO were not content with the first report and an amended report has now been received from WHSCT and they have advised 4 independent reports from experts reviewing the aspects of care will be submitted as appendices to the report. Two of these reports have been received.</p> <p>DRO is awaiting the final two reports and input from the coroner in Manchester</p> <p>It was noted there is a delay due to difficulty obtaining an independent report regarding the GP and Community Nursing aspect.</p> <p>It was agreed Governance Team will request two remaining reports from Western Trust and copy email to DRO.</p> | Review June 2017 |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|--|--------|
| | | | | | | <p>Relist for December meeting</p> <p>Action: Governance Team / E Hamilton</p> <p>Ask trust to ensure we get two additional reports!</p> <p>UPDATE 12 JANUARY 2015:</p> <p>FURTHER INFORMATION REQUIRED: There was a delay with the GP report but DRO advised GP and Intensive Care Report will be issued in the near future. There is still no date agreed for Coroner to proceed with the inquest.</p> <p>DRO will request recommendations in the investigation report to be reviewed following submission of all reports.</p> <p>It was agreed this item will remain on the agenda for review.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Review at February meeting</i></p> <p>Update 16 February 2015: FURTHER INFORMATION REQUIRED Still awaiting a report on intensive care treatment. GP report is imminent and will soon be with Trust.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Relist for March meeting</i></p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|---|--------|
| | | | | | | <p>Update 16 March 2015: The GP report is currently being compiled. ICU report has been submitted.</p> <p>It was agreed due to the complexities of this SAI Paul will provide an update to Dr Carolyn Harper.</p> <p>Relist for April meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 21 May 2015: DRO has been liaising with Dr McKinney Medical Director in the Trust regarding this SAI. DRO Will provide an update to Dr Harper.</p> <p>Relist for June meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 15 June 2015: DRO has received a verbal update from Therese Brown WHSCT. Dr Harper has been advised.</p> <p>Relist for July meeting</p> <p>ACTION: Governance Team</p> <p>Update 21 July 2015: It was noted a Coroner's Report from Manchester was awaited. The status of this would be reviewed at the next meeting.</p> <p>ACTION: Governance Team</p> <p>Update 18 August 2015: : <u>FURTHER</u></p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|--|--------|
| | | | | | | <p><u>INFORMATION REQUIRED</u> – Members agreed an email would be sent from the HSCB Governance Team to the Trust for the attention of the Medical Director on behalf of the DRO stating the following:</p> <p><i>'Can the Trust please provide an updated final report by 30 October 2015 to incorporate the findings of the original review and the independent reports commissioned over recent months.</i></p> <p><i>The updated report would be expected to provide the findings, recommendations and a tracking and monitoring report on the actions taken to address the recommendations of the various reports.'</i></p> <p>ACTION: Governance Team</p> <p><u>Update 24 November 2015:</u> DRO had a telecom with Dr A McKinney and T Brown with Lourda Geoghegan and Mary McElroy to discuss progress. Trust action plan has been reviewed and a series of responses have been prepared in respect of all the products of the original report and the speciality reports. DRO awaiting the comments back from Lourda and Mary to our combined response. Once agreed DRO will issue to Trust (via SAs) our overall comments. It is understood this case will be considered by the Manchester Coroner within the next few months.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|---|--------|
| | | | | | | <p>ACTION: DRO (Paul Darragh)</p> <p>Review December Meeting</p> <p>Update 22 December 2015: <u>DEFERRED</u>. DRO not present at meeting.</p> <p>Relist January Meeting</p> <p>Action: Governance Team</p> <p>Update 14 January 2016: <u>FURTHER INFORMATION REQUIRED</u> This SAI was discussed at a recent SHSCG meeting at DHSSPS. Therese Brown advised at the meeting this SAI may be used in the upcoming SAI Event. DRO noted no date has been set for the Manchester Coroner to review the case.</p> <p>Relist for March 2016</p> <p>Action: Governance Team</p> <p>Update 21 March 2016: <u>FURTHER INFORMATION REQUIRED</u> The inquest into this case opened on 28th January and was adjourned by the Coroner.</p> <p>The Coroner has asked the Trust to undertake a number of actions and the Trust is currently working through these and updating the action plan and as part of that process the comments by the</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner.</p> <p>Governance Team to ascertain if there is a timeframe for the response to be submitted to the Coroner? If no timeframe has been specified the response to outstanding HSCB queries should be requested within a two month timeframe.</p> <p>Relist for May 2016</p> <p>Action: Governance Team</p> <p>Update 23 May 2016: A response from the Trust regarding the timeframe to respond to the Coroner remains outstanding. However, it was noted the Coroner's Inquest shouldn't delay any learning. DRO advised Dr L Geoghegan continues to be involved with Mary McElroy concerning issues around cross infection, nursing and community nursing. Dr Geoghegan and Mary McElroy to meet with Dr Farrell to discuss. Dr Farrell to share feedback with the Trust.</p> <p>Action: Dr B Farrell</p> <p>Relist for August 2016</p> <p>Update 18 July 2016 – Dr Farrell to arrange a further meeting with Mary McElroy and Dr</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Geoghegan.</p> <p>Action: Dr B Farrell</p> <p>Review September 2016</p> <p>Update 23 September 2016 - Dr Farrell advised that she had met with Mary McElroy and Dr Geoghegan. An updated Action Plan was received from the Trust on 22 August 2016. DRO content with Action Plan, however wishes to clarify access to community microbiology advice as the RCA report is ambiguous about this. Dr Farrell undertook to raise this with the Pathology Network.</p> <p>Review November meeting.</p> <p>Update 19 December 2016 – Dr Farrell to raise this with the Pathology Network.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Defer to February 2017 meeting.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – Defer to 20 March 2017 meeting.</p> | |

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| | | | | | | <p>Review March 2017</p> <p>Update 20 March 2017 – Dr Farrell advised a response has been received from the Pathology Network and undertook to share the response with Mary McElroy. However, the response doesn't accurately address the query therefore a revised query is to be submitted to the Pathology Network.</p> <p>Action: Dr Farrell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED. SAI Deferred to next meeting</p> <p>Review June 2017</p> <p>Brid will send letter to Pathology review again</p> <p>Update 9 June 2017: FURTHER INFORMATION REQUIRED. DRO will review response from Pathology Network and report back at July Meeting.</p> <p>Action: Dr Farrell</p> <p>Review July 2017</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING - 16 SEPTEMBER 2014- ALL ACTIONS COMPLETED

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 5 AUGUST 2014

Date: 5 August 2014

Lead Officers: Janet Little, Louise Heron, Paul Darragh, Miriam McCarthy, Paul Darragh, Caroline McGeary (for item BHSCT/SAI Personal Informa),
Muhammad Sartaj

In attendance: Jacqui Burns

ACUTE SERVICES SAI REVIEW TEAM MEETING – 8 JULY 2014 ALL ACTIONS COMPLETED

Donna Britton

From: Anne Kane
Sent: 03 July 2017 15:51
To: Margaret Marshall (NIPEC Contact)
Cc: Quinn, AnneM (Personal Information redacted by the USI);
 corporate.governance (Personal Information redacted by the USI)
Subject: FW: DRO Queries - Trust Ref: ID (Personal Informa) Level 2 / HSCB Ref: (Personal Informa)

Dear Margaret

I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed.

Many thanks

Regards
 Anne

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID (Personal Informa) Level 2 / HSCB Ref: (Personal Informa)

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath
 Ann Redpath
 Governance Support Officer
 Health and Social Care Board - Southern Office

Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Inform] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Informa]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient t10] [Personal Inform] SAI Report

Dear Colleague

Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

Donna Britton

From: Anne Kane
Sent: 03 July 2017 16:19
To: serious incidents
Subject: FW: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]
Categories: Work in progress

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 03 July 2017 16:09
To: Anne Kane
Cc: Margaret Marshall (NIPEC Contact)
Subject: RE: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Anne,

I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.

Kind regards

Lindsey

Lindsey Liggett
 Southern Health & Social Care Trust
 Corporate Governance Assistant
 Corporate Clinical & Social Care Governance Office
 Beechfield House
 Craigavon Area Hospital Site
 68 Lurgan Road
 PORTADOWN BT63 5QQ
Telephone [Personal Information redacted by the USI]
Ext [Personal Information redacted by the USI]



From: Anne Kane [mailto:[Personal Information redacted by the USI]]
Sent: 03 July 2017 15:51
To: Marshall, Margaret
Cc: Quinn, AnneM; Corporate.Governance
Subject: FW: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

"This email is covered by the disclaimer found at the end of the message."

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Many thanks

AERedpath
Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

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Corporate Governance

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Dear Colleague

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Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team

Directorate of Acute Services

The Maples

Craigavon Area Hosptial

Personal Information redacted by
the USI

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Donna Britton

From: serious incidents
Sent: 17 July 2017 14:25
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: Outstanding Response to DRO Queries - Trust Ref: ID (Personal Informa) Level 2 / HSCB Ref: (Personal Informa)

Importance: High

Lindsey,

Further to your email below, can you follow-up the outstanding response to queries raised by the DRO in respect of the above incident. See email below, 12/6/17. The DRO would be grateful for a response by return.

Regards.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR

Tel: (Personal Information redacted by the USI)

Email: (Personal Information redacted by the USI)

www.hscboard.hscni.net

From: Corporate.Governance [<mailto:> (Personal Information redacted by the USI)]
Sent: 03 July 2017 16:09
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Cc: Margaret Marshall (NIPEC Contact)
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Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ
Telephone (Personal Information redacted by the USI)

Ext Personal Information
redacted by the USI



From: Anne Kane [<mailto:>Personal Information
redacted by the USI]
Sent: 03 July 2017 15:51
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Cc: Quinn, AnneM; Corporate.Governance
Subject: FW: DRO Queries - Trust Ref: ID Personal Inform Level 2 / HSCB Ref: Personal Informa

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Regards

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Corporate Governance

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Subject: SAI [Patient 110] [Personal Information redacted by the USI] SAI Report

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Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Donna Britton

From: serious incidents
Sent: 02 August 2017 14:41
To: Elaine Hamilton (HSCB)
Subject: Escalation: SHSCT SAI [Personal Inform]; HSCB REF: [Personal Inform]
Attachments: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Elaine

Can you please escalate the following Southern Trust SAI. I have attached the most recent email to the Trust (17/7/17) for your information.

| Trust Ref | HSCB Ref | Information outstanding | Due Date |
|-----------------------------|-------------------|-------------------------|---|
| SHSCT SAI [Personal Inform] | [Personal Inform] | DRO queries | 1 st requested 12/6/17 Reminders issued 3/7/17 & 17/7/17 Telephone call 25/7/17 |

Thanks
Elaine

Donna Britton

From: serious incidents
Sent: 09 August 2017 13:19
To: Elaine Hamilton (HSCB)
Subject: RE: Escalation: SHSCT SAI [Personal Inform]; HSCB REF: [Personal Inform]
Importance: High
Sensitivity: Confidential

Elaine

Can you please advise if the outstanding DRO queries have been escalated with SHSCT.

Regards

Jacqui

From: serious incidents
Sent: 02 August 2017 14:41
To: Elaine Hamilton (HSCB)
Subject: Escalation: SHSCT SAI [Personal Inform]; HSCB REF: [Personal Inform]

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Thanks
 Elaine

Donna Britton

From: Elaine Hamilton (HSCB)
Sent: 09 August 2017 13:30
To: Jacqui Burns
Cc: serious incidents
Subject: RE: Escalation: SHSCT SAI [Personal Inform]; HSCB REF: [Personal Inform]

Sensitivity: Confidential

Categories: Ann

No Jacqui – I will escalate it now

Elaine

From: serious incidents
Sent: 09 August 2017 13:19
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Subject: RE: Escalation: SHSCT SAI [Personal Inform]; HSCB REF: [Personal Inform]
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Sent: 09 August 2017 14:05
To: Margaret Marshall (NIPEC Contact)
Cc: Corporate.governance[REDACTED]; serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [REDACTED] Level 2 / HSCB Ref: [REDACTED]
Importance: High

Margaret,

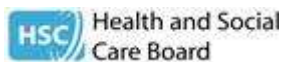
In line with the HSCB Internal escalation process this SAI has been escalated to myself as there are a number of outstanding DRO queries which haven't been responded to (please refer to email below of 12 June 2017).

I would be grateful if a response could be forwarded as a matter of urgency to seriousincidents@hscni.net to avoid further escalation of this matter.

Regards,

Elaine

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [REDACTED]

Internal Ext: [REDACTED]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

From: serious incidents
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Tel: [REDACTED]
Email: [REDACTED]
www.hscboard.hscni.net

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Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 /HSCB Ref: [Personal Inform]

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Inform] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Inform]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22

To: Corporate.Governance

Subject: SAI Patien 1.10 Personal Informa SAI Report

Dear Colleague

Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team

Directorate of Acute Services

The Maples

Craigavon Area Hosptial

Personal Information redacted by
the USI

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Donna Britton

From: Elaine Hamilton (HSCB)
Sent: 14 August 2017 11:11
To: serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Categories: Ann

Please record on Datix – and add follow up date of 22 August 2017

Thanks

Elaine

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 10 August 2017 15:55
To: Elaine Hamilton (HSCB)
Cc: Margaret Marshall (NIPEC Contact)
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Hello Elaine,

The staff member currently dealing with this case is on leave until 21st August.

Kind regards

Lindsey
Corporate Governance

From: Elaine Hamilton (HSCB) [mailto:[Personal Information redacted by the USI]]
Sent: 09 August 2017 14:05
To: Marshall, Margaret
Cc: Corporate.Governance; serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Margaret,

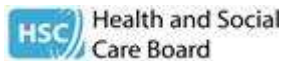
In line with the HSCB Internal escalation process this SAI has been escalated to myself as there are a number of outstanding DRO queries which haven't been responded to (please refer to email below of 12 June 2017).

I would be grateful if a response could be forwarded as a matter of urgency to seriousincidents@hscni.net to avoid further escalation of this matter.

Regards,

Elaine

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [Personal Information redacted by the USI]
Internal Ext: [Personal Information redacted by the USI]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

From: serious incidents
Sent: 17 July 2017 14:25
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Information redacted by the USI] Level 2 / HSCB Ref: [Personal Information redacted by the USI]
Importance: High

Lindsey,

Further to your email below, can you follow-up the outstanding response to queries raised by the DRO in respect of the above incident. See email below, 12/6/17. The DRO would be grateful for a response by return.

Regards.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 03 July 2017 16:09
To: Anne Kane
Cc: Margaret Marshall (NIPEC Contact)
Subject: RE: DRO Queries - Trust Ref: ID [Personal Information redacted by the USI] Level 2 / HSCB Ref: [Personal Information redacted by the USI]

Anne,

I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.

Kind regards

Lindsey

Lindsey Liggett

Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



From: Anne Kane [[mailto:](#) [Personal Information redacted by the USI]]
Sent: 03 July 2017 15:51
To: Marshall, Margaret
Cc: Quinn, AnneM; Corporate.Governance
Subject: FW: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Dear Margaret

I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed.

Many thanks

Regards
Anne

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Inform] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Inform].

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient Personal Inform] SAI Report

Dear Colleague
Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell
Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

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Donna Britton

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 23 August 2017 10:09
To: serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Categories: Work in progress

Hello,

I wish to advise that a response to DRO queries is currently with the Assistant Director for approval .

Kind regards

Lindsey
Corporate Governance

[Personal Information redacted by the USI]

From: Elaine Hamilton (HSCB) [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 09 August 2017 14:05
To: Marshall, Margaret
Cc: Corporate.Governance; serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Margaret,

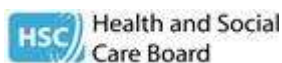
In line with the HSCB Internal escalation process this SAI has been escalated to myself as there are a number of outstanding DRO queries which haven't been responded to (please refer to email below of 12 June 2017).

I would be grateful if a response could be forwarded as a matter of urgency to seriousincidents@hscni.net to avoid further escalation of this matter.

Regards,

Elaine

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [Personal Information redacted by the USI]
Internal Ext: [Personal Inform]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

From: serious incidents
Sent: 17 July 2017 14:25
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]
Importance: High

Lindsey,

Further to your email below, can you follow-up the outstanding response to queries raised by the DRO in respect of the above incident. See email below, 12/6/17. The DRO would be grateful for a response by return.

Regards.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 03 July 2017 16:09
To: Anne Kane
Cc: Margaret Marshall (NIPEC Contact)
Subject: RE: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Anne,

I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ
Telephone [Personal Information redacted by the USI]
Ext [Personal Information redacted by the USI]



From: Anne Kane [mailto:Personal Information redacted by the USI]
Sent: 03 July 2017 15:51
To: Marshall, Margaret
Cc: Quinn, AnneM; Corporate.Governance
Subject: FW: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Dear Margaret

I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed.

Many thanks

Regards
Anne

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

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- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath
Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill

Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Information redacted] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Information redacted]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient 140] [Personal Information redacted] SAI Report

Dear Colleague
Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell
Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

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Donna Britton

From: Mareth Campbell on behalf of serious incidents
Sent: 30 August 2017 14:52
To: 'Corporate.Governance (Personal Information redacted by the USI)'
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID (Personal Inform) Level 2 / HSCB Ref: (Personal Inform)

Lindsey

Our telephone conversation today refers. You advised on 23 August 2017 that the response to DRO queries was with the Assistant Director for approval. To date the response hasn't been received. During our conversation, you undertook to follow-up with the Directorate and if the response is approved, submit it or provide an update on when it will be submitted.

Regards
Mareth

Mareth Campbell
Governance Support Manager
Health and Social Care Board - Southern Office
Tower Hill
ARMAGH BT61 9DR
Tel: (Personal Information redacted by the USI)
E-mail: (Personal Information redacted by the USI)

From: Corporate.Governance [mailto:(Personal Information redacted by the USI)]
Sent: 23 August 2017 10:09
To: serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID (Personal Inform) Level 2 / HSCB Ref: (Personal Inform)

Hello,

I wish to advise that a response to DRO queries is currently with the Assistant Director for approval .

Kind regards

Lindsey
Corporate Governance
(Personal Information redacted by the USI)

From: Elaine Hamilton (HSCB) [mailto:(Personal Information redacted by the USI)]
Sent: 09 August 2017 14:05
To: Marshall, Margaret
Cc: Corporate.Governance; serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID (Personal Inform) Level 2 / HSCB Ref: (Personal Inform)
Importance: High

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Margaret,

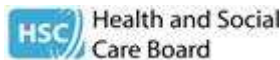
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Regards,

Elaine

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

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(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

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Anne,

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Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

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Dear Margaret

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Anne

From: serious incidents
Sent: 12 June 2017 12:22
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Subject: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

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Many thanks

Ann Redpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

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From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Information redacted] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Information redacted]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient 140] [Personal Information redacted] SAI Report

Dear Colleague
Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell
Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples

Craigavon Area Hospital

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Donna Britton

From: serious incidents
Sent: 01 September 2017 16:52
To: Anne Kane
Subject: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] / HSCB Ref: [Personal Inform]
Attachments: Position Report [Personal Inform].pdf

Importance: High

Anne,

Please see SAI below for escalation, I have highlighted Governance action to date in the table below.

See attached position report for ease of reference.

| Trust | POC | Trust Ref | HSCB Ref: | Information Outstanding | Governance Team Action to Date |
|-------|-------|---------------------------------|-------------------|---------------------------------------|--|
| SHSCT | Acute | [Personal Information redacted] | [Personal Inform] | Reponse to DRO Queries as of 12/06/17 | <p>12/06/17: DRO queries to Trust</p> <p>03/07/17: 1st reminder to Trust</p> <p>17/07/17: 2nd reminder to Trust</p> <p>25/07/17: Telephone call to Trust</p> <p>09/08/17: Escalation email from E Hamilton to M Marshall</p> <p>14/08/17: Update received from Trust noting that 'The staff member currently dealing with this case is on leave until 21st August'.</p> <p>23/08/17: Update received from Trust noting 'I wish to advise that a response to DRO queries is currently with the Assistant Director for approval.'</p> <p>30/08/17: Telephone call to Trust</p> |

Thanks
Geraldine

From: Elaine Hamilton (HSCB)
Sent: 09 August 2017 14:05
To: Margaret Marshall (NIPEC Contact)
Cc: Corporate.governance [Personal Information redacted by the USI]; serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]
Importance: High

Margaret,

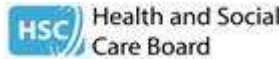
In line with the HSCB Internal escalation process this SAI has been escalated to myself as there are a number of outstanding DRO queries which haven't been responded to (please refer to email below of 12 June 2017).

I would be grateful if a response could be forwarded as a matter of urgency to seriousincidents@hscni.net to avoid further escalation of this matter.

Regards,

Elaine

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [Personal Information redacted by the USI]
Internal Ext: [Personal Information redacted by the USI]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

From: serious incidents
Sent: 17 July 2017 14:25
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Information redacted by the USI] Level 2 / HSCB Ref: [Personal Information redacted by the USI]
Importance: High

Lindsey,

Further to your email below, can you follow-up the outstanding response to queries raised by the DRO in respect of the above incident. See email below, 12/6/17. The DRO would be grateful for a response by return.

Regards.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 03 July 2017 16:09
To: Anne Kane
Cc: Margaret Marshall (NIPEC Contact)
Subject: RE: DRO Queries - Trust Ref: ID [Personal Information redacted by the USI] Level 2 / HSCB Ref: [Personal Information redacted by the USI]

Anne,

I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone Personal Information redacted by the USI

Ext Personal Information redacted by the USI



From: Anne Kane [<mailto:Personal Information redacted by the USI>]
Sent: 03 July 2017 15:51
To: Marshall, Margaret
Cc: Quinn, AnneM; Corporate.Governance
Subject: FW: DRO Queries - Trust Ref: ID Personal Inform Level 2 / HSCB Ref: Personal Inform

Dear Margaret

I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed.

Many thanks

Regards
Anne

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID Personal Inform Level 2 / HSCB Ref: Personal Inform

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?

- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Information redacted by the USI] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Information redacted by the USI]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient 110] [Personal Information redacted by the USI] SAI Report

Dear Colleague
Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell
Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Donna Britton

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 15 September 2017 15:32
To: serious incidents
Subject: FW: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Information] Level 2 / HSCB
Ref: [Personal Information]

Categories: Work in progress

Please see below response to DRO queries

Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.

- The CT MRI and US were ordered by or on behalf of an individual Consultant General Surgeon. A further CT was ordered by a Breast Surgeon.
- The Trust currently has a short life working group reviewing systems and processes for the management of results
- *I am checking if the case was presented at M&M for wider learning*

The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?

- This SAI was in relation to triage by one urologist, the Trust has addressed this issue with the Consultant involved
- Electronic triage has been rolled out for Urology, this should mitigate against late or uncompleted triage within the specialty.

Ensure Trust Urologists are compliant in accordance with IEAP

- The Trust Urology team have been made aware of the requirements within the IEAP in relation to triage of clinical referrals

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ
Telephone [Personal Information redacted by the USI]
Ext [Personal Information redacted by the USI]



From: serious incidents [<mailto:seriousincidents@hscni.net>]
Sent: 17 July 2017 14:25
To: Corporate.Governance
Subject: Outstanding Response to DRO Queries - Trust Ref: ID [Personal Informa] Level 2 / HSCB Ref: [Personal Informa]
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

Further to your email below, can you follow-up the outstanding response to queries raised by the DRO in respect of the above incident. See email below, 12/6/17. The DRO would be grateful for a response by return.

Regards.

Elaine Hyde
Governance Office
Health and Social Care Board - Southern Office
Tower Hill
Armagh BT61 9DR
Tel: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [<mailto:> [Personal Information redacted by the USI]]
Sent: 03 July 2017 16:09
To: Anne Kane
Cc: Margaret Marshall (NIPEC Contact)
Subject: RE: DRO Queries - Trust Ref: ID [Personal Informa] Level 2 / HSCB Ref: [Personal Informa]

Anne,

I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust

Corporate Governance Assistant
 Corporate Clinical & Social Care Governance Office
 Beechfield House
 Craigavon Area Hospital Site
 68 Lurgan Road
 PORTADOWN BT63 5QQ
Telephone [Personal Information redacted by the USI]
Ext [Personal Information redacted by the USI]



From: Anne Kane [mailto:[Personal Information redacted by the USI]]
Sent: 03 July 2017 15:51
To: Marshall, Margaret
Cc: Quinn, AnneM; Corporate.Governance
Subject: FW: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

Dear Margaret

I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed.

Many thanks

Regards
 Anne

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

www.hscboard.hscni.net

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Information redacted by the USI] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Information redacted by the USI]

Regards

Eileen Conlon
Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI [Patient Personal Information redacted by the USI] SAI Report

Dear Colleague
Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell
Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hospital

[Personal Information redacted by the USI]

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Donna Britton

From: serious incidents
Sent: 15 September 2017 17:23
To: Joanne McClean
Subject: Trust Response - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]
Attachments: Position Report [Personal Inform].pdf

Joanne,

Please see below Trust response to DRO queries:

Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.

- The CT MRI and US were ordered by or on behalf of an individual Consultant General Surgeon. A further CT was ordered by a Breast Surgeon.
- The Trust currently has a short life working group reviewing systems and processes for the management of results
- *I am checking if the case was presented at M&M for wider learning*

The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?

- This SAI was in relation to triage by one urologist, the Trust has addressed this issue with the Consultant involved
- Electronic triage has been rolled out for Urology, this should mitigate against late or uncompleted triage within the specialty.

Ensure Trust Urologists are compliant in accordance with IEAP

- The Trust Urology team have been made aware of the requirements within the IEAP in relation to triage of clinical referrals

Please advise if any further action is required, otherwise this SAI will be listed at the next Paediatric Review Team Meeting. A Position Report is attached for ease of reference.

Regards

Roísín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 12 June 2017 12:22
To: 'Corporate.Governance'
Subject: DRO Queries - Trust Ref: ID [Personal Inform] Level 2 / HSCB Ref: [Personal Inform]

The DRO has now considered the RCA Report for the above SAI and would request further clarification on the following points:

- Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
- The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
- Ensure Trust Urologists are compliant in accordance with IEAP

Please submit your response to seriousincidents@hscni.net

Many thanks

AERedpath
Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 16 March 2017 11:49
To: serious incidents
Cc: ClientLiaison, AcutePatient
Subject: Encryption SAI Reports And Checklist ID [Personal Inform] Level 2

Please find attached approved report and checklist in respect of SAI ID [Personal Inform]

Regards

Eileen Conlon

Corporate Governance

From: Farrell, Roisin
Sent: 16 March 2017 09:22
To: Corporate.Governance
Subject: SAI Patien 140 Personal Inform SAI Report

Dear Colleague

Please find attached approved report & Checklist for submission to HSCB on our behalf.

Kind Regards

Roisin Farrell

Clinical & Social Care Governance Team
Directorate of Acute Services
The Maples
Craigavon Area Hosptial

Personal Information redacted by
the USI

Donna Britton

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 08 August 2017 12:19
To: serious incidents
Cc: Geraldine McArdle
Subject: RE: SHSCT - Checklist Validation 01.10.16 to 31.03.17
Attachments: Copy of SHSCT - Checklist Validation 01.10.16 - 31.03.17 (2).xlsx

Categories: Yellow Category

Please find attached for your information and appropriate action.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



From: serious incidents [mailto:seriousincidents@hscni.net]
Sent: 04 August 2017 16:44
To: Corporate.Governance
Subject: SHSCT - Checklist Validation 01.10.16 to 31.03.17

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As the Board has a monitoring role in relation to the level of engagement with carers /service users /families following a SAI, we are now seeking updates on SAIs where the Trust had previously indicated further engagement was planned based on checklists received between 01.10.16 – 31.03.17.

I have attached a spreadsheet for your Trust which references the SAls where the Final Report had not been shared. I would be grateful if you would review the information and complete the columns highlighted in yellow, indicating if/when the report was subsequently shared, if the report has not yet been shared please provide a rationale and indicate if further engagement is planned by the Trust.

Please return the completed spreadsheet to seriousincidents@hscni.net copied to Personal Information redacted by the USI as soon as possible.

We will continue to monitor this information on a six monthly basis, and include as part of the SAI analysis contained within the Bi-annual SAI Learning Report.

If you require any further information, please do not hesitate to contact me.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: Personal Information redacted by the USI

E: Personal Information redacted by the USI

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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 25 SEPTEMBER 2017

Date: 25 September 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Christine McMaster, Dr Joanne McClean (Via Teleconference), Angela Carrington, Dr Jenny Mack SPR Public Health Medicine

Apologies: Mary McElroy, Dr Joanne McClean, Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|----|--|-----------|----------|-------------------|--------|---|---|--------------------------|
| | Personal Information redacted by the USI | | | | | | | |
| 2a | | | R McHugh | Y | Y | <p>First Review 25 September 2017: CLOSE based on the information provided including the engagement checklist. New regional learning was identified.</p> <p>It was noted the insulin thematic review is currently being finalised and is applicable to the issues raised within this SAI.</p> <p>Rose McHugh will refer this SAI to the Diabetes Network In-patient Group for action and devise a newsletter article for Learning Matters.</p> <p>Action: Rose McHugh / Elaine Hamilton</p> | <p>Close</p> <p>Refer to the Regional SAI Review Team Meeting</p> | Diabetes – insulin error |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|----|--|-----------|-----------------|-------------------|--------|--|--|-------------------|
| | Personal Information redacted by the USI | | | | | | | |
| 2b | | | Dr McCarthy | Y | Y | First Review 25 September 2017: DEFERRED. DRO was not present. SAI deferred to next meeting Review 6 October 2017 | Review 6 October 2017 | |
| 2c | | | Dr S McGuinness | Y | Y | First Review 25 September 2017: CLOSE based on the information provided including the engagement checklist. New regional learning was identified and the Trust has raised this regionally at the Managed Radiology Clinic Network. | Close Refer to the Regional SAI Review Team | |
| 5b | | | Dr McCarthy | | | First Review 25 September 2017 DEFERRED. DRO was not present. SAI deferred to next meeting Review 6 October 2017 | Review 6 October 2017 | |
| 5c | | | Dr McCarthy | | | First Review 25 September 2017: FURTHER INFORMATION REQUIRED. At the time of closure the Trust intended to share the learning through the CCanNI network. Governance team to confirm with Linda Mulholland CCanNI network this action was completed. Dr McCall advised Alert <i>HSC(SQSD) 17/10 - preventing fatalities from medication</i> | Review when a response is received from CCanNI | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|----|----------|--|-------------|-------------------|--------|---|--------|-------------------|
| | | | | | | <i>loading doses</i> was previously actioned by the SQAT team. | | |
| | | Personal Information redacted by the USI | | | | Action: Governance Team | | |
| 6a | | | Dr J McCall | | | First Review 25 September 2017: CLOSE based on information provided from the Trust. An SAI is not required to be submitted. | CLOSE | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 4 SEPTEMBER 2017

Date: 4 September 2017

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Sinead McGuinness, Dr Joanne McClean, Mrs Mary McElroy (via teleconference), Dr Louise Herron. Ms Angela Carrington, Dr Muhammad Sartaj

Apologies: Dr Christine McMaster, Siobhan Donald

In attendance: Elaine Hamilton, Dr Damien Bennett (for item 2)

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|----------|--|-----------------|-------------------|--------|---|--------|
| | | Personal Information redacted by the USI | | | | | |
| 3d | | | Dr S McGuinness | Y | Y | First Review 4 September 2017: DRO TO BE REALLOCATED and LEVEL 2 SAI TO BE SUBMITTED. SAI was discussed and it was agreed this SAI should be reallocated to a | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|-------------------------|-----------|---|--------|
| | | | | | | <p>DRO within Health Protection. Members of the Group felt this SAI has met the criteria for a level 2 investigation and should be resubmitted from the Trust as Level 2.</p> <p>Governance Team to request SAI to be resubmitted as level 2 SAI as agreed by member of the Acute SAI Review Team including the DRO.</p> <p>Action Governance Team</p> <p>Elaine Hamilton will request a DRO from Health Protection. Action: Elaine Hamilton</p> <p>Review 6 October 2017</p> <p>Update 25 September 2017: CLOSE DRO was reallocated to Dr Philip Veal. Dr Veal is content to close the SAI based on the information provided including the engagement checklist. No new Regional Learning was identified.</p> <p>Governance Team to advise Dr Veal The Acute SAI Review Team were in</p> | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | agreement with his comments. Action: Governance Team | |
| 3e | | Personal Information redacted by the USI | S Donald | Y | Y | First Review 4 September 2017: DEFERRED DRO has now received the full SEA report and will provide an update at the meeting on 16 October meeting. Action: Siobhan Donald | Review 16 October 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 AUGUST 2017

Date: 21 August 2017

Lead Officers: Dr Louise Herron (Chair) Dr Sinead McGuinness, Dr Joanne McClean (via teleconference), Ms Eleanor Ross, Ms Rose McHugh, Mrs Mary McElroy (via teleconference)

Apologies: Dr Brid Farrell Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Angela Carrington, Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | Personal Information redacted by the USI | | | | | |
| 2b | | | Dr C McMaster | Y | Y | First Review 21 August 2017: FURTHER INFORMATION REQUIRED. DRO was not present at meeting. Members discussed | Pending Closure |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>incident and it was agreed Elaine Hamilton will advise Dr McMaster members felt further clarification was required if medical staff were made aware of abnormal results when it was phoned through to the ward or if they were just recorded in the notes and not notified to medical staff or actioned on.</p> <p>Action: Elaine Hamilton Review 25 September 2017</p> <p>Update 25 September 2017: Pending Closure. Response has not been received from Northern Trust in relation to DRO query noted 21 August 2017. Governance Team to continue to remind Northern Trust to submit response.</p> <p>DRO to consider a referral to pathology when response is received from Trust.</p> <p>If DRO is content with response received the Acute SAI Review Team are content to close SAI.</p> <p>Action: Governance Team / Dr McMaster</p> | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 2c | | | Dr S McGuinness | Y | Y | <p>First Review 21 August 2017: FURTHER ACTION REQUIRED. Dr McGuinness will devise an email to serious incidents for the Western Trust to ask if they would be willing to share the SOP referred to in the report regarding practice that the surgeon will check and read aloud the component type and size rather than the nurse and to discuss its application regionally at the regional Trauma and Orthopaedics group</p> <p>When a response is received from Western Trust Dr McGuinness will contact Dr McClean to add this onto the T&O Group agenda.</p> <p>Action: Dr McGuinness</p> <p>Review when a response has been received from WHSCT.</p> <p>Update 25 September 2017: CLOSE based on the information provided including the engagement checklist. New Regional Learning was identified.</p> <p>The issue within this SAI has been tabled at the Regional T&O Group and all Trusts</p> | <p>Close</p> <p>Refer to the Regional SAI Review Team Meeting</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>are represented at this Group.</p> <p>Dr McClean will devise a Learning Letter re changes within surgery procedures as discussed at the T&O Group.</p> <p>Action: Dr McClean</p> | |
| 2f | Personal Information redacted by the USI | | Dr S McGuinness | Y | Y | <p>First Review 21 August 2017: FURTHER INFORMATION REQUIRED. A newsletter article will be completed in respect of the themes emerging from this SAI and W10624.</p> <p>Governance Team will confirm with the DRO if an interface incident has been received from WHSCT for NIAS and BHSCT. If it hasn't been received Governance Team to request WHSCT to submit an interface incident for NIAS and BHSCT to complete an SAI.</p> <p>Action: Dr McGuinness / Governance Team</p> <p>Review 25 September 2017</p> <p>Update 25 September 2017: CLOSE based</p> | Close |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>on the information provided including the engagement checklist. New Regional Learning was identified.</p> <p>Dr McClean will include the Royal College of Emergency poster in relation to missed aortic dissection in the Learning Matters Newsletter.</p> | |
| 2g | Personal Information redacted by the USI | | Dr C McMaster | Y | Y | <p>First Review 21 August 2017: FURTHER PROFESSIONAL ADVICE REQUIRED. It was agreed to refer this SAI to the Mental Health DRO responsible for this Trust area and Elaine Hamilton will ask Jacqui Burns to add to the next Mental Health Review Team agenda for their professional opinion on regional learning in relation to this incident.</p> <p>Action: Governance Team / Elaine Hamilton</p> <p>Review 16 October 2017</p> | <p>Review 16 October 2017</p> <p>Refer to the Regional SAI Review Team Meeting</p> |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 7 AUGUST 2017

Date: 07 August 2017

Lead Officers: Dr Brid Farrell (chair), Dr Sinead McGuinness, Dr Miriam McCarthy, Dr Christine McMaster, Angela Carrington, Siobhan Donald, Dr Louise Herron

Apologies: Dr Jackie McCall, Dr Joanne McClean, Ms Eleanor Ross, Mrs Mary McElroy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 2e | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: FURTHER INPUT REQUIRED.</p> <p>Elaine Hamilton to forward LSR Section 3 point 8 to Lisa McWilliams (PMSI) to confirm if this is an acceptable ratio of red flag / planned patients / urgent patients / routine patients.</p> <p>Elaine Hamilton to forward LSR to Jackie McCall for consideration within delayed diagnosis scoping exercise.</p> <p>Review when response received from PMSI</p> <p>Action: Elaine Hamilton</p> | <p>Review when response received from PMSI</p> <p>Refer to Regional SAI Review Sub Group</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 2g | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Elaine Hamilton to contact Dr Lorraine Doherty to confirm what regional learning should be disseminated from a Health Protection perspective.</p> <p>Action: Elaine Hamilton</p> <p>Review when response received from Health Protection.</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. A response has been received from Health Protection in relation to this SAI. Dr Farrell will discuss the most appropriate method to review Health Care Associated Infection SAIs with Dr Doherty.</p> <p>Action: Dr Farrell</p> | Review 6 November 2017 |
| | Personal Information redacted by the USI | | | | | Review 6 November 2017 | |
| 2h | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Elaine Hamilton to share report with Health Protection team for their professional opinion on regional learning in relation to</p> | Review 6 November 2017 |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>this incident.</p> <p>Action: Elaine Hamilton</p> <p>Review when response received from Health Protection.</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED: Dr Farrell will discuss the most appropriate method to review Health Care Associated Infection SAls with Dr Doherty.</p> <p>Action: Dr Farrell</p> <p>Review 6 November 2017</p> | |
| 4a | Personal Information redacted by the USI | | Dr L Herron | N | N | <p>First Review 7 August 2017: AWAIT FINAL REPORT. Never Event was discussed and it was agreed no further action needs to be taken at the moment and Governance Team will follow up on LSR with the BHSCT if not received by the due date.</p> <p>Action: Governance Team</p> <p>Review when LSR is received from BHSCT.</p> | Review when LSR is received from BHSCT. |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 5b | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: Shared Learning Proforma to be relisted for 4 September 2017.</p> <p>Review 4 September 2017</p> <p>Update 4 September 2017: The BHSCT have responded to queries the DRO raised in relation to the SAI.</p> <p>Elaine Hamilton to undertake a search on Datix in relation to other SAIs related to epidurals and report back at the meeting on 25 September 2017. A decision on the Regional Learning will be made at that meeting.</p> <p>Action: Elaine Hamilton</p> <p>Review 25 September 2017</p> <p>Update 25 September 2017: DRO was not present. SAI deferred to next meeting</p> <p>Review 6 October 2017</p> | Review6 October 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 3 July 2017

Date: 03 July 2017

Lead Officers: Dr Brid Farrell (chair), Dr Muhammad Sartaj, Dr Miriam McCarthy, Dr Jackie McCall, Dr Joanne McClean (by Teleconference), Mrs Angela Carrington (by Teleconference).

Apologies: Dr Christine McMaster, Ms Eleanor Ross, Mrs Mary McElroy, Dr Louise Herron, Dr Sinead McGuinness

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 5a | | | Dr J McCall | | | <p>First Review 3 July 2017: FURTHER INFORMATION REQUIRED: Governance Team to email the Trust advising this Interface Incident was discussed at the Acute SAI review Team Meeting and it was considered a serious incident. As this incident occurred three years ago the HSCB/PHA will not be requesting a SAI to be submitted on this occasion but would ask for a report detailing the procedures put in place to prevent reoccurrence.</p> <p>Action: Governance Team</p> <p>Review when response received</p> <p>Update 25 September 2017: CLOSE based on information provided from the Trust.</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | An SAI is not required to be submitted. Governance Team will continue to follow up any outstanding queries. Action: Governance Team | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 19 JUNE 2017

Date: 19 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Muhammad Sartaj, Dr Miriam McCarthy, Dr Jackie McCall, Dr Joanne McClean (by Teleconference), Mrs Mary McElroy (by Teleconference), Mrs Angela Carrington (by Teleconference).

Apologies: Dr Christine McMaster, Ms Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 2f | Personal Information redacted by the USI | | Dr M Sartaj | y | y | <p>First Review 19 June 2017: FURTHER INFORMATION REQUIRED. Dr Sartaj to discuss both this SAI and <small>Personal Information</small> with Louise O'Dalaigh (WHSC – Ophthalmology and Optometry) to request further information / clarity on these SAIs.</p> <p>Action: Dr Sartaj Review 3 July 2017</p> <p>Update 3 July 2017: FURTHER INFORMATION REQUIRED. Louise O'Dalaigh is currently on annual leave therefore Dr Sartaj was unable to contact her.</p> <p>Action: Dr McGuinness / Dr Sartaj</p> <p>Review 7 August 2017</p> <p>Update 7 August 2017: Elaine to meet with Dr Sartaj as Dr Sartaj was not present at meeting.</p> <p>Action: Elaine Hamilton</p> | Review with Dr Sartaj at a separate Meeting |
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| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 2i | Personal Information redacted by the USI [REDACTED] | | Dr M Sartaj | | | <p>First Review 19 June 2017: FURTHER INFORMATION REQUIRED. Dr Sartaj to discuss both this SAI and [REDACTED] with Louise O'Dalaigh (WHSCCT – Ophthalmology and Optometry) to request further information / clarity.</p> <p>Action: Dr Sartaj</p> <p>Review 3 July 2017</p> <p>Update 3 July 2017: FURTHER INFORMATION REQUIRED. Louise O'Dalaigh is currently on annual leave and therefore Dr Sartaj was unable to contact her.</p> <p>Action: Dr McGuinness / Dr Sartaj</p> <p>Review 7 August 2017</p> <p>Update 7 August 2017: Elaine to meet with Dr Sartaj as Dr Sartaj was not present at meeting.</p> <p>Action: Elaine Hamilton</p> | Review with Dr Sartaj at a separate Meeting |

ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 9 JUNE 2017

Date: 9 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Christine McMaster, Dr Muhammad Sartaj, Eleanor Ross

Apologies: Dr Joanne McClean, Dr Jackie McCall, Dr Louise Herron, Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Miriam McCarthy

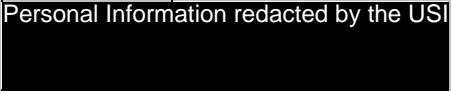
In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3d | | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED. Dr McCarthy to draft an email for Governance Team to BHSC Vascular Service requesting confirmation of care pathway for carotid surgery. Dr McCarthy to share report with Vascular Network for their consideration.</p> <p>Refer to Regional SAI Group to note referral to Vascular Network.</p> <p>Action Dr McCarthy / Governance Team</p> <p>Update 7 August 2017: FURTHER INFORMATION REQUIRED.</p> | <p>Review when response is received from BHSC and Vascular Network</p> <p>Refer to Regional SAI Group</p> |

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| | | | | | | <p>Governance Team to email BHSCT with the following points:</p> <ul style="list-style-type: none"> • Thanking them for forwarding the Draft Carotid Artery Intervention Vascular Pathway. • What involvement has there been with Dr Ivan Wiggam and the Regional TIA Group in developing this pathway • BHSCT to advise what steps are required to formalise this Pathway as the Stroke Network would like to implement this on a regional basis and would be happy to take it forward. <p>Governance Team to share the Carotid Artery Intervention Vascular Pathway with the Vascular network requesting their views on it and also asking if they considered the SAI which had previously been issued to them.</p> <p>Action: Governance Team</p> <p>Review when response is received from BHSCT and Vascular Network</p> | |
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| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3f | | | Dr M McCarthy | Y | Y | <p>FIRST REVIEW 9 June 2017: DEFERRED. DRO not present. Will be discussed at the next meeting.</p> <p>Review June 2017</p> <p>Update 19 June 2017: FURTHER INFORMATION REQUIRED. Dr McCarthy to draft an email for Governance Team to issue to BHSCT seeking confirmation on responsibility for post op monitoring of epidurals and request copy of Trust Epidural Policy.</p> <p>Action: Dr McCarthy / Governance Team</p> <p>Review when response received from Trust</p> <p>Update 7 August 2017: FURTHER INFORMATION REQUIRED.</p> <p>Governance Team to email BHSCT with the following points:</p> <ul style="list-style-type: none"> • Thank you for forwarding your guidelines for Epidural Analgesia for Adult Patients. | Pending Closure – review 6 October 2017 |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <ul style="list-style-type: none"> • Could BHSCT provide a considered view as to the extent to which the policy was adhered to in particular Section 7 Care of the Patient and section 8.2 hypotension • Was there a risk that could have been managed more appropriately? <p>Angela Carrington will advise if all five Trusts have epidural policies in place.</p> <p>Action: Governance Team / Angela Carrington</p> <p>Review when response is received from Trust</p> <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Elaine Hamilton to undertake a search on Datix in relation to other SAIs related to epidurals. If there are other similar incidents the SAI will be discussed again on 25 September and if there are no similar cases the SAI can be closed.</p> | |

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| | | | | | | <p>Action: Elaine Hamilton</p> <p>Review 25 September 2017</p> <p>Update 25 September 2017: DRO was not present. SAI deferred to next meeting</p> <p>Review 6 October 2017</p> | |
| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
| 3g | Personal Information redacted by the USI  | | Dr Sartaj | Y | Y | <p>FIRST REVIEW 9 June 2017: PENDING CLOSURE. Close pending receipt of monitoring and tracking report and based on the information provided including the engagement checklist. No regional learning identified.</p> <p>Refer to SAI Sub-Group to note an onward referral to Judith Ewing for SAI to be considered in the review of Oral Anticoagulants.</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 2.1, 3.3 and 5.1 <p>Action: Governance Team</p> <ul style="list-style-type: none"> Learning Lessons Categorisation – 3 & 5 <p>Action: E Hamilton</p> | Close |

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| | | | | | | <p>SAI not required to be reviewed. Will be noted at Group when monitoring and tracking report is received for formal closure</p> <p>Update 25 September 2017: CLOSE based on the information provided including the engagement checklist along with the Monitoring and Tracking Report.</p> <p>No new regional learning was identified by the Acute SAI Review Team but SAI was considered within the review of Oral Anticoagulants.</p> | |
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| 3j | Personal Information redacted by the USI | Dr Sartaj | Y | Y | <p>First Review 9 June 2017: FURTHER INFORMATION REQUIRED. This SAI involved a rare complication of nasogastric insertion causing a pneumothorax. Governance Team to email Jackie McCall requesting information on how many of these cases have been reported nationally and advise DRO.</p> <p>Eleanor Ross agreed to research protocols around chest x-ray following nasogastric insertion and report back to DRO via serious incidents.</p> <p>It was agreed there is regional learning and Dr Sartaj would complete a newsletter article highlighting complications of a common procedures.</p> <p>Elaine Hamilton will ask Jackie McCall if this can be considered for the SAI learning Event 2018.</p> <p>Refer to Regional SAI Review Team to note Learning Matters newsletter article.</p> <p>Actions: Dr Sartaj, Eleanor Ross, Elaine Hamilton, Governance Team Review July 2017</p> <p>Update 7 August 2017: Elaine to meet with Dr Sartaj as Dr Sartaj was not present at meeting.</p> <p>Action: Elaine Hamilton</p> | Review 16 October 2017 |
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| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Dr McCall is currently liaising with NHS England, in relation to the number cases of pneumothorax associated with the insertion of NG tube which was reported nationally.</p> <p>Eleanor Ross has reported back to the DRO in relation to chest x-ray following NG tube insertion.</p> <p>Action: Dr McCall / Dr Sartaj</p> <p>Review 16 October 2017</p> | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 9c | Longest outliers | | | | | <p>Elaine Hamilton referred to a paper which highlighted the longest outliers with the Trusts in the Acute POC. DROs acknowledged there was an issue receiving reports/requested information etc from Trusts in a timely manner. There was a brief discussion and it was felt this could possibly be addressed through a performance management route and the issue should be raised at SMT.</p> <p>Elaine Hamilton will forward the longest outliers to the individual DROs for their comment/advice.</p> <p><i>Additional Note following the meeting: This issue has been discussed at the QSE Group and it has been agreed Mary Hinds will raise with Valerie Watts before listing this item at the Chief Executive Forum Meeting.</i></p> <p>Update 7 August 2017: Elaine Hamilton tabled the longest outliers paper for the Acute POC. DROs were content this issue is being dealt with at the Chief Executive Forum meeting.</p> <p>This report will continue to be brought to the meeting on a regular basis.</p> | Review 6 October 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 MAY 2017

Date: 10 MAY 2017

Lead Officers: Dr Brid Farrell (chair), Siobhan Donnell, Dr McMaster, Eleanor Ross, Dr Jackie McCall, Mary McElroy (via teleconference)

Apologies: Dr Louise Herron, Dr Miriam McCarthy, Dr Joanne McClean

In attendance: Mareth Campbell, Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 4c | Personal Information redacted by the USI | | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. | Review following meeting with SHSCT |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <ul style="list-style-type: none"> The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information] and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> | |

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| | Personal Information redacted by the USI | | | | | | | |
| 4d | | | Dr J McClean | | Y | Y plan to share report | <p><u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email SHSCT with the following points:</p> <ul style="list-style-type: none"> • Can the Trust advise what awareness sessions have been provided in relation to Sepsis following this incident. • Can the Trust advise on progress towards recommendation 3 – implementing the 'Sepsis 6 Bundle' • Seek clarification from the Trust on what protocol is used for communicating positive blood cultures results. <p>DRO noted there was the following</p> | <p>CLOSE</p> <p>Refer to the Regional SAI Review Team</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>errors in this case:</p> <ul style="list-style-type: none"> • Failure to recognise sepsis. • Deteriorating patient not recognised. • Escalation of deteriorating patient. • Recording error of information from lab and conveying of information. • Results were mixed up. <p>Dr McClean will liaise with Dr McCall on the regional work which is ongoing with Sepsis</p> <p>Action: Governance Team / Dr McClean</p> <p>Review when response received from Trust</p> <p>Update 21 August 2017: FURTHER INFORMATION REQUIRED Dr McClean has received protocols from the Trust in respect of communicating positive blood culture results but will contact the Trust directly as further</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>information is required. All information will be copied to serious incidents mailbox.</p> <p>Action: Dr McClean / Elaine Hamilton</p> <p>Review 25 September 2017</p> <p>Update 25 September 2017: CLOSE based on the information provided including the engagement checklist. New regional learning was identified.</p> <p>Dr McClean / Elaine Hamilton will provide a brief summary of learning to the pathology network (Sarah Buckley) requesting advice on what action to take to avoid reoccurrences. Dr McClean suggested the development of a poster to remind staff to repeat results back when recording results telephoned from the laboratory and to remind laboratory only to telephone urgent/critical results to staff.</p> <p>Governance Team will follow up with Pathology network on the outcome of their decision.</p> | |

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| | | | | | | | <p>It was also noted this SAI has been included within the Sepsis Stocktake which is being undertaken.</p> <p>Action: Dr McClean / Elaine Hamilton / Governance Team</p> | |
| 4f | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | <p><u>First Review 10 May 2017: Further Information Required.</u></p> <ul style="list-style-type: none"> • Dr McCall (DRO) advised SET are considering development of a Jump Policy. Dr McCall will request a copy when it's completed. • Dr McCall to share report with Catherine Coyle in respect of transfers to interventional radiology. • Dr McCall to request protocol for contingency plan for interventional radiologist in SET • Dr McCall to request guidelines | Review when full response is received from SET |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>from Radiology Network on timing of CTPA investigations in diagnosis of PE</p> <ul style="list-style-type: none"> • Dr Farrell to Share Stroke Thrombectomy pathway with Dr McCall <p>It was agreed there are a number of regional learning points from this incident to be considered:</p> <ul style="list-style-type: none"> • Quicker recognition of patient bleeding and resuscitation • Learning from Human factors <p>This SAI will be considered for SAI learning Event in the future.</p> <p>Action: Dr McCall / Dr Farrell / Governance Team</p> <p>Review July 2017</p> <p>Update 3 July 2017: DEFERRED DRO Requested SAI to be deferred to August meeting.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Review August 2017</p> <p>Update 21 August 2017. DEFERRED SAI Deferred until 4 September 2017 meeting.</p> <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Not all information has been received in response to the queries raised with the Trust following the meeting on 10 May.</p> <p>Governance Team to chase up outstanding queries.</p> <p>Action: Governance Team</p> <p>SAI to be reviewed when a full response is received from SET.</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 MARCH 2017

Date: 20 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster, Dr Muhammad Sartaj, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| 3d | | | Dr J McClean | | Y | Y | <p>FIRST REVIEW 20 March 2017 – DRO not present. Defer to next meeting.</p> <p>Relist for April meeting.</p> <p>Review 19 April 2017 - DRO not present – defer to next meeting.</p> <p>Update 10 May 2017: DEFERRED DRO not present. Defer to next meeting.</p> <p>Review 9 June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. DRO requested Governance Team to email the Trust with the following point:</p> <ul style="list-style-type: none"> Trust to give consideration of | Review when response received from Trust |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
| | | | | | | | <p>an electronic referral form preferably the white board system to be available on all wards, between specialities and in ED rather than paper based systems.</p> <p>DRO noted the following concerns: Failure to recognise the deteriorating patient and failure to escalate</p> <p>Action: Governance Team Review when response received from Trust</p> <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED.</p> <p>The Trust submitted a response in error in relation to this SAI. Governance Team will liaise with SHSCT for a response to DRO queries raised.</p> <p>Action: Governance Team Review when response received from Trust</p> | |

| | | TRUST REF | | | | | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017 - CLOSE based on the information provided including the engagement checklist, with <u>Regional Learning identified</u> around the correct use of anticoagulants, lack of co-ordination of care and the need for early referral to multi-specialist team/service. Mary McElroy to refer SAI to Geraldine Teague for consideration of regional learning by the Diabetic Foot Team.</p> <p>Action: Governance Team Mary McElroy</p> <p>Refer to SAI Review Sub-Group to note referral to Improving Management of Warfarin, NOACs and Antiplatelets Action Group led by Lynne Charlton, the Diabetic Foot Team and to note an article for Learning Matters (Dr McCall agreed to prepare the article when required).</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p>Learning Themes</p> | <p>Awaiting feedback from Diabetic Foot Team prior to closure</p> <p>Refer to SAI Review Sub-Group</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <ul style="list-style-type: none"> Datix remedial causes – 3.3 Action: Governance Team Learning Lessons Categorisation – 1 and 5 Action: M Campbell | |

| Date | Agenda Item | Action Agreed | Person Responsible |
|---------------|--------------|---|-------------------------------------|
| 20 March 2017 | 9 3p | <p>Feedback from DRO Workshops – Discussion deferred to next meeting.</p> <p>Update 19 April 2017 - DRO Protocol – DROs to discuss DRO Protocol at a staff meeting. Dr Farrell to advise when to relist.</p> <p>Action: Dr Farrell</p> | DR FARRELL TO ADVISE WHEN TO RELIST |
| 20 March 2017 | 10 3q | <p>Acute SAI Review Team - Draft Terms of Reference – Deferred to next meeting.</p> <p>Update 19 April 2017 – Members to consider the Draft Terms of Reference at a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell</p> <p>Update 10 May 2017: Elaine Hamilton to remind Dr Farrell to add this item to a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell / Elaine Hamilton</p> | DR FARRELL TO ADVISE WHEN TO RELIST |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 JANUARY 2017

Date: 16 January 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Muhammad Sartaj, Dr Christine McMaster, Dr Joanne McClean, Mrs Mary McElroy

Apologies: Dr Miriam McCarthy

In attendance: Mrs Eleanor Ross (for item 5b), Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible |
|---------------------------|-------------|---|---|
| 16 January 2017 3j | 9 | <p>Any Other Business</p> <ul style="list-style-type: none"> <div>Personal Inform</div> – SHSCT SAI Members considered the position report in respect of <div>Personal Inform</div> <u>Further information required</u> – Governance Team to ask Southern Trust to forward a copy of their Protocol detailing how lab results are filed following a procedure. The response should also describe how NIECR is being used by the Southern Trust to ensure abnormal bloods are not filed away inappropriately. Action: Governance Team Review February 2017 Update 20 March 2017 – DRO not present. Defer to next meeting. Review April 2017 Update 19 April 2017 – It was noted SHSCT submitted Swab Protocol – this was not the Protocol requested. Trust has been asked to submit Lab Result Protocol. Review SAI when correct Protocol is received from Trust. | CLOSE FROM AGENDA (PENDING CLOSURE WITH TRUST) |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Update 25 September 2017: CLOSE FROM ACUTE GROUP (PENDING CLOSURE WITH TRUST) The laboratory protocols for results have been received from the SHSCT. The DRO (Dr Corrigan) is content SAI is closed. Dr Farrell will review the protocol and advise the Governance Team if she is content with protocols and confirm closure. Governance Team to follow up with Dr Farrell.</p> <p>Members were in agreement SAI did not require to be reviewed again at the meeting.</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 NOVEMBER 2016

Date: 21 November 2016

Lead Officers: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster

In attendance: Mrs Eleanor Ross (for item 4m), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr J McClean | | Y | y | FIRST REVIEW 21 November 2016– Further Information Required – Dr Farrell raised a number of queries | Review 16 October 2017 |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>which are to be forwarded to the Trust for response. Response when received from SHSCT it is to be shared with Dr Farrell and Dr McClean for review.</p> <p>Action: Governance Team</p> <p>Further Professional Input: M Campbell to follow up with Integrated Care (Dr M Dowds) regarding shared care scheme with GP.</p> <p>Action: M Campbell</p> <p>Review January 2017</p> <p>Update 16 January 2017 – A response from the Trust to queries raised remains outstanding. With regards to Dr Dowds query it was clarified the Shared Care Scheme refers to Lithium LES. M Campbell to advise Dr Dowds.</p> <p>Action: M Campbell</p> <p>Review February 2017</p> <p>Update 20 March 2017 – A response</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>from the Trust to queries raised remains outstanding. Governance Team continue to follow up.</p> <p>Action: Governance Team</p> <p>With regards the prescribing of lithium via a Shared Care Scheme, the GP practice has advised that this patient was not prescribed Lithium under a Shared Care Scheme.</p> <p>RCA report to be shared with Angela Carrington to consider.</p> <p>Southern Trust to be advised that this patient wasn't prescribed lithium under shared care scheme. This would imply the Trust was responsible for monitoring lithium – Trust to be asked to provide comment on this.</p> <p>Action: M Campbell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: AWAITING FURTHER INFORMATION: DRO awaiting a response to queries. Governance Team will continue to liaise with the Trust.</p> <p>Action: Governance Team</p> <p>Review when response received from Trust</p> <p>Update 7 August 2017: FURTHER INFORMATION REQUIRED. Dr McClean to contact CCaNNI for an update on ICU admission criteria.</p> <p>Governance Team to confirm if a response to Dr Farrell's comments in November 2016 has been received.</p> <p>Siobhan Donald will provide nursing advice/comments on this SAI.</p> <p>Action: Governance Team / Siobhan</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | Personal Information redacted by the USI | | | | | Donald / Dr McClean Review 16 October 2017 | |
| | | | Dr J McClean | DRO has query with membership of Review Group | N | N | <p>FIRST REVIEW 21 November 2016 REVIEW TEAM MEMBERSHIP – The DRO has requested that a Vascular Surgeon is involved in the Review Team. The Trust has advised that the SAI is in relation to an aortic aneurysm (arterial). The Trust has vascular surgeons but not arterial surgeons and feel it would not be appropriate to include them in the SAI Group.</p> <p>Governance Team to advise Trust the DRO is content with Terms of Reference and Team Membership.</p> <p>Action: Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives RCA report.</p> | Review at a future meeting when RCA report is received |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 AUGUST 2016

Date: 22 August 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Jackie McCall, Dr Christine McMaster, Mrs Mary McElroy

Apologies: Dr Joanne McClean, Dr Muhammad Sartaj

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Date | Agenda Item | Action Agreed | Person Responsible |
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| 22 August 2016 | | <p>(iii) Key Words With regards the surveillance of SAIs to identify patterns/clusters/trends, it was agreed to consider the identification of key words. Mary to provide a list of key words for discussion at the October meeting.</p> <p>Action: Mary McElroy</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Mary McElroy advised she had obtained a list of key words compiled and used by Mental Health and Learning Disability Teams and undertook to share with the group. Mary and Mareth to produce a list of key words identified to date by the Acute Team and circulate for review at the November meeting. Dr McCall to check with other countries if they have a list of key words.</p> | <p>Review November 2016</p> <p>Mary McElroy</p> <p>Mary McElroy</p> <p>Mary McElroy/Mareth Campbell</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
|------|-------------|--|--|
| | | <p>Review November 2016</p> <p>Update 21 November 2016 – Members considered the list of key words identified by the Acute Team since April 2016 along with the key words identified and used by the Mental Health and Learning Disability Teams. To be further reviewed at the December meeting when list of key words from NHS England is available.</p> <p>Review December 2016</p> <p>Update 19 December 2016 – Members considered the list of incident types provided by NHS England Clinical Incident review process circulated with the papers. Dr McCall is awaiting a further list from Julian Johnston which is used at Mortality and Morbidity reviews in Trusts. It was agreed a few officers would meet to consider all lists with a view to compiling a list of key words for the acute team.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Members considered the list of learning lesson categorisations used at Mortality and Morbidity meetings. Dr McCall advised she would share the list with Lynne Charlton, Mary McElroy and Jacqui Burns. She is meeting with them to review this and NHS England classification and identify key words which in turn could be used to identify key themes.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – It has been agreed that in order to ‘theme SAIs’ the Acute SAI Group would consider the Learning Lessons and DATIX remedial causes categorisations when closing SAIs. This will run as a pilot.</p> | <p>Review December 2016</p> <p>Review February 2017</p> <p>Review September 2017</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Update 25 September 2017: The Learning Lessons and Remedial Causes have not been used by the Acute Team since the meeting on 19 June 2017 as it was felt they were too time consuming and will not help to identify patterns/clusters/trends.</p> <p>Dr Farrell will raise this issue at the next staff meeting to discuss the best method to identify patterns/clusters/trends.</p> <p>Action: Dr Farrell</p> <p>Review December 2017</p> | Review December 2017 |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 APRIL 2016

Date: 18 April 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Jackie McCall, Dr Muhammad Sartaj

Apologies: Dr Janet Little

In attendance: Mrs Elaine Hamilton, Mrs Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible | Status |
|---------------|-------------|--|--|---|
| 18 April 2016 | 7 | <p>Any Other Business</p> <p>(i) Safety Forum – Learning Event Jackie McCall advised members the Safety Forum are commencing plans for the next regional Learning Event for 2016/17. Jackie requested for DROs to highlight any suitable SAIs that could be used for learning at the event. ‘Good Standard of Report’ is a key word which is captured on Datix and it was agreed DROs will use this if they deem an SAI appropriate for use at the event. This item will be added onto the agenda for each Acute meeting to remind DROs.</p> <p>Update 23 May 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 20 June 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 18 July 2016 - Members agreed to identify three anticoagulant drug related SAIs to showcase at the Learning Event. It was agreed these could be identified during the review being</p> | <p>All members/Mareth Campbell</p> <p>Dr Jackie McCall</p> | To be a reviewed at each meeting of Acute SAI Review Team |

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| | | <p>undertaken by Dr Jackie McCall.</p> <p>Update 22 August 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 23 September 2016 – SAI SHSCT SAI (Personal Information redacted by the) was highlighted as a SAI that could be used at the learning event.</p> <p>Update 17 October 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 21 November 2016 – SAI (Personal Information redacted by the) – SHSCT SAI (Personal Information redacted by the) was highlighted as a SAI that could be considered for the Regional Learning Event.</p> <p>Update 19 December 2016 - SAI (Personal Information redacted by the) was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Update 16 January 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) – showing patient journey ○ SHSCT SAI (Personal Information redacted by the USI) <p>Update 9 March 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) ○ SAI (Personal Information redacted by the USI) <p>Update 20 March 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 19 April 2017 - No SAIs identified for the Regional Learning</p> | | |
|--|--|--|--|--|

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| | | <p>Event.</p> <p>Update 10 May 2017: [Personal Information redacted by the USI] will be considered for a future SAI Learning Event.</p> <p>Update 9 June 2017: [Personal Information redacted by the USI] will be considered for a future learning event.</p> <p>Update 19 June 2017: No SAIs identified for the Regional Learning Event.</p> <p>Update 3 July 2017: No SAIs identified for the Regional Learning Event.</p> <p>Update 7 August 2017: Delayed Diagnosis is a theme which will need to be considered</p> <p>Update 21 August 2017: BHSCT/SAI/[Personal Information redacted by the USI] Elaine Hamilton to confirm with Dr McCarthy if this will be referred for consideration at the next Learning Event.</p> <p>Update 4 September 2017: Scoping Exercise on Delayed diagnosis.</p> <p>Update 25 September 2017: SHSCT SAI [Personal Information redacted by the USI] and [Personal Information redacted by the USI] / [Personal Information redacted by the USI]</p> | Elaine Hamilton | |
|--|--|--|-----------------|--|

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 28 OCTOBER 2014

Date: 28 October 2014

Lead Officers: Dr Miriam McCarthy, Dr Paul Darragh, Dr Louise Herron, Dr Muhammad Sartaj, Mrs Mary McElroy

Apologies: Dr Janet Little, Mrs Jacqui Burns

In attendance: Mrs Elaine Hamilton

Actions highlighted in grey are now complete and will be removed following next Acute Services SAI Group meeting.

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|-----------|--------------|--|--------------------|--------|--|--|
| Personal Information redacted by the USI | | Dr B Farrell | The inquest into this case opened on 28th January and was adjourned by the Coroner. The Coroner has asked the Trust to undertake a number of actions and Trust are currently working through these and updating the action plan as part of that process and the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner. | y | n/a | <p>FIRST REVIEW 28 October 2014: Further Information: The family and DRO were not content with the first report and an amended report has now been received from WHSCT and they have advised 4 independent reports from experts reviewing the aspects of care will be submitted as appendices to the report. Two of these reports have been received.</p> <p>DRO is awaiting the final two reports and input from the coroner in Manchester</p> <p>It was noted there is a delay due to difficulty obtaining an independent report regarding the GP and Community Nursing aspect.</p> <p>It was agreed Governance Team will request two remaining reports from Western Trust and copy email to DRO.</p> <p>Relist for December meeting</p> <p>Action: Governance Team / E Hamilton</p> <p>Ask trust to ensure we get two additional reports!</p> | CLOSE FROM AGENDA (PENDING CLOSURE WITH TRUST) |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|--|--------|
| | | | | | | <p>UPDATE 12 JANUARY 2015:</p> <p>FURTHER INFORMATION REQUIRED: There was a delay with the GP report but DRO advised GP and Intensive Care Report will be issued in the near future. There is still no date agreed for Coroner to proceed with the inquest.</p> <p>DRO will request recommendations in the investigation report to be reviewed following submission of all reports.</p> <p>It was agreed this item will remain on the agenda for review.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Review at February meeting</i></p> <p>Update 16 February 2015: FURTHER INFORMATION REQUIRED Still awaiting a report on intensive care treatment. GP report is imminent and will soon be with Trust.</p> <p>ACTION: GOVERNANCE TEAM</p> <p><i>Relist for March meeting</i></p> <p>Update 16 March 2015: The GP report is currently being compiled. ICU report has been submitted.</p> <p>It was agreed due to the complexities of this SAI Paul</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|--|--------|
| | | | | | | <p>will provide an update to Dr Carolyn Harper.</p> <p>Relist for April meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 21 May 2015: DRO has been liaising with Dr McKinney Medical Director in the Trust regarding this SAI. DRO Will provide an update to Dr Harper.</p> <p>Relist for June meeting</p> <p>ACTION: Paul Darragh / Governance Team</p> <p>Update 15 June 2015: DRO has received a verbal update from Therese Brown WHSCT. Dr Harper has been advised.</p> <p>Relist for July meeting</p> <p>ACTION: Governance Team</p> <p>Update 21 July 2015: It was noted a Coroner's Report from Manchester was awaited. The status of this would be reviewed at the next meeting.</p> <p>ACTION: Governance Team</p> <p>Update 18 August 2015: : <u>FURTHER INFORMATION REQUIRED</u> – Members agreed an email would be sent from the HSCB Governance Team to the Trust for the attention of the Medical</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|---|--------|
| | | | | | | <p>Director on behalf of the DRO stating the following:</p> <p><i>'Can the Trust please provide an updated final report by 30 October 2015 to incorporate the findings of the original review and the independent reports commissioned over recent months.</i></p> <p><i>The updated report would be expected to provide the findings, recommendations and a tracking and monitoring report on the actions taken to address the recommendations of the various reports.'</i></p> <p>ACTION: Governance Team</p> <p><u>Update 24 November 2015:</u> DRO had a telecom with Dr A McKinney and T Brown with Lourda Geoghegan and Mary McElroy to discuss progress. Trust action plan has been reviewed and a series of responses have been prepared in respect of all the products of the original report and the speciality reports. DRO awaiting the comments back from Lourda and Mary to our combined response. Once agreed DRO will issue to Trust (via SAs) our overall comments. It is understood this case will be considered by the Manchester Coroner within the next few months.</p> <p>ACTION: DRO (Paul Darragh)</p> <p>Review December Meeting</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|---|--------|
| | | | | | | <p>Update 22 December 2015: <u>DEFERRED</u>. DRO not present at meeting.</p> <p>Relist January Meeting</p> <p>Action: Governance Team</p> <p>Update 14 January 2016: <u>FURTHER INFORMATION REQUIRED</u> This SAI was discussed at a recent SHSCG meeting at DHSSPS. Therese Brown advised at the meeting this SAI may be used in the upcoming SAI Event. DRO noted no date has been set for the Manchester Coroner to review the case.</p> <p>Relist for March 2016</p> <p>Action: Governance Team</p> <p>Update 21 March 2016: <u>FURTHER INFORMATION REQUIRED</u> The inquest into this case opened on 28th January and was adjourned by the Coroner.</p> <p>The Coroner has asked the Trust to undertake a number of actions and the Trust is currently working through these and updating the action plan and as part of that process the comments by the HSCB will be taken into consideration when the plan is being reviewed. Trust will respond when the information is ready to be shared with the Coroner.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|-------------|--------------|-----|------------------|--------------------------|-----------|---|--------|
| | | | | | | <p>Governance Team to ascertain if there is a timeframe for the response to be submitted to the Coroner? If no timeframe has been specified the response to outstanding HSCB queries should be requested within a two month timeframe.</p> <p>Relist for May 2016</p> <p>Action: Governance Team</p> <p>Update 23 May 2016: A response from the Trust regarding the timeframe to respond to the Coroner remains outstanding. However, it was noted the Coroner's Inquest shouldn't delay any learning. DRO advised Dr L Geoghegan continues to be involved with Mary McElroy concerning issues around cross infection, nursing and community nursing. Dr Geoghegan and Mary McElroy to meet with Dr Farrell to discuss. Dr Farrell to share feedback with the Trust.</p> <p>Action: Dr B Farrell</p> <p>Relist for August 2016</p> <p>Update 18 July 2016 – Dr Farrell to arrange a further meeting with Mary McElroy and Dr Geoghegan.</p> <p>Action: Dr B Farrell</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Review September 2016</p> <p>Update 23 September 2016 - Dr Farrell advised that she had met with Mary McElroy and Dr Geoghegan. An updated Action Plan was received from the Trust on 22 August 2016. DRO content with Action Plan, however wishes to clarify access to community microbiology advice as the RCA report is ambiguous about this. Dr Farrell undertook to raise this with the Pathology Network.</p> <p>Review November meeting.</p> <p>Update 19 December 2016 – Dr Farrell to raise this with the Pathology Network.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Defer to February 2017 meeting.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – Defer to 20 March 2017 meeting.</p> <p>Review March 2017</p> <p>Update 20 March 2017 – Dr Farrell advised a response</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>has been received from the Pathology Network and undertook to share the response with Mary McElroy. However, the response doesn't accurately address the query therefore a revised query is to be submitted to the Pathology Network.</p> <p>Action: Dr Farrell</p> <p>Review May 2017</p> <p>Update 10 May 2017: DEFERRED. SAI Deferred to next meeting</p> <p>Review June 2017</p> <p>Brid will send letter to Pathology review again</p> <p>Update 9 June 2017: FURTHER INFORMATION REQUIRED. DRO will review response from Pathology Network and report back at July Meeting.</p> <p>Action: Dr Farrell</p> <p>Review July 2017</p> <p>Update 3 July 2017: FURTHER INFORMATION REQUIRED. Dr Farrell to contact Pathology Network and will provide update at next meeting.</p> | |

| HSCB REF | TRUST REF | DRO | Current Position | Invest. Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Action: Dr Farrell</p> <p>Review August 2017</p> <p>Update 7 August 2017: DRO requested SAI to be relisted for September 2017 review.</p> <p>Update 25 September 2017: CLOSE FROM ACUTE GROUP (PENDING CLOSURE WITH TRUST) DRO has received clarification from Pathology Network as requested. DRO will discuss this clarification with Mary McElroy before formal closure. Members from the Acute team were content SAI does not require to be discussed again at a meeting and can be formally closed by DRO.</p> <p>Governance Team to follow up with DRO regarding formal closure following discussion with Mary McElroy.</p> <p>Action: Dr Farrell / Governance Team</p> | |

serious incidents

From: Elaine Hamilton (HSCB)
Sent: 01 November 2017 11:52
To: Joanne McClean
Cc: serious incidents
Subject: SHSCT SAI [Personal Information redacted by the U]

Categories: Roisin, SHSCT actioned

Joanne,

At the Acute meeting on 25 September 2017 it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information] and to seek assurance processes have been put in place to prevent reoccurrence.

Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?

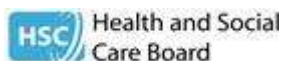
Regards,

Elaine

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof in) |
|--|--------------|------------------|-------------------|------------------------|--|
| [Personal Information redacted by the USI] | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is unacceptable. Can the Trust |

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
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| | | | | | <p>advise this how this has been addressed?</p> <ul style="list-style-type: none"> Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and Personal Information and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> |

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: Personal Information redacted by the ULSI
Internal Ext: Personal Information

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 NOVEMBER 2017

Date: 20 November 2017

Lead Officers: Dr Louise Herron (Chair), Dr Jackie McCall, Dr Sinead McGuinness, Dr Miriam McCarthy, Ms Siobhan Donald, Ms Mary McElroy (via teleconference), Dr Joanne McClean (via teleconference)

Apologies: Dr Brid Farrell, Dr Christine McMaster, Dr Jackie McCall

In attendance: Ms Elaine Hamilton, Ms Angela Carrington

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 2a | | | Dr M McCarthy | Y | Y | First Review 20 November 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified only local learning in respect of unusual complication of surgery and outcome of surgery. | CLOSE | |
| 2b | | | Dr M McCarthy | Y | Y | First Review 20 November 2017: FURTHER PROFESSIONAL ADVICE REQUIRED. Angela Carrington to seek advice on use of sedation medication taking account of patient's other co-morbidities at the Regional Medicines Governance Team Meeting. Action: Angela Carrington To be reviewed following discussion at the Regional Medicines Governance | Review following discussion at the Regional Medicines Governance Team Meeting Refer to the Regional | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | Team Meeting | SAI Review Team Meeting | |
| | Personal Information redacted by the USI | | | | | | | |
| 2c | | | Dr J McClean | Y | Y | First Review 20 November 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified | CLOSE | |
| 2d | | | Dr M McCarthy | Y | Y | First Review 20 November 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified | CLOSE | |
| 3a | | | Dr B Farrell | | | Update 20 November 2017: FURTHER PROFESSIONAL ADVICE REQUIRED. Mary McElroy will formally raise this SAI at the Tissue Viability Nurse Network and at the Regional District Nursing Advisory Group for consideration of regional learning. Mary McElroy and Dr Herron will meet to discuss the outcome of from these groups prior to the SAI being reviewed at the Acute SAI Review Team Meeting. | Review 18 December 2017 | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | Action: Mary McElroy / Dr Herron Review 18 December 2017 | | |
| 3b | Personal Info | Female (DOB Personal Information redacted by the USI) | Dr Corrigan | Y | y | Update 20 November 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified by the Acute SAI Review Team Meeting in relation to this SAI as the issues and learning raised within this SAI have been taken forward within the Delayed Diagnosis Exercise and the Newsletter article 'Accurate Communication of actions and results' which was published in edition 6 of the Learning Matters Newsletter. | CLOSE | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 6 NOVEMBER 2017

Date: 6 November 2017

Lead Officers: Dr Louise Herron (Chair), Dr Christine McMaster, Dr Jackie McCall, Dr Sinead McGuinness, Mary McElroy, Dr Joanne McClean (via teleconference)

Apologies: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Miriam McCarthy, Siobhan Donald, Siobhan McIntyre,

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 2a | | | Dr S McGuinness | y | y | First Review 6 November 2017: FURTHER INFORMATION REQUIRED. DRO will devise an email for Governance Team with a number of queries for issue to WHSCT. Action: Dr McGuinness / Governance Team Review when response is received from WHSCT | Review when response received from WHSCT | |
| 2b | | | Dr S McGuinness | y | y | First Review 6 November 2017: FURTHER INFORMATION / ACTION REQUIRED. As recommended by the Coroner the Trust is considering adding Ramipril to the list of Drugs on the learning memo which has been developed for all | Review when response received from Trust Refer to the Regional | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>medical staff.</p> <p>The Trust will be carrying out the following learning actions:</p> <ul style="list-style-type: none"> • A briefing and link to an e-learning module will be shared with Primary Care Clinicians, including OOH services • A briefing and link to e-learning module will be shared with the Accident and Emergency Departments and AED and AMU Clinicians • The findings as a case review will be presented at the Post Graduate Forum for trainee doctors. <p>Governance Team to email WHSCT with the following points:</p> <ul style="list-style-type: none"> • Did the Trust report this via a yellow card to the MHRA? • Request a copy of the full SEA Report. <p>SAI will be referred to the Medicines Management Team suggesting a</p> | SAI Review Team Meeting | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>newsletter article. Medicines Management team to confirm if this would be a suitable article for the Medicines Governance Newsletter and/or Med Safe Newsletter?</p> <p>Action: Governance Team / Elaine Hamilton</p> <p>Review December 2017</p> | | |
| | Personal Information redacted by the USI | | | | | | | |
| 2c | | | Dr S McGuinness | y | y | <p>First Review 6 November 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Awaiting comments from Siobhan Donald from a nursing perspective. Mary McElroy will provide advice on behalf of the Omitted Medicines Group.</p> <p>Action: Siobhan Donald / Mary McElroy</p> <p>Review when responses have been received.</p> | Review when responses have been received | |
| 2d | | | Dr J McCall | y | y | <p>First Review 6 November 2017: FURTHER INFORMATION REQUIRED. DRO will devise an email/ letter for Governance Team with a number of</p> | Review when responses have been | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>queries for issue to SET.</p> <p>Angela Carrington has forwarded comments to DRO in relation to this case.</p> <p>Action: Dr McCall / Governance Team</p> <p>Review when response received from Trust</p> | received | |
| 2e | Personal Information redacted by the USI | | Dr L Herron | y | y | <p>First Review 6 November 2017: FURTHER ADVICE REQUIRED. Dr Herron will liaise with Paul Cavanagh and Dr Corrigan in relation to this SAI and similar SAIs.</p> <p>Elaine Hamilton to run a search on Datix for other NIAS SAIs involving delayed ambulances.</p> <p>Action: Dr Herron / Elaine Hamilton</p> <p>Review December 2017</p> | Review December 2017 | |
| 2f | | | S Donald | y | y | <p>First Review 6 November 2017: DEFERRED DRO not present. Deferred until DRO can attend meeting.</p> <p>Review when DRO is available to attend</p> | Review when DRO is available to attend | |
| | | | | | | | | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 4A | | | Dr McCall | N | N | First Review 6 November 2017: NO IMMEDIATE ACTION REQUIRED. Never Event was noted. No urgent action required. Will be reviewed when report is received. | Review when report is received. | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 27 OCTOBER 2017

Date: 27 October 2017

Lead Officers: Dr Joanne McClean (Chair), Dr Muhammad Sartaj, Dr Miriam McCarthy, Dr Joanne McClean

Apologies: Dr Brid Farrell, Dr Christine McMaster, Dr Jackie McCall, Dr Sinead McGuinness, Siobhan Donald, Siobhan McIntyre, Mary McElroy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Mrs S McIntyre | Y | Y | First Review 16 October 2017: DEFERRED. DRO was not present. Deferred to next meeting Review 6 November 2017 Update 6 November 2017: PENDING CLOSURE Mary McElroy will liaise with | CLOSE Refer to the Regional SAI Review Team meeting | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>Siobhan and if content members agreed SAI can be closed and no further review required.</p> <p>Action: Siobhan McIntyre / Mary McElroy</p> <p>Review 20 November 2017</p> <p>Update 20 November 2017: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified but the issues raised within this SAI will be captured within the falls evaluation, falls group and within the new escalation of NEWS Group which has been established.</p> <p>Action Mary McElroy</p> | | |
| | Personal Information redacted by the USI | | Dr S McGuinness | Y | Y | First Review 27 October 2017: NO IMMEDIATE ACTION REQUIRED. Never event was noted and will be reviewed when report is received. | Review when report is received | NEVER EVENT |
| | | | Dr J McCall | Y | Y | First Review 27 October 2017: NO IMMEDIATE ACTION REQUIRED. Never event was noted and will be reviewed when report is received. | Review when report is received | NEVER EVENT |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 OCTOBER 2017

Date: 16 October 2017

Lead Officers:

Apologies:

In attendance:

MEETING SCHEDULED FOR 16 OCTOBER WAS CANCELLED AND ADDITIONAL MEETING ARRANGED FOR 27 OCTOBER 2017

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 6 OCTOBER 2017

Date: 6 October 2017

Lead Officers:

Apologies:

In attendance:

MEETING SCHEDULED FOR 6 OCTOBER WAS CANCELLED AND ALL ITEMS LISTED FOR DISCUSSION 16 OCTOBER 2017

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 25 SEPTEMBER 2017

Date: 25 September 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Christine McMaster, Dr Joanne McClean (Via Teleconference), Angela Carrington, Dr Jenny Mack SPR Public Health Medicine

Apologies: Mary McElroy, Dr Joanne McClean, Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 2b | | | Dr McCarthy | Y | Y | <p>First Review 25 September 2017: DEFERRED. DRO was not present. SAI deferred to next meeting</p> <p>Review 6 October 2017</p> <p>Update 27 October 2017: FURTHER INFORMATION REQUIRED. Governance Team to confirm with BHSCT the patient was informed of the SAI as stated in the engagement checklist.</p> <p>Governance Team to request a copy of the following from BHSCT:</p> <ul style="list-style-type: none"> • The action plan tracker report referred to in section 11 of the recommendations • The learning letter template which is being developed in relation to this case for consideration of regional learning. • TOR and composition of the review panel involved in this | Review when a response has been received from BHSCT | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>investigation.</p> <p>Action: Governance Team</p> <p>Review when a response has been received from BHSCT</p> | | |
| 5c | Personal Information redacted by the USI | | Dr McCarthy | | | <p>First Review 25 September 2017: FURTHER INFORMATION REQUIRED. At the time of closure the Trust intended to share the learning through the CCanNI network. Governance team to confirm with Linda Mulholland CCanNNI network this action was completed.</p> <p>Dr McCall advised Alert <i>HSC(SQSD) 17/10 - preventing fatalities from medication loading doses</i> was previously actioned by the SQAT team.</p> <p>Action: Governance Team / Elaine Hamilton</p> <p>Review when a response is received from CCanNI</p> <p>Update 20 November 2017: CLOSE this will not be issued as regional learning. <i>HSC(SQSD) 17/10 - preventing fatalities</i></p> | CLOSE | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p><i>from medication loading doses</i> was previously actioned by the SQAT team and would cover the issues raised within the SAI this Shared Learning Proforma links to.</p> <p>It was noted the Regional Medicines Governance Team are currently exploring areas around fatalities from medication loading dose.</p> | | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 4 SEPTEMBER 2017

Date: 4 September 2017

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Sinead McGuinness, Dr Joanne McClean, Mrs Mary McElroy (via teleconference), Dr Louise Herron. Ms Angela Carrington, Dr Muhammad Sartaj

Apologies: Dr Christine McMaster, Siobhan Donald

In attendance: Elaine Hamilton, Dr Damien Bennett (for item 2)

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 3e | | | S Donald | Y | Y | <p>First Review 4 September 2017: DEFERRED DRO has now received the full SEA report and will provide an update at the meeting on 16 October meeting.</p> <p>Action: Siobhan Donald</p> <p>Update 27 October 2017: FURTHER INFORMATION REQUIRED. DRO advised Lynne Charlton is contacting Suzanne Pullins in Northern Trust to discuss this incident. DRO will provide an update following this discussion.</p> <p>Action: Siobhan Donald</p> <p>Review 20 November 2017</p> <p>Update 20 November 2017: FURTHER INFORMATION REQUIRED. The new escalation of NEWS Group which has been established will take the issues raised within this SAI into consideration. Lynne Charlton will raise the Governance Issues directly with NHSCT Governance Staff.</p> <p>Action: Lynne Charlton / Mary McElroy</p> | <p>Review when DRO advises all information has been received.</p> <p>Refer to the Regional SAI Review Group</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | Review following clarification of all issues | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 AUGUST 2017

Date: 21 August 2017

Lead Officers: Dr Louise Herron (Chair) Dr Sinead McGuinness, Dr Joanne McClean (via teleconference), Ms Eleanor Ross, Ms Rose McHugh, Mrs Mary McElroy (via teleconference)

Apologies: Dr Brid Farrell Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Angela Carrington, Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 7 AUGUST 2017

Date: 07 August 2017

Lead Officers: Dr Brid Farrell (chair), Dr Sinead McGuinness, Dr Miriam McCarthy, Dr Christine McMaster, Angela Carrington, Siobhan Donald, Dr Louise Herron

Apologies: Dr Jackie McCall, Dr Joanne McClean, Ms Eleanor Ross, Mrs Mary McElroy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | Personal Information redacted by the USI | | | | | | |
| 2e | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: FURTHER INPUT REQUIRED.</p> <p>Elaine Hamilton to forward LSR Section 3 point 8 to Lisa McWilliams (PMSI) to confirm if this is an acceptable ratio of red flag / planned patients / urgent patients / routine patients.</p> <p>Elaine Hamilton to forward LSR to Jackie McCall for consideration within delayed diagnosis scoping exercise.</p> <p>Review when response received from PMSI</p> <p>Action: Elaine Hamilton</p> <p>Update 6 November 2017: DEFERRED. DRO not present. Defer until DRO is in attendance.</p> <p>Review when DRO is in attendance</p> <p>Update 20 November 2017: CLOSE Based on the information provided including the engagement checklist. No new regional</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | learning was identified. | |
| | Personal Information redacted by the USI | | | | | | |
| 2g | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Elaine Hamilton to contact Dr Lorraine Doherty to confirm what regional learning should be disseminated from a Health Protection perspective.</p> <p>Action: Elaine Hamilton</p> <p>Review when response received from Health Protection.</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. A response has been received from Health Protection in relation to this SAI. Dr Farrell will discuss the most appropriate method to review Health Care Associated Infection SAIs with Dr Doherty.</p> <p>Action: Dr Farrell</p> <p>Review 6 November 2017</p> <p>Update 6 November 2017: DEFERRED.</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>DRO not present. Defer until DRO is in attendance.</p> <p>Update 20 November 2017: CLOSE Based on the information provided including the engagement checklist. No new regional learning was identified. Anne Kane will continue to liaise with Dr Doherty in relation to a DRO from Health Protection.</p> | |
| | Personal Information redacted by the USI | | | | | | |
| 2h | | | Dr M McCarthy | Y | Y | <p>First Review 7 August 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Elaine Hamilton to share report with Health Protection team for their professional opinion on regional learning in relation to this incident.</p> <p>Action: Elaine Hamilton</p> <p>Review when response received from Health Protection.</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED: Dr Farrell will discuss the most appropriate method to review Health Care Associated Infection SAIs with Dr Doherty.</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | <p>Action: Dr Farrell</p> <p>Review 6 November 2017</p> <p>Update 6 November 2017: DEFERRED. DRO not present. Defer until DRO is in attendance.</p> <p>Review when DRO is in attendance</p> <p>Update 20 November 2017: CLOSE Based on the information provided including the engagement checklist. No new regional learning was identified. Anne Kane will continue to liaise with Dr Doherty in relation to a DRO from Health Protection.</p> | |

ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 9 JUNE 2017

Date: 9 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Christine McMaster, Dr Muhammad Sartaj, Eleanor Ross

Apologies: Dr Joanne McClean, Dr Jackie McCall, Dr Louise Herron, Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Miriam McCarthy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3j | Personal Information redacted by the USI | | Dr Sartaj | Y | Y | <p>First Review 9 June 2017: FURTHER INFORMATION REQUIRED. This SAI involved a rare complication of nasogastric insertion causing a pneumothorax. Governance Team to email Jackie McCall requesting information on how many of these cases have been reported nationally and advise DRO.</p> <p>Eleanor Ross agreed to research protocols around chest x-ray following nasogastric insertion and report back to DRO via serious incidents.</p> <p>It was agreed there is regional learning and Dr Sartaj would complete a newsletter article highlighting complications of a common procedures.</p> <p>Elaine Hamilton will ask Jackie McCall if this can be considered for the SAI learning Event 2018.</p> <p>Refer to Regional SAI Review Team to note Learning Matters newsletter article.</p> <p>Actions: Dr Sartaj, Eleanor Ross, Elaine Hamilton, Governance Team Review July 2017</p> <p>Update 7 August 2017: Elaine to meet with Dr Sartaj as Dr Sartaj was not present at meeting.</p> <p>Action: Elaine Hamilton</p> | Review when information has been received from NHS England |
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| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|-------------------------|-----------|--|--------|
| | | | | | | <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Dr McCall is currently liaising with NHS England, in relation to the number cases of pneumothorax associated with the insertion of NG tube which was reported nationally.</p> <p>Eleanor Ross has reported back to the DRO in relation to chest x-ray following NG tube insertion.</p> <p>Action: Dr McCall / Dr Sartaj</p> <p>Review 16 October 2017</p> <p>Update 27 October 2017: PENDING CLOSURE. Newsletter article highlighting complications of common procedures has been completed. Currently awaiting information from NHS England before formally closing SAI.</p> <p>Action: Dr McCall / Dr Sartaj</p> <p>Review when information has been received from NHS England</p> | |

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| 9c | Longest outliers | <p>Elaine Hamilton referred to a paper which highlighted the longest outliers with the Trusts in the Acute POC. DROs acknowledged there was an issue receiving reports/requested information etc from Trusts in a timely manner. There was a brief discussion and it was felt this could possibly be addressed through a performance management route and the issue should be raised at SMT.</p> <p>Elaine Hamilton will forward the longest outliers to the individual DROs for their comment/advice.</p> <p><i>Additional Note following the meeting: This issue has been discussed at the QSE Group and it has been agreed Mary Hinds will raise with Valerie Watts before listing this item at the Chief Executive Forum Meeting.</i></p> <p>Update 7 August 2017: Elaine Hamilton tabled the longest outliers paper for the Acute POC. DROs were content this issue is being dealt with at the Chief Executive Forum meeting.</p> <p>This report will continue to be brought to the meeting on a regular basis.</p> <p>Update 27 October 2017: The position of Longest outliers as at the 30 September 2017 was noted by members</p> | Review December 2017 |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 MAY 2017

Date: 10 MAY 2017

Lead Officers: Dr Brid Farrell (chair), Siobhan Donnell, Dr McMaster, Eleanor Ross, Dr Jackie McCall, Mary McElroy (via teleconference)

Apologies: Dr Louise Herron, Dr Miriam McCarthy, Dr Joanne McClean

In attendance: Mareth Campbell, Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----|--|-----------|--------------|------------------|-------------------|------------------------|---|---|
| | Personal Information redacted by the USI | | | | | | | |
| 4c | | | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. | <p>Review January 2017</p> <p>Refer to the Regional SAI Review Team</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|--|--------|
| | | | | | | | <ul style="list-style-type: none"> The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and Personal Information and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> | |

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| | | | | | | | <p>Update 20 November 2017: FURTHER INFORMATION REQUIRED. SAI to be referred to the Elective Care Group (Michael Bloomfield and Lisa McWilliams) in respect of timely triage and categorisation. Request the Elective Care Group to seek assurance from other Trusts if E-Triage would manage the risk of a similar situation.</p> <p>Action: Elaine Hamilton</p> | |
| 4f | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | <p><u>First Review 10 May 2017: Further Information Required.</u></p> <ul style="list-style-type: none"> • Dr McCall (DRO) advised SET are considering development of a Jump Policy. Dr McCall will request a copy when it's completed. • Dr McCall to share report with Catherine Coyle in respect of transfers to interventional radiology. • Dr McCall to request protocol | Review when response is received from Trust. |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
| | | | | | | | <p>for contingency plan for interventional radiologist in SET</p> <ul style="list-style-type: none"> • Dr McCall to request guidelines from Radiology Network on timing of CTPA investigations in diagnosis of PE • Dr Farrell to Share Stroke Thrombectomy pathway with Dr McCall <p>It was agreed there are a number of regional learning points from this incident to be considered:</p> <ul style="list-style-type: none"> • Quicker recognition of patient bleeding and resuscitation • Learning from Human factors <p>This SAI will be considered for SAI learning Event in the future.</p> <p>Action: Dr McCall / Dr Farrell / Governance Team</p> <p>Review July 2017</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
| | | | | | | | <p>Update 3 July 2017: DEFERRED DRO Requested SAI to be deferred to August meeting.</p> <p>Review August 2017</p> <p>Update 21 August 2017. DEFERRED SAI Deferred until 4 September 2017 meeting.</p> <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Not all information has been received in response to the queries raised with the Trust following the meeting on 10 May.</p> <p>Governance Team to chase up outstanding queries.</p> <p>Action: Governance Team</p> <p>SAI to be reviewed when a full response is received from SET.</p> <p>Update 27 October 2017: DEFERRED. SAI deferred until DRO is present.</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
| | | | | | | | <p>Review 6 November 2017</p> <p>Update 6 November 2017: FURTHER INFORMATION REQUIRED. Governance Team to continue to follow up outstanding issues with the SE Trust.</p> <p>Action: Governance Team Review when response is received from Trust.</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 MARCH 2017

Date: 20 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster, Dr Muhammad Sartaj, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|--|-----------|---------------|------------------|-------------------|--------|---|--------|
| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr M McCarthy | | Y | Y | <p>FIRST REVIEW 20 March 2017 - CLOSE based on the information provided including the engagement checklist, with <u>Regional Learning identified</u> around the correct use of anticoagulants, lack of co-ordination of care and the need for early referral to multi-specialist team/service. Mary McElroy to refer SAI to Geraldine Teague for consideration of regional learning by the Diabetic Foot Team.</p> <p>Action: Governance Team Mary McElroy</p> <p>Refer to SAI Review Sub-Group to note referral to Improving Management of Warfarin, NOACs and Antiplatelets Action Group led by Lynne</p> | CLOSE |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | | | <p>Charlton, the Diabetic Foot Team and to note an article for Learning Matters (Dr McCall agreed to prepare the article when required).</p> <p>Action: M Campbell/DRO (Dr McCarthy)</p> <p>Learning Themes</p> <ul style="list-style-type: none"> Datix remedial causes – 3.3 Action: Governance Team Learning Lessons Categorisation – 1 and 5 Action: M Campbell <p>Update 6 November 2017: DEFERRED. DRO not present. Defer until DRO is in attendance.</p> <p>Update 20 November 2017: CLOSE Based on the information provided including the engagement checklist.</p> <p>The Diabetic Foot team responded to acknowledge the issues are specific to Intervention Radiology, Vascular and Endocrine teams and the actions outlined will address this situation</p> | |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
| | | | | | | | <p>reoccurring.</p> <p>There was no new regional learning identified but the actions recommended will support the Multi-disciplinary Diabetic Foot Team once established.</p> <p>Work which is being undertaken in terms of the use of anticoagulation will also address the issues raised within this SAI.</p> | |

| Date | Agenda Item | Action Agreed | Person Responsible |
|---------------|--------------|---|-------------------------------------|
| 20 March 2017 | 9 3p | <p>Feedback from DRO Workshops – Discussion deferred to next meeting.</p> <p>Update 19 April 2017 - DRO Protocol – DROs to discuss DRO Protocol at a staff meeting. Dr Farrell to advise when to relist.</p> <p>Action: Dr Farrell</p> | DR FARRELL TO ADVISE WHEN TO RELIST |
| 20 March 2017 | 10 3q | <p>Acute SAI Review Team - Draft Terms of Reference – Deferred to next meeting.</p> <p>Update 19 April 2017 – Members to consider the Draft Terms of Reference at a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> | Dr Herron |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Action: Dr Farrell</p> <p>Update 10 May 2017: Elaine Hamilton to remind Dr Farrell to add this item to a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell / Elaine Hamilton</p> <p>Update 6 November 2017: Draft INTERIM Terms of Reference was discussed and amendments noted. Elaine Hamilton will incorporate agreed amendments and circulate for further comment / approval before the next meeting on 20 November 2017.</p> <p>Action: Elaine Hamilton</p> <p>Update 20 November 2017: Further comments / amendments received were discussed and incorporated into the draft interim TOR. It was agreed Dr Herron would circulate the TOR for final comments prior to the next meeting.</p> <p>Action: Dr Herron</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 NOVEMBER 2016

Date: 21 November 2016

Lead Officers: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster

In attendance: Mrs Eleanor Ross (for item 4m), Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr J McClean | DRO has query with membership of Review Group | N | N | <p>FIRST REVIEW 21 November 2016</p> <p>REVIEW TEAM MEMBERSHIP – The DRO has requested that a Vascular Surgeon is involved in the Review Team. The Trust has advised that the SAI is in relation to an aortic aneurysm (arterial). The Trust has vascular surgeons but not arterial surgeons and feel it would not be appropriate to include them in the SAI Group.</p> <p>Governance Team to advise Trust the DRO is content with Terms of Reference and Team Membership.</p> <p>Action: Governance Team</p> <p>SAI will be listed for review at a future meeting when DRO receives RCA report.</p> <p>Update 20 November 2017: CLOSE Based on the information provided including the engagement checklist.</p> | <p>CLOSE</p> <p>Refer to the Regional SAI Review Team Meeting to note referral to the Escalation of NEWS Group</p> |

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input)- | STATUS |
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| | | | | | | | <p>The Royal College of Emergency Medicine Developed a poster reminding clinical teams to consider the diagnosis of aortic dissection and this will be included in a Learning Matters Newsletter.</p> <p>Mary McElroy will include this SAI within the Escalation of NEWS work which is underway.</p> <p>Action: Mary McElroy</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 AUGUST 2016

Date: 22 August 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Jackie McCall, Dr Christine McMaster, Mrs Mary McElroy

Apologies: Dr Joanne McClean, Dr Muhammad Sartaj

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| Date | Agenda Item | Action Agreed | Person Responsible |
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| 22 August 2016 | | <p>(iii) Key Words With regards the surveillance of SAls to identify patterns/clusters/trends, it was agreed to consider the identification of key words. Mary to provide a list of key words for discussion at the October meeting.</p> <p>Action: Mary McElroy</p> <p>Review October 2016</p> <p>Update 17 October 2016 – Mary McElroy advised she had obtained a list of key words compiled and used by Mental Health and Learning Disability Teams and undertook to share with the group. Mary and Mareth to produce a list of key words identified to date by the Acute Team and circulate for review at the November meeting. Dr McCall to check with other countries if they have a list of key words.</p> <p>Review November 2016</p> <p>Update 21 November 2016 – Members considered the list of key words identified by the Acute Team since April 2016 along with the key words identified and used by the Mental Health and Learning Disability Teams. To be further reviewed at the December meeting when list of key words from NHS England is available.</p> <p>Review December 2016</p> | <p>Review November 2016</p> <p>Mary McElroy</p> <p>Mary McElroy</p> <p>Mary McElroy/Mareth Campbell</p> <p>Review December 2016</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Update 19 December 2016 – Members considered the list of incident types provided by NHS England Clinical Incident review process circulated with the papers. Dr McCall is awaiting a further list from Julian Johnston which is used at Mortality and Morbidity reviews in Trusts. It was agreed a few officers would meet to consider all lists with a view to compiling a list of key words for the acute team.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Members considered the list of learning lesson categorisations used at Mortality and Morbidity meetings. Dr McCall advised she would share the list with Lynne Charlton, Mary McElroy and Jacqui Burns. She is meeting with them to review this and NHS England classification and identify key words which in turn could be used to identify key themes.</p> <p>Review February 2017</p> <p>Update 9 March 2017 – It has been agreed that in order to ‘theme SAIs’ the Acute SAI Group would consider the Learning Lessons and DATIX remedial causes categorisations when closing SAIs. This will run as a pilot.</p> <p>Update 25 September 2017: The Learning Lessons and Remedial Causes have not been used by the Acute Team since the meeting on 19 June 2017 as it was felt they were too time consuming and will not help to identify patterns/clusters/trends.</p> <p>Dr Farrell will raise this issue at the next staff meeting to discuss the best method to identify patterns/clusters/trends.</p> <p>Action: Dr Farrell Review December 2017</p> | <p>Review February 2017</p> <p>Review September 2017</p> <p>Review 20 November 2017</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
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| | | <p>Update 6 November 2017: The Learning Lessons and Remedial Causes pilot was not successful and this will be noted at the Regional SAI Review Team Meeting.</p> <p>It was agreed the Acute Team will run a pilot using the Donaldson areas of systemic service failures from the Analysis of the Patient-safety-related adult deaths in NHS acute hospital settings. Elaine Hamilton will link with Governance Team colleagues to determine how this is best recorded on Datix and devise a worksheet DROs can complete when they are reviewing their reports.</p> <p>Elaine Hamilton will discuss the high level themes/areas Dr Farrell previously requested to be recorded with Governance Team Colleagues and report back to the Acute Group.</p> <p>Action: Elaine Hamilton / Acute Team members.</p> <p>Review 20 November 2017</p> <p>Update 20 November 2017: Elaine Hamilton advised the Governance Team are currently reviewing Datix to establish the most appropriate way to capture this data. A worksheet will be issued to all DROs to assist them to use the Donaldson areas of systemic service failures when reviewing their reports.</p> <p>Elaine Hamilton will include the high level themes on the agenda beside each SAI for DRO approval at the Acute SAI Review Team Meetings.</p> <p>Action: Elaine Hamilton / Acute Team members</p> <p>Review January 2018</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 APRIL 2016

Date: 18 April 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Jackie McCall, Dr Muhammad Sartaj

Apologies: Dr Janet Little

In attendance: Mrs Elaine Hamilton, Mrs Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible | Status |
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| 18 April 2016 | 7 | <p>Any Other Business</p> <p>(i) Safety Forum – Learning Event Jackie McCall advised members the Safety Forum are commencing plans for the next regional Learning Event for 2016/17. Jackie requested for DROs to highlight any suitable SAIs that could be used for learning at the event. ‘Good Standard of Report’ is a key word which is captured on Datix and it was agreed DROs will use this if they deem an SAI appropriate for use at the event. This item will be added onto the agenda for each Acute meeting to remind DROs.</p> <p>Update 23 May 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 20 June 2016 – No SAIs identified for the Regional Learning Event.</p> | All members/Mareth Campbell | To be a reviewed at each meeting of Acute SAI Review Team |

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| | | <p>Update 18 July 2016 - Members agreed to identify three anticoagulant drug related SAIs to showcase at the Learning Event. It was agreed these could be identified during the review being undertaken by Dr Jackie McCall.</p> <p>Update 22 August 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 23 September 2016 – SAI SHSCT SAI (Personal Information redacted by the) was highlighted as a SAI that could be used at the learning event.</p> <p>Update 17 October 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 21 November 2016 – SAI (Personal Information redacted by the) – SHSCT SAI (Personal Information redacted by the) was highlighted as a SAI that could be considered for the Regional Learning Event.</p> <p>Update 19 December 2016 - SAI (Personal Information redacted by the USI) was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Update 16 January 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) – showing patient journey ○ SHSCT SAI (Personal Information redacted by the) <p>Update 9 March 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ (Personal Information redacted by the USI) ○ SAI (Personal Information redacted by the USI) <p>Update 20 March 2017 - No SAIs identified for the Regional Learning</p> | Dr Jackie McCall | |
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| | | <p>Event.</p> <p>Update 19 April 2017 - No SAls identified for the Regional Learning Event.</p> <p>Update 10 May 2017: [Personal Information redacted by the USI] will be considered for a future SAI Learning Event.</p> <p>Update 9 June 2017: [Personal Information redacted by the USI] will be considered for a future learning event.</p> <p>Update 19 June 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 3 July 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 7 August 2017: Delayed Diagnosis is a theme which will need to be considered</p> <p>Update 21 August 2017: BHSCT/SAI/[Personal Information] Elaine Hamilton to confirm with Dr McCarthy if this will be referred for consideration at the next Learning Event.</p> <p>Update 4 September 2017: Scoping Exercise on Delayed diagnosis.</p> <p>Update 25 September 2017: SHSCT SAI [Personal Information redacted by the USI] and [Personal Information redacted by the USI] / [Personal Information redacted by the USI]</p> <p>Update 6 November 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 20 November 2017: No SAls identified for the Regional</p> | Elaine Hamilton | |
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| | | Learning Event. | | |
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LEARNING ACTIONS FOR NOTING AT HSCB/PHA QUALITY SAFETY AND EXPERIENCE GROUP – 10 JANUARY 2018**THIS IS A COMPOSITE REPORT OF LEARNING ACTIONS AGREED BY PROFESSIONAL GROUPS NOTED BY HSCB/PHA SAI REVIEW SUB GROUP****MATERNITY SAI REVIEW TEAM****Date of Meeting - 24 OCTOBER 2017**

| DESCRIPTION OF INCIDENT |
|---|
| <p>***Linked to [Personal Information] now de-escalated as NT leading review*** ***Incident learning links with [Personal Information] BHSCT - SAI [Personal Information]</p> <p>[Personal Information] was a para 4+0 who had labour induced at Term + 9 days gestation of pregnancy. During second stage of labour there was a shoulder dystocia and despite manoeuvres there was a 20 minute delay before delivery of the body was achieved. Baby was born on [Personal Information] at 19.34 hours, apgars 0 at 1 minute and 0 at 5 minutes. Consultant Paediatrician present for delivery and baby had active resuscitation and was transferred to Altnagelvin NNU for on-going management.</p> <p>Baby died on [Personal Information redacted by the USI]. GENDER: [Person] AGE: [Personal Information]</p> |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE BY SQAT YES / NO |
|--|---|---|---------------------|---------|-------------|---|----------------------------|
| [Personal Information redacted by the USI] | <p>REGIONAL LEARNING from this SAI is to be included in an article covering</p> <ul style="list-style-type: none"> • risk assessment; • discussion with expectant mother on mode of delivery and • documentation | <p>REGIONAL LEARNING PROPOSED: Consider including a learning article for the next MATERNITY SPECIAL EDITION OF LEARNING MATTERS - Vol. 2</p> | For action | C Coyle | In progress | Learning Matters Editorial Team & Maternity Learning Matters Editorial Team | NO |

Personal Information redacted by the USI DESCRIPTION OF INCIDENT

****LINKED TO EARLY ALERT TRUST REF: [Personal Information redacted by USI] / HSCB REF: [Personal Information] ****

On [Personal Information] at approx. 18.00 hours discolouration of water within the Causeway Maternity Unit was identified. This was reported at approx. 22.00 hours with escalation to the Estates Dept. within the NHSCT.

During the above period a woman had been admitted with spontaneous rupture of membranes and it has been established that she had bathed in the discoloured water as a mechanism for pain relief from approx. 18.00 to 20.00 hours. Fetal heart rate recorded hourly with normal rate last documented at 01.00 hours on [Personal Information].

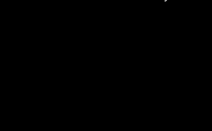
Mother transferred to Delivery Suite at approx. 02.00 hours for augmentation of labour. At 02.30 hours no fetal heart rate was detected on routine auscultation. Mother transferred to theatre and a category 1 caesarean section under general anaesthetic performed. A stillborn baby girl delivered at 02.56 hours on [Personal Information]. Families were aware of the issue with the water and are concerned that this may have contributed to the stillbirth of their baby.

Trust Estates were on site on [Personal Information] and water samples were taken and a thermal disinfection of the area was completed. In consultation with the Infection Control Team inpatients within Maternity were advised not to bath or shower and not to bath their babies in the water from the hot water system. Water was running clear and established safe for use at 18.30 hours on [Personal Information].

One patient in potential labour was diverted to Antrim Maternity Unit.

GENDER: Female AGE: [Personal Information]

CURRENT CONDITION OF SERVICE USER: Mother of infant stable and being care for in Causeway Maternity.

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| <p>Personal Information redacted by the USI</p>  | <p>REGIONAL LEARNING from this SAI is to be included in an article referencing the updated RCOG - Green-top Guideline No. 36) Group B Streptococcal Disease, Early-onset Published: 13/09/2017</p> <p>The Trust in their report had made recommendations that:</p> <ul style="list-style-type: none"> • regional consideration should be given to point of care diagnostic tools • examine evidence regarding membrane sweeping in presence of GBS <p>The updated RCOG guidance has a new recommendation stating “membrane sweeping is not contraindicated in women who are carriers of GBS” and near- patient testing at the onset of labour is not recommended .</p> | <p>REGIONAL LEARNING PROPOSED: Consider including a learning article for the next MATERNITY SPECIAL EDITION OF LEARNING MATTERS - Vol. 2</p> | <p>For action</p> | <p>D Boulter</p> | <p>In progress</p> | <p>Learning Matters Editorial Team & Maternity Learning Matters Editorial Team</p> | <p>NO</p> |

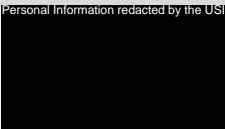
PAEDIATRIC SAI REVIEW TEAM

Date of Meeting - 24 OCTOBER 2017

| DESCRIPTION OF INCIDENT |
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| <p>Personal Information redacted by the USI</p> <p>**Linked to Interface <small>Personal Information</small> Now closed** Interface notification received by the SET from Integrated Care - South Eastern Office (HSCB)</p> <p>Integrated care referred a number of medication incidents which were notified to them relating to an ADHD clinic. There were two issues highlighted.</p> <ol style="list-style-type: none"> 1. Failure of clinic staff to complete medication summary properly – local learning and to be taken forward by Trust involved through their usual processes. 2. An agreed shared care guideline was not available at the time of the incidents. This meant the roles and responsibility for monitoring Guanfacine, which is an amber drug, in primary and secondary care were not clear. A shared care guideline has since been developed. <p>There is a risk of incidents like this happening in the period between a drug becoming available and a shared care guideline being developed. This learning has been shared with the medicines management group in HSCB for consideration as to whether they need to take any action to prevent recurrence.</p> |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE BY SQAT YES / NO |
|--|--|---|----------------------------|------------|--------|--|----------------------------|
| Personal Information redacted by the USI | Roles and responsibilities in relation to Amber Drugs List drugs – particularly in the period between the drug becoming available and a shared care guideline being implemented. | DRO has shared this case and another similar interface incident involving the same drug with B Bradley and L Keenan who chairs the medicines management group to consider if they should take action to reduce the risk of similar things arising again. | For information and action | J Mc Clean | | B Bradley & Lynne Keenan (Amber Drugs Team) | NO |

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| Personal Information redacted by the USI | | | | | | | |
| Personal Information | Personal Information | | | | | | |

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| Personal Information redacted by the USI  | The lack of written escalation plans for DGH paediatric services. | This case will be used as an example to commence discussion with all Trusts about whether escalation plans for DGHs should be developed to complement the plan which is in place in RBHSC. To be discussed at CCaNNI paediatric sub group on 21st November. | For information | J Mc Clean | | J Mc Clean | No |

ACUTE SAI REVIEW TEAM**Date of Meeting: 27 October 2017**

| WHSCS SAI <small>Personal Information</small> | DESCRIPTION OF INCIDENT |
|---|---|
| | <p>Due to an error with the wash cycle of a clinical biochemistry analyser on the Altnagelvin Site, a number of incorrect clinical biochemistry test results were reported over a 4 hour time window on 27th June 2017. This has particularly affected the following analytes: creatinine, uric acid, calcium and total CO2. The numbers of samples affected is as follows:</p> <p>" 228 hospital blood samples re-analysed and 136 amended reports issued</p> <p>" 168 GP blood samples re-analysed and 128 amended reports issued</p> <p>" 60 urine samples re-analysed and 30 amended reports issued.</p> <p>We are aware of one patient who was sent to A&E by a GP for repeat blood testing on the basis of the incorrect result initially issued. Communication has been made with both Altnagelvin hospital and all GP service users regarding this problem. The detailed cause of the incident is under active investigation.</p> <p>ADVERSE EVENT: laboratory Investigations failed / incorrect</p> |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE YES / NO |
|--|---|--|---------------------|----------------|-----------|----------------|-----------------------|
| <small>Personal Information re</small> | <p>WHSCS have the following regional recommendations within their Report:</p> <ol style="list-style-type: none"> To alert other Trusts with the same analysers to: <ul style="list-style-type: none"> Separate the storage of the acid/alkaline wash solutions Put additional label/mark on wash bottles clearly to | <p>No new regional learning was identified by the Acute SAI Review Team.</p> <p>Action Plan has been received from WHSCS detailing dates for actions completed / to be completed</p> | FOR NOTING | Dr McGuninness | Completed | WHSCS | No |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBIL ITY | ASSURANCE YES / NO |
|------------------|--|------------------------|------------------------|-----|--------|--------------------|-----------------------|
| | <p>flag their identity.</p> <ul style="list-style-type: none"> review their analyser maintenance procedure with an alert advising operators to check that the correct wash solution has been put in position. <p>2. To alert the analyser manufacturer of the incident and request that future models have non-transferable containers or ports.</p> <p>Actions to be carried out by clinical chemistry laboratory staff, Lead Biomedical Scientist will coordinate.</p> | | | | | | |

SAI Personal Information **DESCRIPTION OF INCIDENT**

Male patient had a delayed Ophthalmology review appointment which may have contributed to a loss of vision. The delay was 6 months beyond the "clinically indicated time (CIT)" requested by the Consultant which resulted in a missed opportunity for a laser treatment which may have increased the chance of preventing the patient's visual loss.

GENDER: M

AGE: Personal years

ADVERSE EVENT: Failure to follow up / Delay in diagnosis

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE BY SQAT YES / NO |
|---------------|--|--|---------------------|-------------|-------------|----------------------|-------------------------------|
| W8847 | No new regional learning was identified by the Acute SAI Review Team but the issue of failure to follow up and delays within Ophthalmology Services in the WHSCT will be highlighted to the Unscheduled Care Team. | REFERRAL TO AN EXISTING WORKSTREAM / NETWORK Referred to Lisa McWilliams PMSI to make them aware of this SAI in light of the ongoing review of Ophthalmology Services. | For information | Dr M Sartaj | In Progress | Lisa McWilliams PMSI | No |

| SAI <small>Personal Information</small> DESCRIPTION OF INCIDENT |
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| <p>Female patient was seen in Optometry clinic and suspicious eye lesion was noted. Discussed with Consultant, patient to be reviewed in 1 month for biopsy. Patient listed for 3 month review. In addition, due to review backlog, the patient waited a further 3 months from her "clinically indicated time (CIT)" which resulted in a total of 5 months delay. When patient was reviewed she presented with a malignant lesion.</p> <p>GENDER: F AGE: <small>Personal</small> years</p> <p>ADVERSE EVENT: Failure to follow up / Delay in diagnosis</p> |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE BY SQAT YES / NO |
|-------------------------------------|--|--|---------------------|-------------|--------------------|----------------------|-------------------------------|
| <small>Personal Information</small> | No new regional learning was identified by the Acute SAI Review Team but the issue of failure to follow up and delays within Ophthalmology Services in the WHSCT will be highlighted to the Unscheduled Care Team. | REFERRAL TO AN EXISTING WORKSTREAM / NETWORK Referred to Lisa McWilliams PMSI to make them aware of this SAI in light of the ongoing review of Ophthalmology Services. | For information | Dr M Sartaj | In Progress | Lisa McWilliams PMSI | No |

BHSCT/SAI/Personal Information DESCRIPTION OF INCIDENT

Patient was referred by Altnagelvin Hospital (WHST) into the BHSCT Vascular Service for carotid surgery following a stroke. Patient was seen at BHSCT Vascular clinic on 2nd February 2016. A carotid duplex confirmed 70 - 75% stenosis of the right internal carotid artery. NICE guidance CG 68 "Stroke and transient ischaemic attack in over 16s: diagnosis and initial management" advises that patient with this level of stenosis should have an endarterectomy within 2 weeks of presentation. The patient could not be scheduled on to the vascular theatre list until 5th March 2016. On 4th March 2016 Altnagelvin Hospital contacted and informed the vascular team that the patient had a further neurological event and he was no longer fit for surgery.

The patient's condition sadly continued to deteriorate and he died on Personal Information redacted by the USI.

GENDER: M

AGE: Personal Information years

ADVERSE EVENT: Delay in treatment / failure to monitor

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE BY SQAT YES / NO |
|----------------------|--|---|---------------------|---------------|-------------|-------------------------------------|-------------------------------|
| Personal Information | <p>In respect of overall capacity HSCB and PHA are working with the Belfast Trust to agree the capacity gap and identify the resources required as part of the implementation of the vascular review</p> <p>As part of the work following on from the vascular review, a draft pathway on carotid endarterectomy was developed by the vascular</p> | <p>NOTE REGIONAL LEARNING BEING TAKEN FORWARD</p> <p>No new regional learning was identified by the Acute SAI Review Team – to note Pathway on carotid endarterectomy has been developed and will be issued on a regional basis.</p> | For information | Dr M McCarthy | In Progress | <p>BHSCT</p> <p>Catherine Coyle</p> | No |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILI TY | ASSURANCE BY SQAT YES / NO |
|------------------|--|------------------------|---------------------------|-----|--------|--------------------|----------------------------------|
| | surgeons and shared with wider stakeholders (along with other vascular pathways) at a workshop earlier in the year. Following further consultation it will be issued for final agreement for implementation on a regional basis. | | | | | | |

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| Personal Information | <p>Referred to CCANNI as DRO had a query in relation to ICU admission criteria for DKA and non ketotic diabetic acidosis.</p> <p>Referred to Lynn Keenan Pharmacy Coordinator Integrated Care regarding management of an Amber Drug.</p> | <p>No Regional Learning was identified by the Acute SAI Review Team but it was referred to CCANNI for advice and consideration of regional learning.</p> <p>No Regional Learning was identified by the Acute SAI Review Team referred to Pharmacy Coordinator</p> | <p>For information to seek advice on possible regional learning</p> <p>For information to seek advice on</p> | Dr J McClean | In progress | Dr J McClean | No |

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ACUTE SAI REVIEW TEAM

Date of Meeting: 6 November 2017

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| <div>Personal Information</div> |

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| Personal Information re | Learning issues highlighted by | SAI will be referred to the | For action | Dr | In progress | Angela | No |

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | STATUS | RESPONSIBILITY | ASSURANCE YES / NO |
|---------------|--|--|---------------------|------------|--------|----------------|-----------------------|
| | <p>the Trust are as follows:</p> <ul style="list-style-type: none"> Consider drug reactions as a cause of unusual rashes even in the presence of other explanations for a rash. Identify and stop potential drug causes. If a drug is thought to be the cause of a skin reaction, it should be stopped as soon as possible – stopping early improves outcomes. Contact primary care clinician or specialist primarily responsible for starting / supervising use of the medication at the earliest stage possible. <p>No new regional learning was identified the Acute SAI Review Team but it was agreed to refer the above learning to the Medicines Governance Team for consideration of a newsletter article.</p> | Medicines Management Team suggesting a newsletter article. Medicines Management team to confirm if this would be a suitable article for the Medicines Governance Newsletter and/or Med Safe Newsletter and to confirm the appropriate content based on the SEA Report? | | McGuinness | | Carrington | |

MENTAL HEALTH & LEARNING DISABILITY DRO MEETING**Date of Meeting – 14 November 2017**

| <div>Personal Information</div> - DESCRIPTION OF INCIDENT | | | | | | | |
|---|--|---|---------------------------------------|-----------|-----------------------|---|--------------------------------|
| <p>The Western Trust was made aware of the death of a female client via a PSNI SD1 form. This lady died as a result of hanging on <div>Personal Information redacted by the USI</div> at her home address. The deceased client was known to the <div>Personal Information</div> Community Mental Health Team, her last face to face contact was on 15th July 2016 for a Mental State Assessment. She also attended an IMORC Recovery College facilitator update on 21st July 2016.</p> <p>AGE: <div>Pers onal</div> years</p> <p>ADVERSE EVENT: Suicide (completed), whether proven or suspected</p> | | | | | | | |
| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL FOR ACTION/ INFO. | DRO | STATUS | RESPONSIBILITY | ASSURANCE REQUIRED BY YES / NO |
| <div>Personal Information</div> | <p>The SAI highlighted an important issue in relation to the level of family/carer involvement in the safety planning for those patients attending in crisis.</p> <p>The SAI also highlighted a deficit in relation to guidance available for team managers regarding the management of caseloads in the event of unplanned absence.</p> | <p>SAI LEARNING EVENT FOR CONSIDERATION</p> <p>- SAI to be referred onto Safety Forum for consideration of inclusion with the Annual SAI Learning Event to be held in 2018.</p> <p>(Suggest Ciaran McKenny / Angela O'Neill - Adult Mental Health & Disability Services from WHSCT could present the SAI at the event)</p> | ACTION | E Darragh | To be actioned | <p>Jackie McCall / Mark Roberts</p> <p>Copy to Dawn Clarke (Safety Forum)</p> | No |

ACUTE SAI REVIEW TEAM

Date of Meeting: 20 November 2017

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| Personal Informa | <p>No new regional learning was identified by the Acute SAI Review Team.</p> <p>The issues raised within this SAI will be captured within the falls evaluation</p> | <p>Referred Regional Falls Group.</p> <p>The issues raised within this SAI will be captured within the falls evaluation</p> | For information | Ms S McIntyre | Regional Falls Group: Mrs M McElroy | No |

SHSCT SAI Personal Information **DESCRIPTION OF INCIDENT**

Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney.

US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate.

MRI performed 2/9/2014

Referral to Urology was not triaged on receipt. Patient 10 sent OP appointment for 6/1/2016. Patient 10 was seen in clinic on 6/1/16. The sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer.

The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning.

GENDER: F AGE: Personal Information year

Adverse Event: Failure in referral process

| SAI REFERENCE | LEARNING ISSUES HIGHLIGHTED | LEARNING ACTION AGREED | REASON FOR REFERRAL | DRO | RESPONSIBILITY | ASSURANCE YES / NO |
|-------------------------------------|---|---|---------------------|--------------|--------------------|---|
| <small>Personal Information</small> | Timely triage and categorisation. Acute SAI Review Team proposes that Trusts use an E-Triage system to manage the risk of a similar situation. | Referred to a group for Action: SAI to be referred to the Elective Care Group (Lisa McWilliams) in respect of timely triage and categorisation. Request the Elective Care Group to seek advice from other Trusts if E-Triage would manage the risk of a similar situation. | For action | Dr J McClean | Ms Lisa McWilliams | Yes Elective Care Group to Respond back to the Governance Team following consideration |

INTEGRATED CARE SAI REVIEW TEAM

Date of Meeting –13 December 2017

| <div>Personal Information</div> DESCRIPTION OF INCIDENT | | | | | | | |
|---|----------------------------|---|---|---------------------------------------|---------|---|-----------------------------|
| <p>Patient prescribed and dispensed cellcept 1g daily instead of 1g bd from 4/1 until 18/2. Then patient correctly prescribed cellcept1gbd but dispensed one tablet (500mg) bd for 3 weeks.</p> <p>GENDER: M AGE: <div>Personal Information</div> years</p> <p>ADVERSE EVENT: Dose or strength was wrong or unclear</p> | | | | | | | |
| SAI REFERENCE | LEARNING IDENTIFIED YES/NO | LEARNING ISSUES HIGHLIGHTED | ACTION AGREED | REASON FOR REFERRAL FOR ACTION/ INFO. | DRO | RESPONSIBILITY | ASSURANCE REQUIRED YES / NO |
| <div>Personal Information</div> | Yes | The SAI highlighted an important issue in relation to Transplant Medication that is a high risk drug. | <p>SPECIAL EDITION NEWSLETTER - regional learning to be included in a special edition newsletter to GPs and Pharmacists focussing on Transplant Medications that are high risk drugs.</p> <p>Note: Matthew Dolan to link with Angela Carrington re learning and to consider if Secondary Care should also be included in the distribution list for the Newsletter.</p> | For Action | M Dolan | <p>Integrated Care via</p> <p>(1) Matthew Dolan (DRO) linking with</p> <p>(2) Angela Carrington</p> <p>(3) <div>Personal Information redacted by the USI</div></p> <p><div>Personal Information redacted by the USI</div> (PMMT Medicines Matters Newsletter)</p> <p>(4) <div>Personal Information redacted by the USI</div></p> <p><div>Personal Information redacted by the USI</div></p> | No |

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| Personal Information redacted | | | | | | | |
| Personal Information redacted | | | | | | | |
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| Personal Information redacted | Yes | Positioning of Beta blockers – should be separated from main stock in the dispensary. | <p>(1) Referral onto a Group for Action - Beta Blockers – Discuss any other options for action with Pharmacy Networking Group.</p> <p>(2) Newsletter - Community Pharmacy Newsletter article - include an article in the Community Pharmacy Newsletter referencing the previous two SAIs (Personal Information redacted by USI) which resulted in a Learning Letter (LL/SAI/2014/026 – Dispensing Beta Blockers – Selection Errors), this SAI and the further Adverse Incidents that have occurred subsequently. This will be a standing</p> | <p>For Action</p> <p>For Action</p> | <p>B Bradley</p> <p>B Bradley</p> | <p>B Bradley to link with the PNG Group</p> <p>Integrated Care via Brenda Bradley (DRO) linking with</p> <ul style="list-style-type: none"> Personal Information redacted by the USI (CP PRN Newsletter) | No |

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| | | | item in the newsletter to update on the increase/decrease of incidents from the previous Newsletters. | | | | |
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| <div>Personal Information</div> DESCRIPTION OF INCIDENT | | | | | | | |
|--|----------------------------|---|---|---------------------------------------|---------|---|-----------------------------|
| <p>The patient has had a kidney transplant and is receiving immunosuppression medication.</p> <p>The patient was admitted to the Belfast City Hospital Nephrology Unit for an elective procedure on 11 June 2017. On admission the patient stated that there had been an error in dispensing their immunosuppression medication from their community pharmacy. The patient had been prescribed Prograf 5mg by their GP but Prograf 0.5mg had been dispensed by the community pharmacy. This had been labelled as 5mg.</p> <p>The prescription was collected by the patient's husband and the error was discovered later by the patient.</p> <p>The patient realised the error and did not take the incorrect dose of Prograf, so the patient did not come to harm. However, the consequences had the patient taken the incorrect prescription would have been a drop in Tacrolimus levels and a potential for kidney transplant rejection.</p> <p>GENDER: F AGE: <div>Personal Information</div> years</p> <p>ADVERSE EVENT: Dose or strength was wrong or unclear</p> | | | | | | | |
| SAI REFERENCE | LEARNING IDENTIFIED YES/NO | LEARNING ISSUES HIGHLIGHTED | ACTION AGREED | REASON FOR REFERRAL FOR ACTION/ INFO. | DRO | RESPONSIBILITY | ASSURANCE REQUIRED YES / NO |
| <div>Personal Information</div> | Yes | The SAI highlighted an important issue in relation to Transplant Medication that is a high risk drug. | <p>SPECIAL EDITION NEWSLETTER - regional learning to be included in a special edition newsletter to GPs and Pharmacists focussing on Transplant Medications that are high risk drugs.</p> <p>be featured in a Special Edition Newsletter to GPs and Pharmacists focussing on Transplant Medications that are high risk drugs</p> | For Action | M Dolan | <p>Integrated Care via</p> <p>(1) Matthew Dolan (DRO) <u>linking with</u></p> <p>(2) <div>Personal Information redacted by the USI</div> (PMMT Medicines Matters Newsletter)</p> <p>(3) <div>Personal Information redacted by the USI</div></p> | No |

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| <div>Personal Information</div> - DESCRIPTION OF INCIDENT | | | | | | | |
|---|----------------------------|---|---|---------------------------------------|---------|---|-----------------------------|
| <p>The incident was reported to HSCB as an Interface Incident BHSC <div>Personal Information redacted</div></p> <p>The patient attended the Belfast City Hospital renal transplant clinic on 23/03/2017. The patient informed the Consultant Nephrologist that there had been an error in dispensing their immunosuppression medication from their community pharmacy. The patient had been issued a box of Prograf® 5mg capsules by the community pharmacist but some of the blister strips inside the box were Prograf® 0.5mg capsules.</p> <p>The patient recognized that the capsules were the incorrect strength and did not take any of the medication dispensed - so the patient did not come to harm. However, the consequences had the patient taken the incorrect prescription would have been a drop in Tacrolimus levels and a potential for kidney transplant rejection.</p> <p>The date the medication was dispensed is not known at the time of submitting this SAI notification.</p> <p>GENDER: F AGE: <div>Personal Information redacted</div> years</p> <p>ADVERSE EVENT: Dose or strength was wrong or unclear</p> | | | | | | | |
| SAI REFERENCE | LEARNING IDENTIFIED YES/NO | LEARNING ISSUES HIGHLIGHTED | ACTION AGREED | REASON FOR REFERRAL FOR ACTION/ INFO. | DRO | RESPONSIBILITY | ASSURANCE REQUIRED YES / NO |
| <div>Personal Information redacted</div> | Yes | The SAI highlighted an important issue in relation to Transplant Medication that is a high risk drug. | <p>(1) Referral onto a Group for Action - refer to MSSG to consider supply arrangements;</p> <p>(2) Newsletter article - include an article in a Special Edition Newsletter to GPs and Pharmacists focussing on Transplant Medications that are high risk drugs - Note - The newsletter will also feature learning from SAI <div>Personal Information redacted</div></p> | <p>For Action</p> <p>For Action</p> | M Dolan | <p>(1) Angela Carrington via MSSG</p> <p>(2) Integrated Care via</p> <ul style="list-style-type: none"> Matthew Dolan (DRO) linking with <div>Personal Information redacted by the USI</div> (PMMT Medicines | No |

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| | | | <p>and <small>Personal Information</small>; A similar incident occurred in the past involving under dosing of the immunosuppressant tacrolimus (Advaraf® 5mg). This resulted in organ rejection and the death of a patient. Refer to the Safety and Quality Reminder of Best Practice letter issued in June 2015 on Prescribing and dispensing high risk drugs e.g. immunosuppressant's such as tacrolimus; In light that this is now the third dispensing incident regarding the selection of Prograf® 0.5mg instead of Prograf® 5mg remind of the selection problems with Prograf® strengths.</p> | | | <p>Matters Newsletter)</p> <ul style="list-style-type: none">• <small>Personal Information redacted by the USI</small> | |
|--|--|--|---|--|--|--|--|

HSCB - PHA SAI REVIEW TEAM**Date of Meeting - 20 December 2017**

| Personal Information - SHSCT SAI | | DESCRIPTION OF INCIDENT | | | | | |
|--|----------------------------|--|--|--|---------|---------------------------------|-----------------------------|
| At 22.20hrs, during checks on Bronte Ward, patient X did not respond when staff called and her door was locked. The Nursing Auxiliary called for assistance and, on entering the room, staff found patient X lying on the floor between the bedroom and bathroom with a plastic bag tied over her head. Staff removed this and activated alarms. Patient X was put in the recovery position and pulse and respiratory effort checked. Oxygen therapy was applied. Clinical observations were continuously checked and the Night Coordinator and Duty Doctor attended. A 999 ambulance was called and patient X was transferred to the Emergency Department at 22:45hrs. Patient X was alert / responsive and she was transferred back to Bronte Ward at approx. 23:40hrs after being deemed medically fit. | | | | | | | |
| GENDER: Female | | AGE: <div>Personal Information</div> years | | | | | |
| ADVERSE EVENT: Attempted suicide, whether | | | | | | | |
| SAI REFERENCE | LEARNING IDENTIFIED YES/NO | LEARNING ISSUES HIGHLIGHTED | ACTION AGREED | REASON FOR REFERRAL FOR ACTION/ INFO. | DRO | RESPONSIBILITY | ASSURANCE REQUIRED YES / NO |
| <div>Personal Information redacted by</div> | YES | <div>The SAI highlighted important issues relating to access to plastic bags from other patients / visitors bringing bags on to the ward.</div> <div>All Trust’s Infection Control Departments should advise how to manage this issue in keeping with infection control measures and the need for a safe and effective disposal of clinical waste.</div> | <div>LEARNING MATTERS NEWSLETTER ARTICLE - include an article in a future edition of the newsletter.</div> <div>REFERRAL TO AN EXISTING WORKSTREAM / NETWORK - DRO to refer learning issues to Regional Bed Management Group to make them aware of this SAI.</div> | <div>For ACTION</div> <div>For INFORMATION</div> | B Quinn | Learning Matters Editorial Team | NO |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 JANUARY 2018

Date: 10 January 2018

Lead Officers: Dr Louise Herron (Chair), Dr Christine McMaster, Dr Jackie McCall, Dr Sinead McGuinness, Dr Joanne McClean (via teleconference) Mrs Elaine Hamilton,

Apologies: Dr Brid Farrell, Ms Mary McElroy, Ms Siobhan Donald

In attendance: Ms Angela Carrington

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|--|--|-----------|-----------------------|-------------------|--------|--|--------|-----------------------------------|
| | Personal Information redacted by the USI | | | | | | | |
| | | | Acute SAI Review Team | Y | Y | <p>First Review 10 January 2018: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified but regional Learning was previously issued.</p> <p>When notifying the Trust the SAI has been closed by the Acute SAI Review Team the Governance Team to reference the learning previously issued: NICE Guidelines recommending using a head injury proforma when observing patients with head injury and any other learning disseminated in relation to head injury.</p> <p>Governance Ream to update Datix to note previous learning.</p> | CLOSE | Failure to give ordered treatment |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|--|--|-----------|-----------------------|-------------------|--------|--|--------|---|
| | | | | | | Action: Governance Team | | |
| | Personal Information redacted by the USI | | | | | | | |
| | | | Acute SAI Review Team | Y | Y | <p>First Review 10 January 2018: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified but regional Learning was previously issued.</p> <p>Angela advised this incident was included within the Medsafe Newsletter Edition 17 in and an NPSA alert was issued on potassium as well.</p> <p>Governance Ream to update Datix to note previous learning.</p> <p>Action: Governance Team</p> | CLOSE | Medication error. Deficient checking and oversight. |
| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr J McCall | y | y | <p>First Review 10 January 2018: CLOSE based on the information provided including the engagement checklist. No new Regional Learning was identified. Dr McCall will liaise with Ann Hamilton and if any further action is required Dr McCall will contact the Governance Team.</p> | CLOSE | Other |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|--|--|-----------|-------------|-------------------|--------|--|-------------------------|-------------------|
| | | | | | | Action: Dr McCall | | |
| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr McMaster | Y | Y | First Review 10 January 2018: FURTHER ADVICE REQUIRED. Dr McMaster will seek advice from the Radiology Network regarding possible regional learning around hidden injury and will also seek agreement from the Northern Trust regarding sharing of report. Review 19 February 2018 Action: Dr McMaster | Review 19 February 2018 | |
| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr Herron | Y | Y | First Review 10 January 2018: FURTHER ADVICE REQUIRED Dr Herron has shared this SAI with Cara Anderson (Commissioning) and will discuss pathway for patients with Cara. Dr Herron will also liaise with Paula Tweedy (Plastics) to discuss if this has the potential to affect other patients Review 19 February 2018 Action: Dr Herron | Review 19 February 2018 | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr McCarthy | n/a | n/a | First Review 10 January 2018: FURTHER ADVICE REQUIRED. Dr Herron will liaise with Catherine Coyle (Radiology) to seek advice. Dr Herron is the contact person for this Interface Incident. Review 19 February 2017 Action: Dr Herron | Review 19 February 2018 | |
| | Personal Information redacted by the USI | | Dr McCarthy | n/a | n/a | First Review 10 January 2018: FURTHER ADVICE REQUIRED. Dr Herron will liaise with Health Protection colleagues and advise. Postscript 10 January 2018: Dr Herron discussed the early alert with HP colleagues following the Acute meeting and advised the acute outbreak has been declared over and there are ongoing actions within the Trust (screening and monitoring etc) Dr Herron was content to close the | CLOSE | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | Early Alert and emailed the Governance Team to advise of same. | | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Acute SAI Review Team | n/a | n/a | First Review 10 January 2018: No immediate action is required. Acute SAI Review Team will review again when report and checklist are received. | Review when report and checklist rec | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 DECEMBER 2017

Date: 18 December 2017

Lead Officers: Dr Louise Herron (Chair), Ms Siobhan Donald, Ms Mary McElroy (via teleconference), Dr Joanne McClean (via teleconference)
Dr Christine McMaster, Dr Jackie McCall

Apologies: Dr Brid Farrell, Dr Sinead McGuinness,

In attendance: Ms Elaine Hamilton, Ms Angela Carrington

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr S McGuinness | Y | Y | First Review 18 December 2017: Awaiting full Report The Acute SAI Review Team agreed with the recommendation from the DRO that | Review when report is submitted | n/a |

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| | | | | | | <p>the Trust are not required to respond to the question in respect of medical staff as it would be a complex and time consuming analysis.</p> <p>Report will be reviewed when its submitted</p> | | |
| | Personal Information redacted by the USI | | Dr J McClean | Y | Y | <p>First Review 18 December 2017: DEFERRED until DRO is present.</p> <p>Dr McCall referred to a similar case involving cervical spine and ankylosing spondylitis.</p> <p>Elaine Hamilton to confirm SAI number and advise Dr McClean.</p> <p>There was also a previous newsletter article in relation to cervical spine with head injuries and failure to diagnosis which Dr McClean may wish to refer to.</p> <p>Update 10 January 2018: CLOSE based on the information provided including the engagement checklist.</p> <p>An article has been completed in relation to cervical spine with head injuries which covers the issues raised</p> | CLOSE | Failure to give ordered treatment/ support in a timely way |

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| | | | | | | in this SAI. Dr McClean has requested a copy of the article from Grainne Cushley which will be forwarded to the Governance Team to ensure its linked with the SAI. | | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr M McCarthy | Y | Y | <p>First Review 18 December 2017: FURTHER ADVICE REQUIRED. This incident was previously reported as an Adverse Incident through Integrated Care. Angela Carrington will discuss at her team meeting on 19 December 2017 and confirm at the next meeting what action was taken in AI Review.</p> <p>Action: Angela Carrington</p> <p>Review 10th January 2018</p> <p>Update 10 January 2018: CLOSE Angela Carrington confirmed this newer insulin will be included within the medication safety today newsletter and it will be included within new or high risk medications.</p> <p>Action: Governance Team / Angela</p> | CLOSE | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | Carrington | | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr M McCarthy | Y | Y | <p>First Review 18 December 2017: FURTHER PROFESSIONAL ADVICE REQUIRED. It was agreed to forward the SEA Report and the Shared Learning Proforma to Catherine Coyle and request a discussion in relation to point 1 on the Learning Proforma 'an established patient pathway for patients with severe AKI who are likely to require some form of renal replacement therapy.'</p> <p>Action: Elaine Hamilton / Dr Herron</p> <p>Review 22 January 2018</p> | Review 22 January 2018 | |
| | | Personal Information redacted by the USI | | | | | | |
| | | | Dr M McCarthy | Y | Y | <p>First Review 18 December 2017: FURTHER ADVICE REQUIRED. Angela Carrington will raise this early alert at her team meeting on 19 December 2017. There was previous recommendations issued and Angela will confirm these and on the outcome of the team meeting.</p> <p>Elaine Hamilton to confirm if there was</p> | Review 22 January 2018 | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | any regional learning following closure of the SAI. Action: Elaine Hamilton / Angela Carrington Review 22 January 2018 | | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 NOVEMBER 2017

Date: 20 November 2017

Lead Officers: Dr Louise Herron (Chair), Dr Jackie McCall, Dr Sinead McGuinness, Dr Miriam McCarthy, Ms Siobhan Donald, Ms Mary McElroy (via teleconference), Dr Joanne McClean (via teleconference)

Apologies: Dr Brid Farrell, Dr Christine McMaster, Dr Jackie McCall

In attendance: Ms Elaine Hamilton, Ms Angela Carrington

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 2b | | | Dr M McCarthy | Y | Y | First Review 20 November 2017: FURTHER PROFESSIONAL ADVICE REQUIRED. Angela Carrington to seek advice on use of sedation medication taking account of patient's other co-morbidities at the Regional Medicines | Review 19 February 2018 | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>Governance Team Meeting.</p> <p>Action: Angela Carrington</p> <p>To be reviewed following discussion at the Regional Medicines Governance Team Meeting</p> <p>Update 18 December 2017 (postscript): This was not referred to the Regional SAI Review Team for noting until Angela confirms if regional learning is applicable.</p> <p>Update 10 January 2018: FURTHER INFORMATION REQUIRED. Angela Carrington will discuss with Nicola Cullen Improvement advisor with Safety Forum re Delirium toolkit and also confirm if there was a similar AI involving these types of medication.</p> <p>Action: Angela Carrington</p> <p>Review 19 February 2018</p> | | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| 3a | | | Dr B Farrell | | | <p>Update 20 November 2017: FURTHER PROFESSIONAL ADVICE REQUIRED.</p> <p>Mary McElroy will formally raise this SAI at the Tissue Viability Nurse Network and at the Regional District Nursing Advisory Group for consideration of regional learning.</p> <p>Mary McElroy and Dr Herron will meet to discuss the outcome of from these groups prior to the SAI being reviewed at the Acute SAI Review Team Meeting.</p> <p>Action: Mary McElroy / Dr Herron</p> <p>Review 18 December 2017</p> <p>Update 18 December 2017: DEFERRED. The SAI was deferred until the 10th January 2017 due to a member of staff on sick leave.</p> <p>Review 10th January 2018.</p> <p>Update 10 January 2018: FURTHER ADVICE REQUIRED. A separate meeting has been organised for 1.00pm on 10</p> | Review 19 February 2018 | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>January to discuss this SAI. Lynne Charlton will attend in Mary McElroy's absence.</p> <p>Action: Dr Herron / Elaine Hamilton</p> <p>Review 19 February 2018</p> | | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 6 NOVEMBER 2017

Date: 6 November 2017

Lead Officers: Dr Louise Herron (Chair), Dr Christine McMaster, Dr Jackie McCall, Dr Sinead McGuinness, Mary McElroy, Dr Joanne McClean (via teleconference)

Apologies: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Miriam McCarthy, Siobhan Donald, Siobhan McIntyre,

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 2b | | | Dr S McGuinness | y | y | <p>First Review 6 November 2017: FURTHER INFORMATION / ACTION REQUIRED.</p> <p>As recommended by the Coroner the Trust is considering adding Ramipril to</p> | <p>CLOSE</p> <p>Refer to the Regional SAI Review Team</p> | Failure to observe |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>the list of Drugs on the learning memo which has been developed for all medical staff.</p> <p>The Trust will be carrying out the following learning actions:</p> <ul style="list-style-type: none"> • A briefing and link to an e-learning module will be shared with Primary Care Clinicians, including OOH services • A briefing and link to e-learning module will be shared with the Accident and Emergency Departments and AED and AMU Clinicians • The findings as a case review will be presented at the Post Graduate Forum for trainee doctors. <p>Governance Team to email WHSCT with the following points:</p> <ul style="list-style-type: none"> • Did the Trust report this via a yellow card to the MHRA? • Request a copy of the full SEA Report. | Meeting | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>SAI will be referred to the Medicines Management Team suggesting a newsletter article. Medicines Management team to confirm if this would be a suitable article for the Medicines Governance Newsletter and/or Med Safe Newsletter?</p> <p>Action: Governance Team / Elaine Hamilton</p> <p>Review December 2017</p> <p>Update 18 December 2017: following the staff meeting on 19 December 2017 Angela Carrington will confirm the best format to disseminate regional learning in relation to this case.</p> <p>Action: Angela Carrington</p> <p>Review 10 January 2018</p> <p>Update 10 January 2018: CLOSE based on the information provided including the engagement checklist. Regional Learning was identified. Dr McGuinness will develop a newsletter</p> | | |

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| | | | | | | <p>article to raise awareness of rashes when patients start new medication. The article will also include features of Steven Johnston syndrome.</p> <p>Action: Dr McGuinness</p> | | |
| 2c | Personal Information redacted by the USI | | Dr S McGuinness | y | y | <p>First Review 6 November 2017: FURTHER PROFESSIONAL INPUT REQUIRED. Awaiting comments from Siobhan Donald from a nursing perspective. Mary McElroy will provide advice on behalf of the Omitted Medicines Group.</p> <p>Action: Siobhan Donald / Mary McElroy</p> <p>Review when responses have been received.</p> | Review when responses have been received | |
| 2d | Personal Information redacted by the USI | | Dr J McCall | y | y | <p>First Review 6 November 2017: FURTHER INFORMATION REQUIRED. DRO will devise an email/ letter for Governance Team with a number of queries for issue to SET.</p> <p>Angela Carrington has forwarded comments to DRO in relation to this</p> | CLOSE | Oversight medication error. |

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| | | | | | | <p>case.</p> <p>Action: Dr McCall / Governance Team</p> <p>Review when response received from Trust</p> <p>Update 10 January 2018: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified but Angela advised when Medicines Governance Team are carrying out their annual review they will advise if 'communication of how held medication is managed' is a theme within their AIs and if it is they will may consider issuing regional learning at that stage.</p> <p>Action: Angela Carrington</p> | | |
| 2f | Personal Information redacted by the USI | | S Donald | y | y | <p>First Review 6 November 2017: DEFERRED DRO not present. Deferred until DRO can attend meeting.</p> <p>Review when DRO is available to attend</p> <p>Update 18 December 2017: AWAITING</p> | <p>Review April 2018</p> | <p>Key Word: NEWS</p> <p>Systematic Service Failure Area:</p> <p>Failure to detect</p> |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>FURTHER INFORMATION Trust responded to DRO queries on 7 December 2017. It was agreed to seek a progress update from the Trust on the recommendations in April 2018.</p> <p>HSCB Governance Team to contact the Northern Trust in April 2018 to seek an update on progress of recommendations.</p> <p>Action: HSCB Governance Team</p> | | deterioration |
| 4A | Personal Information redacted by the USI | | Dr McCall | N | N | First Review 6 November 2017: NO IMMEDIATE ACTION REQUIRED. Never Event was noted. No urgent action required. Will be reviewed when report is received. | Review when report is received. | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 27 OCTOBER 2017

Date: 27 October 2017

Lead Officers: Dr Joanne McClean (Chair), Dr Muhammad Sartaj, Dr Miriam McCarthy, Dr Joanne McClean

Apologies: Dr Brid Farrell, Dr Christine McMaster, Dr Jackie McCall, Dr Sinead McGuinness, Siobhan Donald, Siobhan McIntyre, Mary McElroy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| | | | Dr S McGuinness | Y | Y | First Review 27 October 2017: NO IMMEDIATE ACTION REQUIRED. Never event was noted and will be reviewed when report is received. | Review when report is received | NEVER EVENT |
| | | | Dr J McCall | Y | Y | First Review 27 October 2017: NO IMMEDIATE ACTION REQUIRED. Never event was noted and will be reviewed when report is received. | Review when report is received | NEVER EVENT |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 16 OCTOBER 2017

Date: 16 October 2017

Lead Officers:

Apologies:

In attendance:

MEETING SCHEDULED FOR 16 OCTOBER WAS CANCELLED AND ADDITIONAL MEETING ARRANGED FOR 27 OCTOBER 2017

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 6 OCTOBER 2017

Date: 6 October 2017

Lead Officers:

Apologies:

In attendance:

MEETING SCHEDULED FOR 6 OCTOBER WAS CANCELLED AND ALL ITEMS LISTED FOR DISCUSSION 16 OCTOBER 2017

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 25 SEPTEMBER 2017

Date: 25 September 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Christine McMaster, Dr Joanne McClean (Via Teleconference), Angela Carrington, Dr Jenny Mack SPR Public Health Medicine

Apologies: Mary McElroy, Dr Joanne McClean, Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 2b | | | Dr McCarthy | Y | Y | <p>First Review 25 September 2017: DEFERRED. DRO was not present. SAI deferred to next meeting</p> <p>Review 6 October 2017</p> <p>Update 27 October 2017: FURTHER INFORMATION REQUIRED. Governance Team to confirm with BHSCT the patient was informed of the SAI as stated in the engagement checklist.</p> <p>Governance Team to request a copy of the following from BHSCT:</p> | Review when a response has been received from BHSCT | |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <ul style="list-style-type: none"> The action plan tracker report referred to in section 11 of the recommendations The learning letter template which is being developed in relation to this case for consideration of regional learning. TOR and composition of the review panel involved in this investigation. <p>Action: Governance Team</p> <p>Review when a response has been received from BHSCT</p> | | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 4 SEPTEMBER 2017

Date: 4 September 2017

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Sinead McGuinness, Dr Joanne McClean, Mrs Mary McElroy (via teleconference), Dr Louise Herron. Ms Angela Carrington, Dr Muhammad Sartaj

Apologies: Dr Christine McMaster, Siobhan Donald

In attendance: Elaine Hamilton, Dr Damien Bennett (for item 2)

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | Personal Information redacted by the USI | | | | | | | |
| 3e | | | S Donald | Y | Y | <p>First Review 4 September 2017: DEFERRED DRO has now received the full SEA report and will provide an update at the meeting on 16 October meeting.</p> <p>Action: Siobhan Donald</p> <p>Update 27 October 2017: FURTHER INFORMATION REQUIRED. DRO advised Lynne Charlton is contacting Suzanne Pullins in Northern Trust to discuss this incident. DRO will provide an update following this discussion.</p> <p>Action: Siobhan Donald</p> <p>Review 20 November 2017</p> <p>Update 20 November 2017: FURTHER INFORMATION REQUIRED. The new escalation of NEWS Group which has been established will take the issues raised within this SAI into consideration. Lynne Charlton will raise the Governance Issues directly with NHSCT Governance Staff.</p> | <p>CLOSE</p> <p>Refer to the Regional SAI Review Team Meeting.</p> | Failure to act on or recognise deterioration |

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| | | | | | | <p>Action: Lynne Charlton / Mary McElroy</p> <p>Review following clarification of all issues</p> <p>Post Script 18 December 2017: This SAI will be forwarded to Dr Jackie McCall for information purposes only in relation to the NEWS issues within this SAI.</p> <p>Update 10 January 2018: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified but the SAI was copied to Jackie McCall for information purposes only in relation to the NEWS issues within this SAI.</p> | | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 AUGUST 2017

Date: 21 August 2017

Lead Officers: Dr Louise Herron (Chair) Dr Sinead McGuinness, Dr Joanne McClean (via teleconference), Ms Eleanor Ross, Ms Rose McHugh, Mrs Mary McElroy (via teleconference)

Apologies: Dr Brid Farrell Dr Jackie McCall, Dr Miriam McCarthy, Dr Christine McMaster, Angela Carrington, Siobhan Donald

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 7 AUGUST 2017

Date: 07 August 2017

Lead Officers: Dr Brid Farrell (chair), Dr Sinead McGuinness, Dr Miriam McCarthy, Dr Christine McMaster, Angela Carrington, Siobhan Donald, Dr Louise Herron

Apologies: Dr Jackie McCall, Dr Joanne McClean, Ms Eleanor Ross, Mrs Mary McElroy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 9 JUNE 2017

Date: 9 June 2017

Lead Officers: Dr Brid Farrell (chair), Dr Christine McMaster, Dr Muhammad Sartaj, Eleanor Ross

Apologies: Dr Joanne McClean, Dr Jackie McCall, Dr Louise Herron, Mary McElroy, Siobhan Donald, Siobhan McIntyre, Dr Miriam McCarthy

In attendance: Elaine Hamilton

| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| 3j | Personal Information redacted by the USI | | Dr Sartaj | Y | Y | <p>First Review 9 June 2017: FURTHER INFORMATION REQUIRED. This SAI involved a rare complication of nasogastric insertion causing a pneumothorax. Governance Team to email Jackie McCall requesting information on how many of these cases have been reported nationally and advise DRO.</p> <p>Eleanor Ross agreed to research protocols around chest x-ray following nasogastric insertion and report back to DRO via serious incidents.</p> <p>It was agreed there is regional learning and Dr Sartaj would complete a newsletter article highlighting complications of a common procedures.</p> <p>Elaine Hamilton will ask Jackie McCall if this can be considered for the SAI learning Event 2018.</p> <p>Refer to Regional SAI Review Team to note Learning Matters newsletter article.</p> <p>Actions: Dr Sartaj, Eleanor Ross, Elaine Hamilton, Governance Team Review July 2017</p> <p>Update 7 August 2017: Elaine to meet with Dr Sartaj as Dr Sartaj was not present at meeting.</p> <p>Action: Elaine Hamilton</p> | Review when information has been received from NHS England |
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| | HSCB REF | TRUST REF | DRO | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
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| | | | | | <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Dr McCall is currently liaising with NHS England, in relation to the number cases of pneumothorax associated with the insertion of NG tube which was reported nationally.</p> <p>Eleanor Ross has reported back to the DRO in relation to chest x-ray following NG tube insertion.</p> <p>Action: Dr McCall / Dr Sartaj</p> <p>Review 16 October 2017</p> <p>Update 27 October 2017: PENDING CLOSURE. Newsletter article highlighting complications of common procedures has been completed. Currently awaiting information from NHS England before formally closing SAI.</p> <p>Action: Dr McCall / Dr Sartaj</p> <p>Review when information has been received from NHS England</p> <p>Update 18 December 2017: PENDING CLOSURE. PENDING CLOSURE. NHS England carried out a review of NRLS data relating to pneumothorax from NG tube insertion. This will be shared with members of the Acute SAI Review Team following a slight amendment required to the paper. NHS England would welcome to be kept informed of any action which will be taken by the HSCB/PHA in relation to this.</p> <p>Dr Sartaj to advise serious incidents of any further action required.</p> <p>Action: Dr Sartaj</p> <p>Review: 22 January 2018</p> | |
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| 9c | Longest outliers | <p>Elaine Hamilton referred to a paper which highlighted the longest outliers with the Trusts in the Acute POC. DROs acknowledged there was an issue receiving reports/requested information etc from Trusts in a timely manner. There was a brief discussion and it was felt this could possibly be addressed through a performance management route and the issue should be raised at SMT.</p> <p>Elaine Hamilton will forward the longest outliers to the individual DROs for their comment/advice.</p> <p><i>Additional Note following the meeting: This issue has been discussed at the QSE Group and it has been agreed Mary Hinds will raise with Valerie Watts before listing this item at the Chief Executive Forum Meeting.</i></p> <p>Update 7 August 2017: Elaine Hamilton tabled the longest outliers paper for the Acute POC. DROs were content this issue is being dealt with at the Chief Executive Forum meeting.</p> <p>This report will continue to be brought to the meeting on a regular basis.</p> <p>Update 27 October 2017: The position of Longest outliers as at the 30 September 2017 was noted by members</p> <p>Update 18 December 2017: the next update will be provided in January 2018 with the position as at 31 December 2017.</p> | Review January 2018 |
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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 10 MAY 2017

Date: 10 MAY 2017

Lead Officers: Dr Brid Farrell (chair), Siobhan Donnell, Dr McMaster, Eleanor Ross, Dr Jackie McCall, Mary McElroy (via teleconference)

Apologies: Dr Louise Herron, Dr Miriam McCarthy, Dr Joanne McClean

In attendance: Mareth Campbell, Elaine Hamilton

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
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| Personal Information redacted by the USI | | | | | | | | |
| | | Dr J McClean | | Y | Y plan to share report | <p><u>First Review 10 May 2017:</u> DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. | CLOSE | Failure to give ordered treatment/support in a timely way |

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | Theme / Key Words |
|----------|-----------|-----|------------------|-------------------|--------|---|--------|-------------------|
| | | | | | | <ul style="list-style-type: none"> The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and Personal Information and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> | | |

| | | | | | | | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS | |
|---|--|--|-------------|--|---|---|--|--|--|
| | | | | | | | <p>Update 20 November 2017: FURTHER INFORMATION REQUIRED. SAI to be referred to the Elective Care Group (Michael Bloomfield and Lisa McWilliams) in respect of timely triage and categorisation. Request the Elective Care Group to seek assurance from other Trusts if E-Triage would manage the risk of a similar situation.</p> <p>Action: HSCB Governance Team</p> <p>Update 10 January 2018: CLOSE based on the information provided including the engagement checklist. Governance Team to confirm with Dr McClean/Elaine Hamilton this was sent to Elective Care Group but no further action / follow up is required.</p> <p>Action: HSCB Governance Team</p> | | |
| f | Personal Information redacted by the USI | | Dr J McCall | | Y | Y | <p><u>First Review 10 May 2017: Further Information Required.</u></p> <ul style="list-style-type: none"> Dr McCall (DRO) advised SET are considering development of a Jump Policy. Dr McCall will | Review when response is received from Trust. | |

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| | | | | | | | <p>request a copy when it's completed.</p> <ul style="list-style-type: none"> • Dr McCall to share report with Catherine Coyle in respect of transfers to interventional radiology. • Dr McCall to request protocol for contingency plan for interventional radiologist in SET • Dr McCall to request guidelines from Radiology Network on timing of CTPA investigations in diagnosis of PE • Dr Farrell to Share Stroke Thrombectomy pathway with Dr McCall <p>It was agreed there are a number of regional learning points from this incident to be considered:</p> <ul style="list-style-type: none"> • Quicker recognition of patient bleeding and resuscitation • Learning from Human factors | | |

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| | | | | | | | <p>This SAI will be considered for SAI learning Event in the future.</p> <p>Action: Dr McCall / Dr Farrell / Governance Team</p> <p>Review July 2017</p> <p>Update 3 July 2017: DEFERRED DRO Requested SAI to be deferred to August meeting.</p> <p>Review August 2017</p> <p>Update 21 August 2017. DEFERRED SAI Deferred until 4 September 2017 meeting.</p> <p>Update 4 September 2017: FURTHER INFORMATION REQUIRED. Not all information has been received in response to the queries raised with the Trust following the meeting on 10 May.</p> <p>Governance Team to chase up</p> | | |

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| | | | | | | | <p>outstanding queries.</p> <p>Action: Governance Team</p> <p>SAI to be reviewed when a full response is received rom SET.</p> <p>Update 27 October 2017: DEFERRED. SAI deferred until DRO is present.</p> <p>Review 6 November 2017</p> <p>Update 6 November 2017: FURTHER INFORMATION REQUIRED. Governance Team to continue to follow up outstanding issues with the SE Trust.</p> <p>Action: Governance Team Review when response is received from Trust.</p> | | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 20 MARCH 2017

Date: 20 March 2017

Lead Officers: Dr Brid Farrell, Dr Jackie McCall, Dr Miriam McCarthy, Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster, Dr Muhammad Sartaj, Dr Joanne McClean, Dr Louise Herron

In attendance: Mareth Campbell

| | HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|
|--|----------|-----------|-----|------------------|-------------------|--------|---|--------|

| Date | Agenda Item | Action Agreed | Person Responsible |
|---------------|--------------|--|-------------------------------------|
| 20 March 2017 | 9 3p | Feedback from DRO Workshops – Discussion deferred to next meeting. Update 19 April 2017 - DRO Protocol – DROs to discuss DRO Protocol at a staff meeting. Dr Farrell to advise when to relist. Action: Dr Farrell | DR FARRELL TO ADVISE WHEN TO RELIST |
| 20 March 2017 | 10 3q | Acute SAI Review Team - Draft Terms of Reference – Deferred to next meeting. Update 19 April 2017 – Members to consider the Draft Terms of Reference at a staff meeting. Dr Farrell to advise when to relist Terms of Reference for discussion. Action: Dr Farrell Update 10 May 2017: Elaine Hamilton to remind Dr Farrell to add this item to a staff | May 2018 |

| Date | Agenda Item | Action Agreed | Person Responsible |
|------|-------------|---|--------------------|
| | | <p>meeting. Dr Farrell to advise when to relist Terms of Reference for discussion.</p> <p>Action: Dr Farrell / Elaine Hamilton</p> <p>Update 6 November 2017: Draft INTERIM Terms of Reference was discussed and amendments noted. Elaine Hamilton will incorporate agreed amendments and circulate for further comment / approval before the next meeting on 20 November 2017.</p> <p>Action: Elaine Hamilton</p> <p>Update 20 November 2017: Further comments / amendments received were discussed and incorporated into the draft interim TOR. It was agreed Dr Herron would circulate the TOR for final comments prior to the next meeting.</p> <p>Action: Dr Herron</p> <p>Update 18 December 2017: Interim TOR have been approved by members and will be reviewed in May 2018</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 21 NOVEMBER 2016

Date: 21 November 2016

Lead Officers: Dr Brid Farrell, Dr Muhammad Sartaj, Dr Jackie McCall, Dr Miriam McCarthy, Dr Joanne McClean (via teleconference), Mrs Mary McElroy (via teleconference)

Apologies: Dr Christine McMaster

In attendance: Mrs Eleanor Ross (for item 4m), Mareth Campbell

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ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 22 AUGUST 2016

Date: 22 August 2016

Lead Officers: Dr Brid Farrell, Dr Miriam McCarthy, Dr Jackie McCall, Dr Christine McMaster, Mrs Mary McElroy

Apologies: Dr Joanne McClean, Dr Muhammad Sartaj

In attendance: Mareth Campbell

| HSCB REF | TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof input) | STATUS |
|----------|-----------|-----|------------------|-------------------|--------|---|--------|
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| Date | Agenda Item | Action Agreed | Person Responsible |
|----------------|-------------|---|---|
| 22 August 2016 | | <p>(iii) Key Words With regards the surveillance of SAIs to identify patterns/clusters/trends, it was agreed to consider the identification of key words. Mary to provide a list of key words for discussion at the October meeting.</p> <p>Action: Mary McElroy</p> <p>Review October 2016</p> | <p>Review November 2016</p> <p>Mary McElroy</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
|------|-------------|---|---|
| | | <p>Update 17 October 2016 – Mary McElroy advised she had obtained a list of key words compiled and used by Mental Health and Learning Disability Teams and undertook to share with the group. Mary and Mareth to produce a list of key words identified to date by the Acute Team and circulate for review at the November meeting. Dr McCall to check with other countries if they have a list of key words.</p> <p>Review November 2016</p> <p>Update 21 November 2016 – Members considered the list of key words identified by the Acute Team since April 2016 along with the key words identified and used by the Mental Health and Learning Disability Teams. To be further reviewed at the December meeting when list of key words from NHS England is available.</p> <p>Review December 2016</p> <p>Update 19 December 2016 – Members considered the list of incident types provided by NHS England Clinical Incident review process circulated with the papers. Dr McCall is awaiting a further list from Julian Johnston which is used at Mortality and Morbidity reviews in Trusts. It was agreed a few officers would meet to consider all lists with a view to compiling a list of key words for the acute team.</p> <p>Review January 2017</p> <p>Update 16 January 2017 – Members considered the list of learning lesson categorisations used at Mortality and Morbidity meetings. Dr McCall advised she would share the list with Lynne Charlton, Mary McElroy and Jacqui Burns. She is meeting with them to review this and NHS England classification and identify key words which in turn could be used to identify key themes.</p> | <p>Mary McElroy</p> <p>Mary McElroy/Mareth Campbell</p> <p>Review December 2016</p> <p>Review February 2017</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
|------|-------------|--|---|
| | | <p>Review February 2017</p> <p>Update 9 March 2017 – It has been agreed that in order to ‘theme SAls’ the Acute SAI Group would consider the Learning Lessons and DATIX remedial causes categorisations when closing SAls. This will run as a pilot.</p> <p>Update 25 September 2017: The Learning Lessons and Remedial Causes have not been used by the Acute Team since the meeting on 19 June 2017 as it was felt they were too time consuming and will not help to identify patterns/clusters/trends.</p> <p>Dr Farrell will raise this issue at the next staff meeting to discuss the best method to identify patterns/clusters/trends.</p> <p>Action: Dr Farrell Review December 2017</p> <p>Update 6 November 2017: The Learning Lessons and Remedial Causes pilot was not successful and this will be noted at the Regional SAI Review Team Meeting.</p> <p>It was agreed the Acute Team will run a pilot using the Donaldson areas of systemic service failures from the Analysis of the Patient-safety-related adult deaths in NHS acute hospital settings. Elaine Hamilton will link with Governance Team colleagues to determine how this is best recorded on Datix and devise a worksheet DROs can complete when they are reviewing their reports.</p> <p>Elaine Hamilton will discuss the high level themes/areas Dr Farrell previously requested to be recorded with Governance Team Colleagues and report back to the Acute Group.</p> | <p>Review September 2017</p> <p>Review 20 November 2017</p> |

| Date | Agenda Item | Action Agreed | Person Responsible |
|------|-------------|--|--------------------|
| | | <p>Action: Elaine Hamilton / Acute Team members.</p> <p>Review 20 November 2017</p> <p>Update 20 November 2017: Elaine Hamilton advised the Governance Team are currently reviewing Datix to establish the most appropriate way to capture this data. A worksheet will be issued to all DROs to assist them to use the Donaldson areas of systemic service failures when reviewing their reports.</p> <p>Elaine Hamilton will include the high level themes on the agenda beside each SAI for DRO approval at the Acute SAI Review Team Meetings.</p> <p>Action: Elaine Hamilton / Acute Team members</p> <p>Review January 2018</p> | |

ACUTE SERVICES SAI REVIEW TEAM MEETING – ACTION LOG UPDATED 18 APRIL 2016

Date: 18 April 2016

Lead Officers: Dr Paul Darragh (Chair), Dr Miriam McCarthy, Dr Jackie McCall, Dr Muhammad Sartaj

Apologies: Dr Janet Little

In attendance: Mrs Elaine Hamilton, Mrs Mareth Campbell

| Date | Agenda Item | Action Agreed | Person Responsible | Status |
|---------------|-------------|--|--|---|
| 18 April 2016 | 7 | <p>Any Other Business</p> <p>(i) Safety Forum – Learning Event Jackie McCall advised members the Safety Forum are commencing plans for the next regional Learning Event for 2016/17. Jackie requested for DROs to highlight any suitable SAIs that could be used for learning at the event. ‘Good Standard of Report’ is a key word which is captured on Datix and it was agreed DROs will use this if they deem an SAI appropriate for use at the event. This item will be added onto the agenda for each Acute meeting to remind DROs.</p> <p>Update 23 May 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 20 June 2016 – No SAIs identified for the Regional Learning Event.</p> <p>Update 18 July 2016 - Members agreed to identify three anticoagulant drug related SAIs to showcase at the Learning Event. It was agreed these could be identified during the review being undertaken by Dr Jackie McCall.</p> <p>Update 22 August 2016 - No SAIs identified for the Regional Learning Event.</p> <p>Update 23 September 2016 – SAI SHSCT SAI (Personal Information redacted by the) was highlighted as a SAI that could be used at the learning event.</p> <p>Update 17 October 2016 - No SAIs identified for the Regional Learning Event.</p> | <p>All members/Mareth Campbell</p> <p>Dr Jackie McCall</p> | To be a reviewed at each meeting of Acute SAI Review Team |

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| | | <p>Update 21 November 2016 – SAI [Personal Information] – SHSCT SAI [Personal Information] was highlighted as a SAI that could be considered for the Regional Learning Event.</p> <p>Update 19 December 2016 - SAI [Personal Information redacted by the USI] was highlighted as a possible SAI for use at the SAI Learning Event.</p> <p>Update 16 January 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ [Personal Information redacted by the USI] – showing patient journey ○ SHSCT SAI [Personal Information redacted by the USI] <p>Update 9 March 2017 – Two SAIs were highlighted as possible SAIs to be considered for the SAI Learning Event.</p> <ul style="list-style-type: none"> ○ [Personal Information redacted by the USI] ○ SAI 41-16 [Personal Information redacted by the USI] <p>Update 20 March 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 19 April 2017 - No SAIs identified for the Regional Learning Event.</p> <p>Update 10 May 2017: [Personal Information redacted by the USI] will be considered for a future SAI Learning Event.</p> <p>Update 9 June 2017: [Personal Information redacted by the USI] will be considered for a future learning event.</p> <p>Update 19 June 2017: No SAIs identified for the Regional Learning Event.</p> | | |
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| | | <p>Update 3 July 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 7 August 2017: Delayed Diagnosis is a theme which will need to be considered</p> <p>Update 21 August 2017: BHSCT/SA [Personal Information redacted] Elaine Hamilton to confirm with Dr McCarthy if this will be referred for consideration at the next Learning Event.</p> <p>Update 4 September 2017: Scoping Exercise on Delayed diagnosis.</p> <p>Update 25 September [redacted] NT-SAI-17-001</p> <p>Update 6 November 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 20 November 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 18 December 2017: No SAls identified for the Regional Learning Event.</p> <p>Update 22 January 2018: No SAls identified for the Regional Learning Event.</p> | Elaine Hamilton | |
|--|--|--|-----------------|--|

serious incidents

From: serious incidents
Sent: 26 January 2018 16:38
To: Corporate.Governance (Personal Information redacted by the USI)
Cc: 'Joanne McClean'
Subject: Closure of SAI - Trust Ref: SHSCT SAI (Personal Inform HSCB Ref: (Personal Inform

The DRO and other relevant officers, having reviewed the Learning Summary Report/Review Report and any other information, are satisfied based on the information provided that this incident can be closed from their perspective. However, if further information is made available to the reporting organisation (for example the Coroner's Report), which impacts on the outcome of the initial review it should be communicated to the HSCB / PHA DRO via the serious incidents mailbox.

Learning from this incident is being considered by the HSCB/PHA for regional dissemination. If learning is agreed the Trust will be advised in due course.

In line with the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), please note that it is the responsibility of the Trust to take forward any local recommendations or further actions identified (*including, where appropriate, on-going or further liaison with service users or families*) and monitor these through the Trust's own internal governance arrangements. This is an essential element in reassuring the public that lessons learned, where appropriate have been embedded in practice.

Regards
Roísín

Roisin Hughes
 Governance Support Officer
 Corporate Services Department
 Health & Social Care Board
 Tower Hill
 Armagh

E: (Personal Information redacted by the USI)
 T: (Personal Information redacted by the USI)

Donna Britton

From: Geraldine McArdle on behalf of QSE Team
Sent: 30 January 2018 11:41
To: Lisa McWilliams
Cc: Joanne McClean; serious incidents; 'Corporate.Governance
(Personal Information redacted by the USI)'
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI (Personal Inform) / HSCB Ref: (Personal Inform)
Attachments: Learning Outcomes Paper.docx

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

Can you please take forward any action as specified within the attached.

If you require any further information in relation to this incident please contact the seriousincidents@hscni.net mailbox.

A separate email will follow shortly with the password to access the attachment to this email.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: (Personal Information redacted by the USI)
E: (Personal Information redacted by the USI)

serious incidents

From: serious incidents
Sent: 12 February 2018 10:30
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI (Personal Informa) HSCB Ref: (Personal Informa)
Attachments: Learning Outcomes Paper.docx
Importance: High

Lindsey,

Please see email below and attached extract , in relation to the above SAI.

Can the Trust please advise if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks

Roísín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: (Personal Information redacted by the USI)

T: (Personal Information redacted by the USI)

From: Geraldine McArdle **On Behalf Of** QSE Team

Sent: 30 January 2018 11:41

To: Lisa McWilliams

Cc: Joanne McClean; serious incidents; 'Corporate.Governance (Personal Information redacted by the USI)'

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI (Personal Informa) / HSCB Ref: (Personal Informa)

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Geraldine

Geraldine McArdle
Governance Support Manager

Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 27 February 2018 10:08
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI (Personal Informa) / HSCB Ref: (Personal Informa)
Attachments: Learning Outcomes Paper.docx

Importance: High

Lindsey,

Please see email trail below and attached extract, in relation to the above SAI.

Can the Trust please advise if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

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Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: Geraldine McArdle **On Behalf Of** QSE Team

Sent: 30 January 2018 11:41

To: Lisa McWilliams

Cc: Joanne McClean; serious incidents; 'Corporate.Governance ([Personal Information redacted by the USI])'

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

Can you please take forward any action as specified within the attached.

If you require any further information in relation to this incident please contact the [Personal Information redacted by the USI] mailbox.

A separate email will follow shortly with the password to access the attachment to this email.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 15 March 2018 11:45
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: Final Reminder - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI (Personal Inform) / HSCB Ref: (Personal Inform)
Attachments: Learning Outcomes Paper.docx
Importance: High

Lindsey,

Please see email trail below and attached extract, in relation to the above SAI.

Can the Trust please advise, **by return of email**, if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

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T: (Personal Information redacted by the USI)

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Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI (Personal Inform) / HSCB Ref: (Personal Inform)
Importance: High

Lindsey,

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Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill

Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 12 February 2018 10:30
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]
Importance: High

Lindsey,

Please see email below and attached extract , in relation to the above SAI.

Can the Trust please advise if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks

*Róisín***Roisin Hughes**

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: Geraldine McArdle **On Behalf Of** QSE Team
Sent: 30 January 2018 11:41
To: Lisa McWilliams
Cc: Joanne McClean; serious incidents; 'Corporate.Governance ([Personal Information redacted by the USI])'
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

Can you please take forward any action as specified within the attached.

If you require any further information in relation to this incident please contact the seriousincidents@hscni.net mailbox.

A separate email will follow shortly with the password to access the attachment to this email.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager

Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 29 March 2018 16:50
To: Elaine Hamilton (HSCB)
Subject: Escalation - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform]/
HSCB Ref: [Personal Inform]
Attachments: Learning Outcomes Paper.docx
Importance: High

Elaine,

Can you please escalate the above SAI, as no response has been received from Southern Trust?

Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 15 March 2018 11:45
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: Final Reminder - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]
Importance: High

Lindsey,

Please see email trail below and attached extract, in relation to the above SAI.

Can the Trust please advise, **by return of email**, if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 27 February 2018 10:08
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Informa] / HSCB Ref: [Personal Informa]
Importance: High

Lindsey,

Please see email trail below and attached extract, in relation to the above SAI.

Can the Trust please advise if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks

Róisín

Roisin Hughes

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Tower Hill
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Health & Social Care Board
Tower Hill
Armagh

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From: Geraldine McArdle **On Behalf Of** QSE Team

Sent: 30 January 2018 11:41

To: Lisa McWilliams

Cc: Joanne McClean; serious incidents; 'Corporate.Governance ([Personal Information redacted by the USI])'

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Informa] / HSCB Ref: [Personal Inform]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

Can you please take forward any action as specified within the attached.

If you require any further information in relation to this incident please contact the seriousincidents@hscni.net mailbox.

A separate email will follow shortly with the password to access the attachment to this email.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 10 April 2018 11:04
To: serious incidents
Subject: Encryption - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Informa]
HSCB Ref: [Personal Inform]
Attachments: Report to HSCB.PDF; AP for SAI.DOCX

Please find attached response to DRO query.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ
Telephone [Personal Information redacted by the USI]
Ext [Personal Information redacted by the USI]



From: serious incidents [<mailto:seriousincidents@hscni.net>]
Sent: 15 March 2018 11:45
To: Corporate.Governance
Subject: Final Reminder - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Informa] / HSCB Ref: [Personal Informa]
Importance: High

This message contains encrypted attachments that could not be verified virus free. Open only if you were expecting this message.

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

Please see email trail below and attached extract, in relation to the above SAI.

Can the Trust please advise, **by return of email**, if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation?

Many Thanks
Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents

Sent: 27 February 2018 10:08

To: Corporate.Governance ([Personal Information redacted by the USI])

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Importance: High

Lindsey,

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Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents

Sent: 12 February 2018 10:30

To: Corporate.Governance ([Personal Information redacted by the USI])

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Importance: High

Lindsey,

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Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Geraldine McArdle **On Behalf Of** QSE Team

Sent: 30 January 2018 11:41

To: Lisa McWilliams

Cc: Joanne McClean; serious incidents; 'Corporate.Governance ([Personal Information redacted by the USI])'

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Information redacted by the USI] HSCB Ref: [Personal Information redacted by the USI]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

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Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

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any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from any computer.

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

Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Organisation's Unique Case Identifier: ID Personal Information redacted

| Recommendation | Action | Achieved |
|--|---|---|
| This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with IEAP | This is monitored through ETriage on a weekly basis and through recording paper copy referrals received on a database that is also monitored on a weekly basis for Urgent and Routine and daily for red flags | Yes through weekly monitoring by Head of Service, Red Flag Team and Booking Centre Team and appropriate timely escalation if required |
| In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP. | As above. Monitored by HOS, Red Flag Team and Booking Centre Team | Yes through weekly monitoring by Head of Service, Red Flag Team and Booking Centre Team and appropriate timely escalation if required |

serious incidents

From: serious incidents
Sent: 10 April 2018 16:09
To: Joanne McClean
Cc: Elaine Hamilton (HSCB)
Subject: Trust Ref: SHSCT SAI [redacted] / HSCB Ref: [redacted]
Attachments: Response to DRO Q re Learning [redacted].pdf; Position Report [redacted].pdf

Joanne,

Please find attached Trust response to your query below. I have also attached a Position Report. **This SAI is closed.*

Please advise if any further action is required?

Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [redacted] Personal Information redacted by the USI

T: [redacted] Personal Information redacted by the USI

From: Corporate.Governance [mailto:[redacted] Personal Information redacted by the USI]
Sent: 10 April 2018 11:04
To: serious incidents
Subject: Encryption - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [redacted] / HSCB Ref: [redacted]

Please find attached response to DRO query.

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [redacted] Personal Information redacted by the USI

Ext [redacted] Personal Information redacted by the USI



From: serious incidents [<mailto:seriousincidents@hscni.net>]

Sent: 15 March 2018 11:45

To: Corporate.Governance

Subject: Final Reminder - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Informa]

Importance: High

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Many Thanks

Róisín

Roisin Hughes

Governance Support Officer

Corporate Services Department

Health & Social Care Board

Tower Hill

Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents

Sent: 27 February 2018 10:08

To: Corporate.Governance ([Personal Information redacted by the USI])

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Importance: High

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Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: serious incidents
Sent: 12 February 2018 10:30
To: Corporate.Governance ([Personal Information redacted by the USI])
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Importance: High

Lindsey,

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Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: Geraldine McArdle **On Behalf Of** QSE Team
Sent: 30 January 2018 11:41
To: Lisa McWilliams
Cc: Joanne McClean; serious incidents; 'Corporate.Governance ([Personal Information redacted by the USI])'
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Information] / HSCB Ref: [Personal Information]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

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Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 12 April 2018 09:26
To: Lisa McWilliams
Subject: For Action: Trust Ref: SHSCT SAI [Personal Information redacted by the USI] / HSCB Ref: [Personal Information redacted by the USI]
Attachments: Learning Outcomes Paper.docx

Lisa,

Can you please advise if the Elective Care Group have sought advice from other Trusts re E-Triage as per attached outcomes paper.

Please give me a call if you have any queries.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

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Governance Support Manager
Corporate Services Department
Health & Social Care Board

Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: Joanne McClean
Sent: 17 April 2018 10:28
To: serious incidents
Subject: RE: Trust Ref: SHSCT SAI [Personal Informa] / HSCB Ref: [Personal Informa]

Thanks Roisin

That is fine. There is no further action required. The SAI is closed.
Joanne

From: serious incidents
Sent: 10 April 2018 16:09
To: Joanne McClean
Cc: Elaine Hamilton (HSCB)
Subject: Trust Ref: SHSCT SAI [Personal Informa] / HSCB Ref: [Personal Informa]

Joanne,

Please find attached Trust response to your query below. I have also attached a Position Report. **This SAI is closed.*

Please advise if any further action is required?

Many Thanks

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

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From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 10 April 2018 11:04
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Please find attached response to DRO query.

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Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office

Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone Personal Information redacted by the USI

Ext Personal Information redacted by the USI



From: serious incidents [<mailto:seriousincidents@hscni.net>]

Sent: 15 March 2018 11:45

To: Corporate.Governance

Subject: Final Reminder - For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI Personal Inform / HSCB Ref: Personal Inform

Importance: High

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Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: Personal Information redacted by the USI

T: Personal Information redacted by the USI

From: serious incidents

Sent: 27 February 2018 10:08

To: Corporate.Governance (Personal Information redacted by the USI)

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI Personal Inform / HSCB Ref: Personal Inform

Importance: High

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Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: serious incidents

Sent: 12 February 2018 10:30

To: Corporate.Governance ([Personal Information redacted by the USI])

Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Information redacted] / HSCB Ref: [Personal Information redacted]

Importance: High

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Health & Social Care Board
Tower Hill
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E: [Personal Information redacted by the USI]

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From: Geraldine McArdle **On Behalf Of** QSE Team

Sent: 30 January 2018 11:41

To: Lisa McWilliams

Cc: Joanne McClean; serious incidents; 'Corporate.Governance ([Personal Information redacted by the USI])'

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Health & Social Care Board
Tower Hill
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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

serious incidents

From: Lisa McWilliams
Sent: 19 April 2018 09:11
To: serious incidents
Cc: Beth Minnis
Subject: RE: For Action: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Categories: Work in progress

Regional Scheduled Care Group have discussed the learning outcomes and specialty leads have discussed with clinicians.

E-Triage is only available for use in secondary care by clinicians to triage referrals from GPs which are transmitted by CCG to ECR. E-Triage is specifically linked to CCG and there is no mechanism for secondary care clinicians to use CCG, and nor would it be appropriate to do so, therefore E-Triage as currently facilitated is not available for consultant to consultant referrals. Future developments of EHCR may facilitated this in time.

Fail safes in the absence of an electronic consultant to consultant triage is via the relevant cancer MDT meeting where by an onward referral is agreed, recorded and actioned by the MDT clinical lead and MDT tracker. Patients will be notified for required discussion with MDT B by the relevant personnel in MDT A.

The specific incident associated with this learning outcomes report was part of wider look back exercise of clinical practice from a number of years ago – and in this case referrals did not flow via MDT meetings – embedded practice would prevent this for happening now.

Trust this is helpful
 Lisa

From: serious incidents
Sent: 12 April 2018 09:26
To: Lisa McWilliams
Subject: For Action: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Lisa,

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Geraldine McArdle
 Governance Support Manager
 Corporate Services Department
 Health & Social Care Board
 Tower Hill
 Armagh

DDI: [Personal Information redacted by the USI]

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Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 19 April 2018 16:48
To: Geraldine McArdle
Subject: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]
Attachments: RE: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Geraldine,

I have saved the email from Lisa McWilliams below to Datix Record. I have attached email from DRO stating no further action. Should Lisa's email be forwarded to Joanne? Please advise if any further action is required.

Thanks

Róisín

Róisín Hughes

Governance Support Officer
 Corporate Services Department
 Health & Social Care Board
 Tower Hill
 Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Lisa McWilliams
Sent: 19 April 2018 09:11
To: serious incidents
Cc: Beth Minnis
Subject: RE: For Action: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

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Please give me a call if you have any queries.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]
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Sent: 30 January 2018 11:41
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Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 20 April 2018 11:47
To: 'Joanne McClean'
Subject: FW: For Action: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Joanne

Please see Lisa's email below for your information.

Regards

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

www.hscboard.hscni.net

From: Lisa McWilliams
Sent: 19 April 2018 09:11
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Cc: Beth Minnis
Subject: RE: For Action: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

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Fail safes in the absence of an electronic consultant to consultant triage is via the relevant cancer MDT meeting where by an onward referral is agreed, recorded and actioned by the MDT clinical lead and MDT tracker. Patients will be notified for required discussion with MDT B by the relevant personnel in MDT A.

The specific incident associated with this learning outcomes report was part of wider look back exercise of clinical practice from a number of years ago – and in this case referrals did not flow via MDT meetings – embedded practice would prevent this for happening now.

Trust this is helpful
Lisa

From: serious incidents
Sent: 12 April 2018 09:26
To: Lisa McWilliams
Subject: For Action: Trust Ref: SHSCT SAI [Personal Information redacted by the USI] / HSCB Ref: [Personal Information redacted by the USI]

Lisa,

Can you please advise if the Elective Care Group have sought advice from other Trusts re E-Triage as per attached outcomes paper.

Please give me a call if you have any queries.

Regards
Geraldine

Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]
E: [Personal Information redacted by the USI]

From: Geraldine McArdle **On Behalf Of** QSE Team
Sent: 30 January 2018 11:41
To: Lisa McWilliams
Cc: Joanne McClean; serious incidents; 'Corporate.Governance [Personal Information redacted by the USI]'
Subject: For Action: Regional Learning re SAI: Trust Ref: SHSCT SAI [Personal Information redacted by the USI] / HSCB Ref: [Personal Information redacted by the USI]

Please see attached extract in relation to the above SAI which was discussed by the Acute SAI Review Team and noted by the PHA/HSCB Quality, Safety and Experience Group (QSE) at its monthly meeting.

Can you please take forward any action as specified within the attached.

If you require any further information in relation to this incident please contact the seriousincidents@hscni.net mailbox.

A separate email will follow shortly with the password to access the attachment to this email.

Regards
Geraldine

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Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: Geraldine McArdle
Sent: 20 April 2018 11:18
To: Elaine Hamilton (HSCB)
Cc: serious incidents
Subject: Response from L McWilliams: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Categories: Work in progress

Elaine,

See below response from Lisa McWilliams – re the e-traige follow up that we discussed.

I have asked Roisin to send it the Joanne (DRO) for information, can you please advise if any further action is required by the Governance Team.

I think it is it complete given that Lisa has confirmed that ‘embedded practice would prevent this for happening now’, just want to check with you.

Thanks
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From: Geraldine McArdle
Sent: 20 April 2018 11:11
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Geraldine McArdle
Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]
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From: serious incidents
Sent: 19 April 2018 16:48
To: Geraldine McArdle
Subject: Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Geraldine,

I have saved the email from Lisa McWilliams below to Datix Record. I have attached email from DRO stating no further action. Should Lisa's email be forwarded to Joanne? Please advise if any further action is required.

Thanks

Roísín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Lisa McWilliams
Sent: 19 April 2018 09:11
To: serious incidents
Cc: Beth Minnis
Subject: RE: For Action: Trust Ref: SHSCT SAI [Personal Information] / HSCB Ref: [Personal Information]

Regional Scheduled Care Group have discussed the learning outcomes and specialty leads have discussed with clinicians.

E-Triage is only available for use in secondary care by clinicians to triage referrals from GPs which are transmitted by CCG to ECR. E-Triage is specifically linked to CCG and there is no mechanism for secondary care clinicians to use CCG, and nor would it be appropriate to do so, therefore E-Triage as currently facilitated is not available for consultant to consultant referrals. Future developments of EHCR may facilitated this in time.

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Health & Social Care Board
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Governance Support Manager
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

DDI: [Personal Information redacted by the USI]

E: [Personal Information redacted by the USI]

serious incidents

From: Elaine Hamilton (HSCB)
Sent: 25 April 2018 13:49
To: Geraldine McArdle
Cc: serious incidents
Subject: RE: Response from L McWilliams: Trust Ref: SHSCT SAI [Personal Information] / HSCB Ref: [Personal Information]
Categories: Work in progress

Thanks Geraldine,

No I don't think any further action is required. Joanne will be aware of the response so I think that was all that is required.

Elaine

From: Geraldine McArdle
Sent: 20 April 2018 11:18
To: Elaine Hamilton (HSCB)
Cc: serious incidents
Subject: Response from L McWilliams: Trust Ref: SHSCT SAI [Personal Information] / HSCB Ref: [Personal Information]

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See below response from Lisa McWilliams – re the e-traige follow up that we discussed.

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 Governance Support Manager

Corporate Services Department
Health & Social Care Board
Tower Hill
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Thanks

Róisín

Róisín Hughes
Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

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Tower Hill

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DDI: [Personal Information redacted by the USI]

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HSCB / PHA SAI POSITION REPORT

| | | |
|---|-------------------------|---|
| UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: | | HSCB REFERENCE NUMBER |
| SHSCT SAI <small>Personal Information redacted by the USI</small> | | <small>Personal Information redacted by the USI</small> |
| DATE SAI NOTIFIED | CURRENT LEVEL OF REVIEW | ORGANISATIONS NOTIFIED (EXTERNAL) |
| 22 March 2016 | SAILV2 | |
| DATE SAI OCCURRED: | DRO: | LSR/RCA REPORT DUE: |
| 6 January 2016 | Dr Joanne McClean | 14 June 2016 |
| CORONER'S REPORT: | DRO SUPPORT OFFICER/S | PROGRAMME OF CARE |
| | | Acute Services |

KEY WORDS

HSCB / PHA Generic Coding

DETERIORATION - Failure to give ordered treatment / support in a timely way

DATIX – COMMON CLASSIFICATION SYSTEM – CCS CODING

| | | |
|------------------------------|-------------------------------|-----------------------------|
| STAGE OF CARE | DETAILS | ADVERSE EVENT |
| Diagnosis, failed or delayed | Cancer - Dx failed or delayed | Failure in referral process |

DATIX – COMMON CLASSIFICATION SYSTEM – CCS2 CODING

| | | |
|--------|--------|--------|
| TIER 1 | TIER 2 | TIER 3 |
| | | |

DESCRIPTION OF INCIDENT

**DRO advises this is similar incident to Personal Information redacted by the USI **

Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney.

US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate.

MRI performed 2/9/2014

Referral to Urology was not triaged on receipt. Patient 110 sent OP appointment for 6/1/2016. Patient 10 was seen in clinic on 6/1/16. The sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer.

The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning.

DOB: Personal Information redacted by the USI GENDER: F AGE: Personal Information redacted by the USI year

WHY INCIDENT CONSIDERED SERIOUS: serious injury to, or the unexpected/unexplained death of a service user

CURRENT CONDITION OF SERVICE USER: The patient is undergoing treatment

HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING INVESTIGATED AS A SAI - NO - The Trust intend to inform the family by letter in the first instance of this serious incident review and will advise HSCB when this has been done.

IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

IMMEDIATE ACTION TAKEN BY HSCB/PHA:

| | | | | |
|----------------------|---------------------|------------------------|---------------|----------------------|
| TOR DUE: | TOR RECEIVED: | SEA RECEIVED: | LSR RECEIVED: | RCA RECEIVED |
| 19 April 2016 | 5 April 2016 | | | 16 March 2017 |
| RR SENT TO RQIA | TRUST ACTION: | DATE DRO CLOSED | SAIRSG DATE | LEARNING REF |
| | | 10 January 2018 | | |

SERVICE USER / FAMILY ENGAGEMENT:

| DATE SU/FAM INFORMED | DATE CLIST RECEIVED | DATE LSR/SEA/RCA SHARED SU/FAM |
|---------------------------|----------------------|--------------------------------|
| 6 January 2016 | 16 March 2017 | 31 March 2017 |
| REASON NO ENGAGEMENT | | |
| REASON SEA/RCA NOT SHARED | | |

RATIONALE NOT INFORMING the S/User / Family / Carer that the incident was being reviewed as a SAI**RATIONALE FOR NOT SHARING LSR/SEA/RCA**

meeting took place on 10/4/17

HSCB-PHA ACTION TAKEN:

22/03/16: Incident Acknowledged and DRO Assigned.

22/03/16: Query to Trust - In relation to the above incident, can you please clarify the Date of Birth of the Service User as on the SAI Notification Form it states the Date of Birth as [Personal Information redacted by the] and age as [Personal Information redacted by the], these don't match. Either the Date of Birth should be [Personal Information redacted by the] or age needs changed to [Personal Information redacted by the]? Can you please clarify correct Date of Birth/Age.

23/03/16: Email from DRO - 'Noted.'

23/03/16: Email from Trust with amended SAI Notification Form attached (amended to read correct DOB and age). Record updated and saved to Datix.

05/04/16: Email from Trust enc TOR and membership - forwarded to DRO

05/04/16: Email from DRO req Position report - forwarded as requested

05/04/16: Email from DRO - 'I would encourage the Trust to consider adding someone from outside the Trust to the Team Membership.'

06/04/16: Email to Trust with DRO Q re Team Membership.

20/04/16: 1st reminder to Trust re DRO query as above.

10/05/16: 2nd reminder to Trust.

02/06/16: Tel call to Trust re response to DRO Comment - advised to send request via email. Final reminder to Trust.

09/06/16: Email from Trust - Further to your email below regarding the team membership of SAI ID 52720, I can advise that Mrs Trudy Reid contacted the DRO and had a lengthy discussion regarding adding an external to the review team. It was agreed during the conversation that the membership would stay the same at present but he did state that during the review the panel may take the opportunity to ask for an independent opinion.

I have enclosed the ToR and Team Membership for your reference.

09/06/16: Email above from Trust forwarded to DRO for their information.

10/06/16: Email from DRO - Noted.

12/08/16: Letter from HSCB CX to Trust CX attaching status report highlighting all review reports that remain outstanding as at 31st July 2016.

23/11/16: Email from Trust with amended ToR attached.

24/11/16: Amended ToR fwded to DRO for approval.

01/12/16: Email to DRO re approval of ToR.

12/12/16: Email to DRO requesting approval of ToR.

20.01.17 - Letter from HSCB CX to Trust attaching status report highlighting all review reports that remain outstanding as at 31 December 2016

27/01/17: Email to DRO requesting approval of ToR.

08/02/17: Email to DRO requesting approval of ToR.

27/02/17: Email to DRO requesting approval of ToR.

HSCB-PHA ACTION TAKEN:

07/03/17: Email to DRO requesting approval of ToR. If no response escalate.
 14/03/17: Email from DRO approving ToR - Thanks. These are fine.
 15/03/17: ToR approval to Trust.
 16/03/17: Final RCA Report (including chklist) received from Trust.
 20/03/17: Email to DRO - Final Report / Position Report.
 26/04/17: Email to DRO re listing for new Acute Meeting.
 28/04/17: Email from DRO - Please list for next meeting.
 02/05/17: Listed for meeting on 22 May 2017.
 ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 10 MAY 2017
 First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.
 Review June 2017
 STATUS - Review at meeting 9 June 2017
 ADDITIONAL ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 6 JUNE 2017
 Governance Team to email the SHSCT with the following points:
 "Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.
 "The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?
 "Ensure Trust Urologists are compliant in accordance with IEAP
 Review when Trust have responded.
 12/06/17: DRO queries forwarded to Trust.
 03/07/17: Email to Trust - I refer to email below sent to SHSCT on 12 June 2017 in relation to queries the DRO has raised in relation to the RCA report submitted to HSCB. I would be grateful if you would respond to HSCB serious incident mailbox as a matter of urgency so as to resolve these queries and allow the SAI to be closed. Many thanks.
 03/07/17: Email from Trust - 'I have forwarded your email onto the Acute Governance team who are dealing with this case. I will forward on their response once I have received it.'
 17/07/17: 2nd reminder to Trust for outstanding response to DRO queries.
 25/07/17: Telephone call from GMcA to SHSCT (Spoke to Lindsey) - she has followed up the outstanding response with the Directorate twice, she is going to follow up again today and provide an update.
 If no response by 01.08.17 escalate from GMcA / EH
 02/08/17: Escalated to Elaine Hamilton
 09/08/17: Escalated to Elaine Hamilton - I will escalate it now
 09/08/17: Email to Margaret Marshall from Elaine Hamilton requesting urgent response to DRO queries to avoid it being escalated further
 14/08/17: Email from Trust - The staff member currently dealing with this case is on leave until 21st August.
 23/08/17: Email from Trust - 'I wish to advise that a response to DRO queries is currently with the Assistant Director for approval.'
 30/08/17: Telephone call from MC to L Liggett + follow-up email. Our telephone conversation today refers. You advised on 23 August 2017 that the response to DRO queries was with the Assistant Director for approval. To date the response hasn't been received. During our conversation, you undertook to follow-up with the Directorate and if the response is approved, submit it or provide an update on when it will be submitted.
 01/09/17: Forwarded to A Kane for Escalation re outstanding response to DRO queries as of 12.06.17.
 08/09/17: AK on annual leave
 08/09/17: Telephone call from MC to Lindsay Liggett. Lindsay advised she didn't have an update but undertook to email the co-ordinator and provide an update on status of response on Monday 11 September 2017.
 14/09/17: Telephone Call from E Hyde to Lindsey Liggett. Lindsey to do an urgent follow-up with Trust Director and contact me to-day by telephone to advise when Trust response to DRO queries will be submitted to HSCB.
 15/09/17: Email from Trust - 'Please see below response to DRO queries,
 Who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the

HSCB-PHA ACTION TAKEN:

investigations.

"The CT MRI and US were ordered by or on behalf of an individual Consultant General Surgeon. A further CT was ordered by a Breast Surgeon.

"The Trust currently has a short life working group reviewing systems and processes for the management of results

"I am checking if the case was presented at M&M for wider learning

The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed?

"This SAI was in relation to triage by one urologist, the Trust has addressed this issue with the Consultant involved

"Electronic triage has been rolled out for Urology, this should mitigate against late or uncompleted triage within the specialty.

Ensure Trust Urologists are compliant in accordance with IEAP

"The Trust Urology team have been made aware of the requirements within the IEAP in relation to triage of clinical referrals

Kind regards'

15/09/17: Trust response fwdd to DRO.

ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 25 SEPTEMBER 2017

Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information redacted] and to seek assurance processes have been put in place to prevent reoccurrence.

SAI to be reviewed following meeting with SHSCT

Action: Dr Farrell / Dr McClean

STATUS - Review following meeting with SHSCT

01/11/17: Email from E Hamilton to DRO - 'At the Acute meeting on 25 September 2017 it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information redacted] and to seek assurance processes have been put in place to prevent reoccurrence. Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?'

Extract from Action Log:

Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information redacted] and to seek assurance processes have been put in place to prevent reoccurrence.

SAI to be reviewed following meeting with SHSCT

Action: Dr Farrell / Dr McClean.

20/11/17: Update from Acute Services SAI Review Team meeting - FURTHER INFORMATION REQUIRED. SAI to be referred to the Elective Care Group (Michael Bloomfield and Lisa McWilliams) in respect of timely triage and categorisation. Request the Elective Care Group to seek assurance from other Trusts if E-Triage would manage the risk of a similar situation.

Action: Elaine Hamilton

ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 10 JANUARY 2018

Update 10 January 2018: CLOSE based on the information provided including the engagement checklist. Governance Team to confirm with Dr McClean/Elaine Hamilton this was sent to Elective Care Group but no further action / follow up is required.

Action: HSCB Governance Team

STATUS - Close

Theme/Key Words - Failure to give ordered treatment/support in a timely way.

10/01/18: SAI Closed.

25/01/18: Composite noting paper received from QSE, see documents.

26/01/18: Trust advised of closure.

12/02/18: Follow up email to Trust if they have sought advice from other Trusts if E-Triage would manage the risk of a similar situation.

27/02/18: Reminder Email to Trust with above Q re learning.

15/03/18: Reminder Email to Trust Q re learning.

28/03/18: Phonecall to Trust by ARedpath. Governance Team to ring back.

30/03/18: RH Tel Conversation with Lindsey SHSCT. Nothing has been received. She will follow up with Acute Directorate again. If no response, escalate to Elaine.

HSCB-PHA ACTION TAKEN:

10/04/18: Email from Trust with attached response - [Personal Information]

10/04/18: Fwdd to DRO cc E Hamilton.

12/04/18: Email to L McWilliams 'Can you please advise if the Elective Care Group have sought advice from other Trusts re E-Triage as per attached outcomes paper.'

18/04/18: Email from DRO - 'That is fine. There is no further action required. The SAI is closed.'

19/04/18: Email from Lisa McWilliams - 'Regional Scheduled Care Group have discussed the learning outcomes and specialty leads have discussed with clinicians.'

E-Triage is only available for use in secondary care by clinicians to triage referrals from GPs which are transmitted by CCG to ECR. E-Triage is specifically linked to CCG and there is no mechanism for secondary care clinicians to use CCG, and nor would it be appropriate to do so, therefore E-Triage as currently facilitated is not available for consultant to consultant referrals. Future developments of EHCR may facilitated this in time.

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Trust this is helpful.

19/04/18: Saved to Datix Record. Fwdd to G McArdle for info.

20/04/18: Email from Geraldine - Can you please forward Lisa's email to Joanne for information.

20/04/18: Lisa's email forwarded to Joanne for information.

20/04/18: Email to E Hamilton - See below response from Lisa McWilliams - re the e-traige follow up that we discussed.

I have asked Roisin to send it the Joanne (DRO) for information, can you please advise if any further action is required by the Governance Team.

I think it is it complete given that Lisa has confirmed that 'embedded practice would prevent this for happening now', just want to check with you.

25/04/18: Email from E Hamilton to G McArdle - 'No I don't think any further action is required. Joanne will be aware of the response so I think that was all that is required.'

serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]
Attachments: 20170921_ SAI Notification [Personal Information redacted by the USI].pdf
Categories: New SAI notification

Please find attached SAI Notification ID [Personal Information redacted by the USI]

Kind regards

Lindsey

Lindsey Liggett
 Southern Health & Social Care Trust
 Corporate Governance Assistant
 Corporate Clinical & Social Care Governance Office
 Beechfield House
 Craigavon Area Hospital Site
 68 Lurgan Road
 PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material.

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

Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | |
|--|--|
| 1. ORGANISATION: Southern Health and Social Care Trust | 2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE 3. ID [Redacted] |
| 4. HOSPITAL / FACILITY / COMMUNITY LOCATION Craigavon Area Hospital | 5. DATE OF INCIDENT: Reported: 12.5.17 |
| 6. DEPARTMENT / WARD / LOCATION EXACT Urology Department | |
| 7. CONTACT PERSON: Mrs Connie Connolly | 8. PROGRAMME OF CARE: Acute Services |

9. DESCRIPTION OF INCIDENT:

1. [Redacted] old male referred to urology following an episode of haematuria on 28 July 2016, it appears the letter was not triaged and the patient was placed on a routine waiting list on 30 September 16. As part of an internal review this patient's referral letter was upgraded to a red flag referral and was reviewed at OPD on 31/01/17. Subsequent investigations diagnosed a pT4 TCC of bladder and prostate. Patient has locally advanced bladder cancer (G3T4a). Datix - [Redacted]
2. [Redacted] - [Redacted] old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis T3a with no nodal metastases. Datix - [Redacted]
3. [Redacted] - [Redacted] old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment. Datix - [Redacted]
4. [Redacted] - [Redacted] old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment. Datix - [Redacted]

The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning relating to this incident.

| SERIOUS ADVERSE INCIDENT NOTIFICATION FORM | | | | |
|--|--|---|---|--|
| D (complete where relevant) | | | | |
| 10. IS THIS INCIDENT A NEVER EVENT? | | | If 'YES' provide further detail on which never event - refer to DoH link below https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars | |
| YES | | NO | x | |
| DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING | | | | |
| STAGE OF CARE: <i>Checking and Oversight</i> | | DETAIL: <i>(refer to Guidance Notes)</i> | | ADVERSE EVENT: <i>(refer to Guidance Notes)</i> |
| 11. <u>IMMEDIATE</u> ACTION TAKEN TO PREVENT RECURRENCE: Notified to the Medical Director on | | | | |
| 12. CURRENT CONDITION OF SERVICE USER: <i>recuperating from initial surgery, awaiting further treatment</i> | | | | |
| 13. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? <i>(please select)</i> | | | | NO |
| 14. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? <i>(please specify where relevant)</i> | | | YES | |
| 15. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: <i>(please select relevant criteria below)</i> | | | | |
| serious injury to, or the unexpected/unexplained death of: | | | | |
| - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) | | | | x |
| - a staff member in the course of their work | | | | |
| - a member of the public whilst visiting a HSC facility. | | | | |
| unexpected serious risk to a service user and/or staff member and/or member of the public | | | | |
| unexpected or significant threat to provide service and/or maintain business continuity | | | | |
| serious self-harm or serious assault <i>(including attempted suicide, homicide and sexual assaults)</i> by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service | | | | |
| serious self-harm or serious assault <i>(including homicide and sexual assaults)</i> | | | | |
| - on other service users, | | | | |
| - on staff or | | | | |
| - on members of the public | | | | |
| by a service user in the community who has a mental illness or disorder <i>(as defined within the Mental Health (NI) Order 1986)</i> and/or known to/referred to mental health and related services <i>(including CAMHS, psychiatry of old age or leaving and aftercare services)</i> and/or learning disability services, in the 12 months prior to the incident | | | | |
| suspected suicide of a service user who has a mental illness or disorder <i>(as defined within the Mental Health (NI) Order 1986)</i> and/or known to/referred to mental health and related services <i>(including CAMHS, psychiatry of old age or leaving and aftercare services)</i> and/or learning disability services, in the 12 months prior to the incident | | | | |
| serious incidents of public interest or concern relating to: | | | | |
| - any of the criteria above | | | | |
| - theft, fraud, information breaches or data losses | | | | |
| - a member of HSC staff or independent practitioner | | | | |
| 16. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: <i>(please select)</i> | | | | NO |
| if 'YES' <i>(full details should be submitted):</i> | | | | |

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | | | |
|---|-----|--|--|
| SERIOUS ADVERSE INCIDENT NOTIFICATION FORM | | | |
| 17. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? | YES | DATE INFORMED: DD/MM/YY | |
| | NO | specify reason: Patients to be informed by Chair of SAI group following first meeting | |
| 18. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? (refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant | | | NO |
| if 'YES' (full details should be submitted including the date notified): | | | |
| 19. OTHER ORGANISATION/PERSONS INFORMED: (please select) | | DATE INFORMED: | OTHERS: (please specify where relevant, including date notified) |
| DoH EARLY ALERT | | | |
| HM CORONER | | | |
| INFORMATION COMMISSIONER OFFICE (ICO) | | | |
| NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC) | | | |
| HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI) | | | |
| POLICE SERVICE FOR NORTHERN IRELAND (PSNI) | | | |
| REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA) | | | |
| SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNi) | | | |
| NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP) | | | |
| 20. LEVEL OF REVIEW REQUIRED: (please select) | | LEVEL 1 | |
| * FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6 | | | |
| 21. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (delete as appropriate) | | | |
| Report submitted by: Connie Connolly Designation: Lead Nurse Acute Governance | | | |
| Email: Personal Information redacted by the USI Telephone: Personal Information redacted by the USI Date: DD / MM / YYYY | | | |
| 22. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: (refer to Guidance Notes) | | | |
| Additional information submitted by: _____ Designation: _____ | | | |
| Email: _____ Telephone: _____ Date: DD / MM / YYYY | | | |

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

serious incidents

From: serious incidents
Sent: 21 September 2017 14:54
To: 'Corporate.Governance'
Subject: Acknowledgement - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI [Personal Information]

HSCB Ref: [Personal Information]

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Róisín

Róisín Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material.

Any review, transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from any computer.

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

Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 21 September 2017 15:05
To: Joanne McClean
Cc: Carolyn Harper; Brid Farrell; Mary Hinds; Lynne Charlton; Mary McElroy; Oriel Brown; Michael Bloomfield; Anne Kane; Jacqui Burns; Margaret McNally; Mareth Campbell; Elaine Hamilton (HSCB); Geraldine McArdle; Elaine Hyde
Subject: DRO Assigned - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]
Attachments: SAI Notification Form [Personal Information].pdf

Joanne,

You have been identified as the DRO for the above SAI.

Please can you advise by email to seriousincidents@hscni.net on any immediate action you have taken or action required; the governance team will update the Datix record for this incident accordingly.

If you require advice in relation to medication related issues please contact Angela Carrington, email:

[Personal Information redacted by the USI]. Please ensure all correspondence to Angela is copied to seriousincidents@hscni.net.

I attach the Serious Adverse Incident Notification from the **Southern Trust** received on 21 September 2017. This notification confirms that a **Level 1** Significant Event Audit (SEA) review will be undertaken.

This incident has been reported to the HSCB in line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference: SHSCT SAI [Personal Inform]

HSCB Reference: [Personal Information]

Programme of Care: Acute Services

An acknowledgement of receipt of this notification has been forwarded to the **Southern Trust**, requesting the redacted **Learning Summary Report** by no later than **16 November 2017**.

If you require any further information, please do not hesitate to contact me.

Regards

Róisín

Roisin Hughes

Governance Support Officer
 Corporate Services Department
 Health & Social Care Board
 Tower Hill
 Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:Personal Information redacted by the USI]
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION Personal Inform

Please find attached SAI Notification ID Personal Informa

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone Personal Information redacted by the USI

Ext Personal Information redacted by the USI



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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: Joanne McClean
Sent: 21 September 2017 16:07
To: serious incidents
Subject: RE: DRO Assigned - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]
Attachments: DOC2DA2.tmp.docx

Can you please also draw the Trust's attention to the attached SAI and check if the cases below were found following a review prompted by this SAI as the case is not on the list of new ones.

Thanks
Joanne

From: Joanne McClean
Sent: 21 September 2017 16:02
To: serious incidents (seriousincidents@hscni.net)
Subject: FW: DRO Assigned - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]
Importance: High

HI

Can you please ask the Trust the following for an urgent response:

1. What action has been taken to prevent further referrals slipping through processes like this
2. Has the Trust assured itself that there are no other urology referrals have slipped through
3. Have they considered if this is likely to be a problem in other specialities

Thanks

Joanne

From: serious incidents
Sent: 21 September 2017 15:05
To: Joanne McClean
Cc: Carolyn Harper; Brid Farrell; Mary Hinds; Lynne Charlton; Mary McElroy; Oriel Brown; Michael Bloomfield; Anne Kane; Jacqui Burns; Margaret McNally; Mareth Campbell; Elaine Hamilton (HSCB); Geraldine McArdle; Elaine Hyde
Subject: DRO Assigned - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]

Joanne,

You have been identified as the DRO for the above SAI.

Please can you advise by email to seriousincidents@hscni.net on any immediate action you have taken or action required; the governance team will update the Datix record for this incident accordingly.

If you require advice in relation to medication related issues please contact Angela Carrington, email:

[Personal Information redacted by the USI]. Please ensure all correspondence to Angela is copied to seriousincidents@hscni.net.

I attach the Serious Adverse Incident Notification from the **Southern Trust** received on 21 September 2017. This notification confirms that a **Level 1** Significant Event Audit (SEA) review will be undertaken.

This incident has been reported to the HSCB in line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference: SHSCT SAI [Personal Information]
HSCB Reference: [Personal Information]
Programme of Care: Acute Services

An acknowledgement of receipt of this notification has been forwarded to the **Southern Trust**, requesting the redacted **Learning Summary Report** by no later than **16 November 2017**.

If you require any further information, please do not hesitate to contact me.

Regards

Róisín

Róisín Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information]

Please find attached SAI Notification ID [Personal Information].

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ
Telephone [Personal Information redacted by the USI]
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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: Elaine Hamilton (HSCB)
Sent: 01 November 2017 11:52
To: Joanne McClean
Cc: serious incidents
Subject: SHSCT SAI [Personal Information redacted by the U]

Categories: Roisin, SHSCT actioned

Joanne,

At the Acute meeting on 25 September 2017 it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information] and to seek assurance processes have been put in place to prevent reoccurrence.

Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?

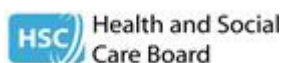
Regards,

Elaine

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof in) |
|----------------------------------|--------------|------------------|-------------------|------------------------|--|
| SHSCT SAI [Personal Information] | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is unacceptable. Can the Trust |

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|-----------|-----|------------------|-------------------|--------|---|
| | | | | | <p>advise this how this has been addressed?</p> <ul style="list-style-type: none"> Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and Personal Information and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> |

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: Personal Information redacted by the HSC
Internal Ext: Personal Information

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

serious incidents

From: Elaine Hamilton (HSCB)
Sent: 16 November 2017 09:40
To: Joanne McClean
Cc: serious incidents; Louise Herron
Subject: RE: SHSCT SAI [Personal Information redacted by the U]

Categories: Work in progress

Joanne,

As per email below can you advise what action is required to be taken in relation to this SAI and [Personal Information] Will I relist for the Acute meeting on 20 November for another discussion or will the meeting go ahead with SHSCT?

Regards,

Elaine

From: Elaine Hamilton (HSCB)
Sent: 01 November 2017 11:52
To: Joanne McClean
Cc: serious incidents
Subject: SHSCT SAI [Personal Information redacted by the U]

Joanne,

At the Acute meeting on 25 September 2017 it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information] and to seek assurance processes have been put in place to prevent reoccurrence.

Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?

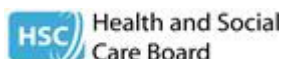
Regards,

Elaine

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof inp |
|----------------------------------|--------------|------------------|-------------------|------------------------|---|
| SHSCT SAI [Personal Information] | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED.</p> |

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|-----------|-----|------------------|-------------------|--------|--|
| | | | | | <p>Governance Team to email the SHSC with the following points:</p> <ul style="list-style-type: none"> Request further clarification who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and <small>Personal Information</small> and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> |

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [Personal Information redacted by the U.S.]
Internal Ext: [Personal Information redacted by the U.S.]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

serious incidents

From: Joanne McClean
Sent: 16 November 2017 11:56
To: Elaine Hamilton (HSCB)
Cc: serious incidents; Louise Herron
Subject: RE: SHSCT SAI [Personal Information redacted by the U]

Categories: Work in progress

Elaine,
 Brid was following this up and I do not think anything has happened in her absence.
 Can you please send me the position reports and re-list for Monday?
 Thanks,
 Joanne

From: Elaine Hamilton (HSCB)
Sent: 16 November 2017 09:40
To: Joanne McClean
Cc: serious incidents; Louise Herron
Subject: RE: SHSCT SAI [Personal Information redacted by the U]

Joanne,

As per email below can you advise what action is required to be taken in relation to this SAI and [Personal Information]. Will I relist for the Acute meeting on 20 November for another discussion or will the meeting go ahead with SHSCT?

Regards,

Elaine

From: Elaine Hamilton (HSCB)
Sent: 01 November 2017 11:52
To: Joanne McClean
Cc: serious incidents
Subject: SHSCT SAI [Personal Information redacted by the U]

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Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?

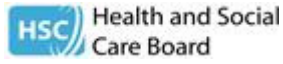
Regards,

Elaine

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|---|--------------|------------------|-------------------|------------------------|---|
| SHSCT SAI <small>Personal Information</small> | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and <small>Personal Information</small> and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> |

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|-----------|-----|------------------|-------------------|--------|--|
| | | | | | |

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: Personal Information redacted by the HSC
Internal Ext: Personal Information redacted by the HSC

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 16 November 2017 12:28
To: serious incidents
Subject: FW: Acknowledgement - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

Please see email below from the Directorate. Please advise the DRO.

Thanks
 Nicole

From: Reid, Trudy
Sent: 16 November 2017 12:19
To: Corporate.Governance; acute.governance
Cc: Connolly, Connie; Boyce, Tracey
Subject: RE: Acknowledgement - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

Good afternoon the first formal SAI meeting was on the 24th October 2017. The next meeting is planned for 28th November 2017, I don't anticipate the report being completed before Christmas

Regards,

Trudy

Trudy Reid
 Acute Clinical and Social Care Governance Coordinator
 Administration Floor
 Craigavon Area Hospital
 68 Lurgan Road
 Portadown
 BT63 5QQ
 Telephone [Personal Information redacted by the USI]
 Mobile [Personal Information redacted by the USI]

From: Corporate.Governance
Sent: 16 November 2017 12:06
To: acute.governance; Reid, Trudy
Subject: FW: Acknowledgement - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

Hi

The Learning Summary Report is due today with the HSCB.

Thanks
 Nicole

From: serious incidents [<mailto:> Personal Information redacted by the USI]
Sent: 21 September 2017 14:54
To: Corporate.Governance
Subject: Acknowledgement - Trust Ref: SHSCT SAI Personal Inform HSCB Ref: Personal Informat

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI Personal Inform
HSCB Ref: Personal Information

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Róisín

Róisín Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 21 September 2017 12:49

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

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serious incidents

From: serious incidents
Sent: 17 November 2017 11:43
To: Joanne McClean
Subject: Trust's update on OS Report - Trust Ref: SHSCT SAI [Personal Inform] / HSCB Ref: [Personal Inform]

Joanne

The Trust have provided the following update:

Good afternoon the first formal SAI meeting was on the 24th October 2017. The next meeting is planned for 28th November 2017, I don't anticipate the report being completed before Christmas

Regards

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

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

www.hscboard.hscni.net

From: Joanne McClean
Sent: 16 November 2017 11:56
To: Elaine Hamilton (HSCB)
Cc: serious incidents; Louise Herron
Subject: RE: SHSCT SAI [Personal Inform] / [Personal Inform]

Elaine,
Brid was following this up and I do not think anything has happened in her absence.
Can you please send me the position reports and re-list for Monday?
Thanks,
Joanne

From: Elaine Hamilton (HSCB)
Sent: 16 November 2017 09:40
To: Joanne McClean
Cc: serious incidents; Louise Herron
Subject: RE: SHSCT SAI [Personal Inform] / [Personal Inform]

Joanne,

As per email below can you advise what action is required to be taken in relation to this SAI and [Personal Inform]. Will I relist for the Acute meeting on 20 November for another discussion or will the meeting go ahead with SHSCT?

Regards,

Elaine

From: Elaine Hamilton (HSCB)
Sent: 01 November 2017 11:52
To: Joanne McClean
Cc: serious incidents
Subject: SHSCT SAI [Personal Information] / [Personal Information]

Joanne,

At the Acute meeting on 25 September 2017 it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information] and to seek assurance processes have been put in place to prevent reoccurrence.

Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?

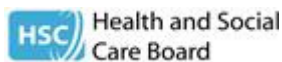
Regards,

Elaine

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|----------------------------------|--------------|------------------|-------------------|------------------------|---|
| SHSCT SAI [Personal Information] | Dr J McClean | | Y | Y plan to share report | <p>First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting.</p> <p>Review June 2017</p> <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSCT with the following points:</p> <ul style="list-style-type: none"> Request further clarification who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? |

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|-----------|-----|------------------|-------------------|--------|---|
| | | | | | <ul style="list-style-type: none"> Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and [Personal Information] and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> |

Elaine Hamilton
Assistant Governance Manager



Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [Personal Information]
Internal Ext: [Personal Information]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

serious incidents

From: serious incidents
Sent: 17 November 2017 13:10
To: Joanne McClean
Subject: SAI Position Report - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Attachments: SAI Position Report - ([Personal Information]).pdf

Joanne

As requested.

Ann

From: Joanne McClean
Sent: 17 November 2017 12:25
To: serious incidents
Subject: RE: Trust's update on OS Report -Trust Ref: SHSCT SAI [Personal Information] / HSCB Ref: [Personal Information]

Ann
Can you please send the position report?
Thanks
Joanne

From: serious incidents
Sent: 17 November 2017 11:43
To: Joanne McClean
Subject: Trust's update on OS Report -Trust Ref: SHSCT SAI [Personal Information] /HSCB Ref: [Personal Information]

Joanne

The Trust have provided the following update:

Good afternoon the first formal SAI meeting was on the 24th October 2017. The next meeting is planned for 28th November 2017, I don't anticipate the report being completed before Christmas

Regards

AERedpath
Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

Tel: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]
www.hscboard.hscni.net

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Joanne,

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Regards,

Elaine

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Sent: 01 November 2017 11:52
To: Joanne McClean
Cc: serious incidents
Subject: SHSCT SAI [Personal Informa] [Personal Informati]

Joanne,

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Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?

Regards,

Elaine

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof inp |
|------------------------------|--------------|------------------|-------------------|------------------------|--|
| SHSCT SAI [Personal Informa] | Dr J McClean | | Y | Y plan to share report | First Review 10 May 2017: DEFERRED DRO not present. SAI to be relisted for next meeting. Review June 2017 |

| TRUST REF | DRO | Current Position | Review Report Rec | CL Rec | OUTCOME OF REVIEW AND ACTION (close / further info / other prof info) |
|-----------|-----|------------------|-------------------|--------|---|
| | | | | | <p>Update 6 June 2017: FURTHER INFORMATION REQUIRED. Governance Team to email the SHSC with the following points:</p> <ul style="list-style-type: none"> Request further clarification who ordered the CT scan, Ultrasound and MRI and why the results were not acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations. The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this how this has been addressed? Ensure Trust Urologists are compliant in accordance with IEAP <p>Action Governance Team</p> <p>Review when Trust have responded</p> <p>Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and <small>Personal Information</small> and to seek assurance processes have been put in place to prevent reoccurrence.</p> <p>SAI to be reviewed following meeting with SHSCT</p> <p>Action: Dr Farrell / Dr McClean</p> |

Elaine Hamilton
Assistant Governance Manager

Corporate Services Department | Health & Social Care Board | Tower Hill | Armagh | BT61 9DR

External Tel Number: [Personal Information redacted by the UST]

Internal Ext: [Personal Information redacted by the UST]

(Office Hours: Monday – Wednesday 9am-5pm, Thursday 9am – 1.30pm)

Ann Redpath

From: Mareth Campbell
Sent: 17 September 2018 17:53
To: serious incidents
Cc: Roisin Hughes (Corporate Services); Elaine Hyde
Subject: FW: SHSCT Outliers - Position @30.06.18
Attachments: SHSCT Outliers - Position @30.06.18.docx

Please find attached report from SHSCT providing updates in relation to outliers included in a report as at 30 June 2018. I would be grateful if you could include the updates in red onto the relevant Datix records – update the investigate field and save the attached report to the records.

Many thanks
Mareth

From: O'Neill, Nicole [mailto:Personal Information redacted by the USI]
Sent: 17 September 2018 15:02
To: Mareth Campbell
Subject: SHSCT Outliers - Position @30.06.18

Hi Mareth

As discussed, please find attached.

Kind regards
Nicole

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

SHSCT Outstanding / Overdue SAI Review Reports – Position at 30th September 2019

| Level of Review | Number of Review Reports Outstanding |
|--------------------|--------------------------------------|
| SAI Report Level 1 | 23 |
| SAI Report Level 2 | 26 |
| SAI Report Level 3 | 2 |
| Total | 51 |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|---------------|-------------------------|------------------------|-------------------------|--------------|--|
| SEA/LSR LEVEL ONE | | | | | | | |
| Personal Information redacted by the USI | | 21/09/2017 | Level 1 | 16/11/2017 | 98 | Acute | This report is being checked for factual accuracy. Will be shared with family and HSCB by the end of December 2019 |
| | | 22/07/2017 | Level 1 | 17/11/2017 | 98 | Acute | This report is being checked for factual accuracy. Will be shared with family and HSCB by the end of December 2019 |
| | | 22/09/2017 | Level 1 | 17/11/2017 | 98 | Acute | 05/12/19 SAI Report submitted to HSCB |
| | | 23/11/2017 | Level 1 | 18/01/2018 | 89 | Acute | 22/10/19 - SAI Report submitted to HSCB |
| | | 27/11/2017 | Level 1 | 22/01/2018 | 89 | Acute | 25/10/19 - SAI Report & Checklist submitted to HSCB |
| | | 11/05/2018 | Level 1 | 06/07/2018 | 65 | Acute | 11/12/19 This report is being checked for factual accuracy. |
| | | 06/07/2018 | Level 1 | 31/08/2018 | 57 | Acute | 05/12/19 SAI report submitted to HSCB |
| | | 27/12/2018 | Level 1 | 21/02/2019 | 32 | Acute | This report is ready for ACG presentation January 2020 |
| | | 09/01/2019 | Level 1 | 06/03/2019 | 31 | MHD | Report sent to HSCB and offered to family on 19-11-19. Meeting to be set up with family in New Year at their request and as agreed in discussion with them 27/11/19. |
| | | 23/01/2019 | Level 1 | 20/03/2019 | 29 | Acute | 02/12/19 SAI report submitted to HSCB |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|---------------|-------------------------|------------------------|-------------------------|--------------|--|
| Personal Information redacted by the USI | | | | | | | |
| | | 29/01/2019 | Level 1 | 26/03/2019 | 28 | Acute | 05/11/19 SAI report submitted to HSCB and shared with family |
| | | 30/01/2019 | Level 1 | 27/03/2019 | 28 | Acute | This report is in final draft and will be ready for presentation at January 2020 ACG |
| | | 19/02/2019 | Level 1 | 17/04/2019 | 25 | MHD | Report sent to HSCB 19/11/19 and sent to family on 25-11-19. Family do not wish to meet Trust. Family contacted 18/12/19 to ask if they have any comments to make. Further bereavement support also offered. |
| | | 12/04/2019 | Level 1 | 07/06/2019 | 17 | MHD | SAI Review held and Report being drafted for circulation to review team for approval. |
| | | 19/04/2019 | Level 1 | 14/06/2019 | 16 | OPPC | 13/11/19 CGO - SEA Report submitted. |
| | | 15/05/2019 | Level 1 | 10/07/2019 | 13 | CYP | SAI submitted to HSCB |
| | | 03/06/2019 | Level 1 | 29/07/2019 | 10 | MHD | SAI meeting to take place 19 Dec 19 |
| | | 05/06/2019 | Level 1 | 31/07/2019 | 10 | Acute | 1 st meeting has taken place and draft report is complete. Will be ready for presentation at January 202 ACG |
| | | 09/07/2019 | Level 1 | 03/09/2019 | 5 | MHD | SAI Review held. Report Drafted and with review team for approval. |
| | | 24/07/2019 | Level 1 | 18/09/2019 | 3 | Acute | Meeting to finalise report on 27/11/19. Will be ready for presentation to January 2020 ACG |
| | | 25/07/2019 | Level 1 | 19/09/2019 | 2 | Acute | 27/12/19 SAI report submitted |
| | | 29/07/2019 | Level 1 | 23/09/2019 | 2 | MHD | SAI Review held. Report Drafted and with review team for approval |
| | | 01/08/2019 | Level 1 | 26/09/2019 | 1 | CYP | 05/12/19 SAI report submitted |
| | | RCA LEVEL TWO | | | | | |
| | | 05/04/2018 | Level 2 | 28/06/2018 | 66 | Acute | 14/11/19 SAI report submitted |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|---------------|-------------------------|------------------------|-------------------------|--------------|---|
| Personal Information redacted by the USI | | 22/05/2018 | Level 2 | 14/08/2018 | 60 | MHD | Report sent to HSCB 12/11/19 and sent to family on 19-11-19. |
| | | 07/06/2018 | Level 2 | 30/08/2018 | 57 | MHD | Report sent to HSCB 12/12/2019 and offered to family same day |
| | | 01/08/2018 | Level 2 | 24/10/2018 | 50 | MHD | SAI submitted to HSCB |
| | | 31/10/2017 | Level 2 | 03/12/2018 | 44 | MHD | Safeguarding report received on 12-09-19. SAI report then drafted and with assistant director for approval. |
| | | 21/09/2018 | Level 2 | 14/12/2018 | 42 | MHD | SAI Review held. Report Drafted and with review team for approval. External chair has advised that he wishes to discuss report with external medical rep on the review team and has requested that the timescale for completion is adjusted to the end of March 2020. |
| | | 15/10/2018 | Level 2 | 07/01/2019 | 39 | Acute | 17/12/19 – ACG meeting December 2019 |
| | | 24/10/2018 | Level 2 | 16/01/2019 | 38 | Acute | Comments with Chairperson for approval before finalising |
| | | 02/11/2018 | Level 2 | 25/01/2019 | 36 | MHD | 10/12/19 Draft SAI report and checklist submitted. Family contacted Trust to advise they do not wish to receive the report.. 16/12/19 – 16/12/2019 Final SAI Report submitted to Coroner, HSCB and RQIA |
| | | 15/01/2019 | Level 2 | 09/04/2019 | 26 | MHD | SAI review held. Report drafted awaiting additional information |
| | | 21/01/2019 | Level 2 | 15/04/2019 | 25 | Acute | 12/11/19 SAI Report submitted to HSCB |
| | | 27/12/2018 | Level 2 | 03/05/2019 | 22 | Acute | 04/12/19 SAI report submitted |
| | | 13/02/2019 | Level 2 | 08/05/2019 | 22 | Acute | 18/10/19 CGO - Terms of Reference and Membership has been approved by HSCB |
| | | 19/02/2019 | Level 2 | 14/05/2019 | 21 | MHD | 16/12/2019 Draft report provided to family. Draft report to HSCB 18/12/2019 pending family engagement. |
| | | 22/02/2019 | Level 2 | 17/05/2019 | 20 | Acute | 05/11/19 RCA report was submitted |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|------------------------|-------------------------|------------------------|-------------------------|--------------|--|
| Personal Information redacted by the USI | | 26/02/2019 | Level 2 | 21/05/2019 | 20 | MHD | Review held. Report being drafted. Review meeting had to be rescheduled. |
| | | 08/03/2019 | Level 2 | 31/05/2019 | 18 | MHD | 11/11/19 Closure of SAI email received from HSCB |
| | | 14/03/2019 | Level 2 | 06/06/2019 | 17 | MHD | ToR and Membership approved by HSCB. Review meeting being set up. |
| | | 20/03/2019 | Level 2 | 12/06/2019 | 17 | MHD | Draft report to HSCB 17/12/2019 pending family engagement. Report to be offered to family post-Christmas period. |
| | | 09/04/2019 | Level 2 | 02/07/2019 | 14 | Acute | 18/10/19- SAI report submitted |
| | | 15/05/2019 | Level 2 | 07/08/2019 | 9 | Acute | 04/10/19 SAI report sent |
| | | 15/05/2019 | Level 2 | 07/08/2019 | 9 | MHD | SAI Review held. Report Drafted and with review team for approval. |
| | | 17/05/2019 | Level 2 | 09/08/2019 | 8 | MHD | SAI Review held. Report Drafted and with review team for approval. |
| | | 14/06/2019 | Level 2 | 06/09/2019 | 4 | MHD | 10/01/2020 Draft SAI report sent |
| | | 19/06/2019 | Level 2 | 11/09/2019 | 4 | MHD | SAI meeting to take place. Provisional date Jan 2020 due to diary commitments. |
| | | 19/06/2019 | Level 2 | 11/09/2019 | 4 | Acute | 27/12/2019 SAI report submitted |
| | | RCA LEVEL THREE | | | | | |
| | | 23/04/2018 | Level 3 | 02/11/2018 | 48 | Acute | 14/11/19 SAI report submitted |
| | | 06/12/2018 | Level 3 | 05/06/2019 | 4 | MHD | Draft report received from External Chair 18-12-2019. |

* Indicates level of review has changed since initial notification

In addition to the above, the completion of the following SAI review report has been deferred pending the outcome of other HSC investigation/review processes or another statutory agency/external body review.

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review |
|--|----------|---------------|---|
| Personal Information redacted by the USI | | 19/06/2019 | Level 1 |
| | | 07/05/2019 | Level 1 |
| | | 14/01/2019 | Level 2 Awaiting outcome of BHST independent review |

Ann Redpath

From: Corporate.Governance <[redacted] >
Sent: 18 February 2020 16:44
To: serious incidents
Subject: Urology SAI [redacted] - Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]
Attachments: Notification [redacted] upgrade to level 3.docx; TOR and team membership urology.docx

Categories: Roisin

Roisin,

Please see attached updated SAI notification and ToR, this was the SAI I discussed with you.

Kind Regards
Diane

From: serious incidents [<mailto:seriousincidents@hscni.net>]
Sent: 21 September 2017 14:54
To: Corporate.Governance
Subject: Acknowledgement - Trust Ref: SHSCT SAI [redacted] HSCB Ref: [redacted]

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI [redacted]
HSCB Ref: [redacted]

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Roisin

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 21 September 2017 12:49

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | |
|--|--|
| 1. ORGANISATION: Southern Health and Social Care Trust | 2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE 3. ID Personal Information |
| 4. HOSPITAL / FACILITY / COMMUNITY LOCATION Craigavon Area Hospital | 5. DATE OF INCIDENT: Reported: 12.5.17 |
| 6. DEPARTMENT / WARD / LOCATION EXACT Urology Department | |
| 7. CONTACT PERSON: Mrs Connie Connolly | 8. PROGRAMME OF CARE: Acute Services |

9. DESCRIPTION OF INCIDENT:

1. Patient 13 - Personal Information old male referred to urology following an episode of haematuria on 28 July 2016, it appears the letter was not triaged and the patient was placed on a routine waiting list on 30 September 16. As part of an internal review this patient's referral letter was upgraded to a red flag referral and was reviewed at OPD on 31/01/17. Subsequent investigations diagnosed a pT4 TCC of bladder and prostate. Patient has locally advanced bladder cancer (G3T4a). Datix - Personal Information
2. Patient 12 - Personal Information old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis T3a with no nodal metastases. Datix - Personal Information
3. Patient 14 - Personal Information old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment. Datix - Personal Information
4. Patient 11 - Personal Information old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment. Datix - Personal Information

The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning relating to this incident.

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

D

(complete where relevant)

10. IS THIS INCIDENT A NEVER EVENT?

If 'YES' provide further detail on which never event - refer to DoH link below
<https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars>

YES

NO

x

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE:

Checking and Oversight

A1500

DETAIL:

(refer to Guidance Notes)

AD1001

ADVERSE EVENT:

(refer to Guidance Notes)

AD 1000

11. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE: Notified to the Medical Director

12. CURRENT CONDITION OF SERVICE USER: recuperating from initial surgery, awaiting further treatment

13. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES?

(please select)

NO

14. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED?

(please specify where relevant)

YES

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

serious injury to, or the unexpected/unexplained death of:

- a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility.

x

unexpected serious risk to a service user and/or staff member and/or member of the public

unexpected or significant threat to provide service and/or maintain business continuity

serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service

serious self-harm or serious assault (including homicide and sexual assaults)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident

suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident

serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner

16. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: (please select)

NO

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

| SERIOUS ADVERSE INCIDENT NOTIFICATION FORM | | | |
|--|------------------|--|--|
| 17. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? | YES | DATE INFORMED: 19/02/2018 | |
| | NO | specify reason: | |
| 18. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? (refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant | | | NO |
| if 'YES' (full details should be submitted including the date notified): | | | |
| 19. OTHER ORGANISATION/PERSONS INFORMED: (please select) | | DATE INFORMED: | OTHERS: (please specify where relevant, including date notified) |
| DoH EARLY ALERT | | | |
| HM CORONER | | | |
| INFORMATION COMMISSIONER OFFICE (ICO) | | | |
| NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC) | | | |
| HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI) | | | |
| POLICE SERVICE FOR NORTHERN IRELAND (PSNI) | | | |
| REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA) | | | |
| SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNi) | | | |
| NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP) | | | |
| 20. LEVEL OF REVIEW REQUIRED: (please select) | | LEVEL 3 | |
| * FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6 | | | |
| 21. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (delete as appropriate) | | | |
| Report submitted by: Patricia Kingsnorth | | Designation: Acting Acute Governance Co-ordinator | |
| Email: <small>Personal Information redacted by the USI</small> | | Telephone: <small>Personal Information redacted by the USI</small> | Date: 11/02/2020 |
| 22. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: (refer to Guidance Notes) | | | |
| Additional information submitted by: _____ | | Designation: _____ | |
| Email: _____ | Telephone: _____ | Date: DD / MM / YYYY | |

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

Terms of Reference and review team for urology cases

1.0 THE REVIEW TEAM

Dr J R Johnston- Consultant Medical Advisor
Mr M Haynes - Consultant Urologist
Mrs K Robinson - Booking & Contact Centre Manager
Mrs T Reid - Acute Clinical & Social Care Governance Co-ordinator

2.0 SAI REVIEW TERMS OF REFERENCE

The terms of reference for the review of the care and treatment provided to Patient t12, Patient t14, Patient t11, Patient t15, and Patient t13 were:

1. To undertake an initial investigation/review of the care and treatment of patients "Patient t15", "Patient t13", "Patient t12", "Patient t14" and "Patient t11", in the period after referral to the SHSCT Urology service using National Patient Safety Agency root cause analysis methodology.
2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to "Patient t15", "Patient t13", "Patient t12", "Patient t14" and "Patient t11" that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

Ann Redpath

From: serious incidents
Sent: 19 February 2020 14:41
To: Brid Farrell; Denise Boulter
Cc: Mareth Campbell
Subject: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]
Attachments: Updated Notification upgrade to LV03 ([Personal Informat]).pdf; ToR & Team Membership ([Personal Informat]).pdf; Position Report ([Personal Informat]).pdf

Brid and Denise,

Please find attached *updated* SAI Notification and Terms of Reference & Team Membership for the above SAI.

This SAI was initially reported as a **Level 1 Review** on 21 September 2017, the Trust have now escalated to a **Level 3 Review**.

This would need to be listed for the next Acute Meeting to:

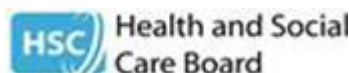
1. Agree to Level 3 Review being carried out;
2. Assign a DRO;
3. Approval / Non approval of Terms of Reference & Team Membership;
4. Submission date for Final Report;
5. Datix record to be updated.

I have also attached a Position Report for ease of reference.

Many Thanks

Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI — Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 18 February 2020 16:44
To: serious incidents
Subject: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

Roisin,

Please see attached updated SAI notification and ToR, this was the SAI I discussed with you.

Kind Regards

Diane

From: serious incidents [<mailto:seriousincidents@hscni.net>]
Sent: 21 September 2017 14:54
To: Corporate.Governance
Subject: Acknowledgement - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI [Personal Inform]

HSCB Ref: [Personal Information]

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 21 September 2017 12:49

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI].

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Ann Redpath

From: Donna Britton
Sent: 22 May 2020 17:02
To: 'Corporate.Governance'
Subject: Review level: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]

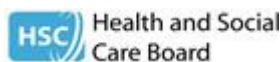
Diane

HSCB/PHA officers have reviewed this case and based on the information provided believe this case does not meet the requirements of a Level 3 SAI Review and would request further information as follows:

- Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented
- Can the Trust review and ensure required changes have been made in light of these cases
- These happened in 2017 so therefore changes should have been put in place when these were identified

I would welcome your response by 5 June 2020.

Warm Regards
Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 18 February 2020 16:44
To: serious incidents
Subject: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]

Roisin,

Please see attached updated SAI notification and ToR, this was the SAI I discussed with you.

Kind Regards
Diane

From: serious incidents [mailto:seriousincidents@hscni.net]
Sent: 21 September 2017 14:54
To: Corporate.Governance
Subject: Acknowledgement - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI Personal Informa

HSCB Ref: Personal Information

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**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Roisin

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 21 September 2017 12:49

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI].

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 29 May 2020 15:02
To: serious incidents
Subject: SAI Report & Checklist for ID [Personal Inform] / [Personal Informat]
Attachments: SAI Report [Personal Inform] pdf
Categories: Work in progress, Ann

Good Afternoon,

Please find attached SAI report and checklist for ID [Personal Inform] / [Personal Informat].

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]



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APPENDIX 6

Revised November 2016 (Version 1.1)

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

Organisation's Unique Case Identifier:

Personal Information redacted

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier:

Personal Information redacted by the U

Service User Details: *(complete where relevant)*

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020

1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient (Patient 15), discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 15 – a [Personal Information redacted by the] -old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, Patient 15 was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 14 – a [Personal Information redacted by the] -old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 11 – a [Personal Information redacted by the] -old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, Patient 11 was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 13 – a [Personal Information redacted by the] -old male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and Patient 13 was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. Patient 13 was reviewed at OPD on 31 January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. Patient 13 has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Patient 12 – a [Personal Information redacted by the] -old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, Patient 12 had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in

obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely

manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients "Patient 12", "Patient 14" and "Patient 11", in the period after referral to the SHSCT Urology service using "Patient 15", "Patient 13",

3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to "Patient 15", "Patient 13", "Patient 12", "Patient 14" and "Patient 11" that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

5.0 DESCRIPTION OF INCIDENT/CASE

The DHSSPSNI **Service Framework for cancer prevention, treatment and care** (Standard 13) of 2011 indicates, *“All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed”*.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICA and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer*, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, *“triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation”*.

This is still the only set of referral guidance for suspected urological cancer available online on the NICA website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.

5.0 DESCRIPTION OF INCIDENT/CASE

NICaN Urology Cancer Clinical Guideline (2016)

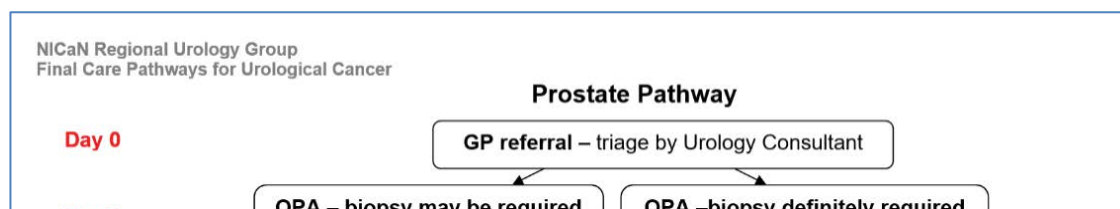
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.



5.3 Triage of GP referrals – SHSCT

The process of Urology triage in CAH is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; and this varied between consultants and specialities. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, *“very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue”*.

5.0 DESCRIPTION OF INCIDENT/CASEInterview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Cons1 was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He had the longest backlog and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate

5.0 DESCRIPTION OF INCIDENT/CASE

patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, *"Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months"*.

5.4 Index case

In 2016, the SHSC Trust investigated (RCA ID Personal Information), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, *".... a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (vide infra) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team"*.

Of the 2 lessons learnt, one indicated that,

"Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration."

5.0 DESCRIPTION OF INCIDENT/CASE

This led to a recommendation that,

“This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).

In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.”


The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with . They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate

5.0 DESCRIPTION OF INCIDENT/CASE

management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

5.5 Look back exercise #2

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

This (RCS Personal Information redacted by the) Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of AMD1, detailed the clinical course and made the following conclusions.

Patient 13 03/06/2016 - Personal Information redacted by the -old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.

The referral was marked Urgent by the GP.

The referral was not triaged on receipt.

09/08/2016 - added to W/L Urgent.

27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.

05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 10-month delay in obtaining diagnosis.

Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 11 28/07/2016 - Personal Information redacted by the -old male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.

The referral was marked Urgent by the GP.

5.0 DESCRIPTION OF INCIDENT/CASE

The referral was not triaged on receipt.

30/09/2016 - added to W/L Urgent.

18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.

20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.

11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 9-month delay in obtaining diagnosis.

Following Review Team consideration, deemed not to be a clinically significant delay.

Patient
13

28/07/2016 - Personal
Information
redacted by the -old male referred to Urology by GP following an episode of haematuria.

The referral was marked Routine by the GP.

The letter was not triaged.

30/09/2016 - Patient
13 was placed on a Routine waiting list.

19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.

31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.

22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.

Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.

Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. *Cancer* March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology* 50 (2006) 1176–1182.

Patient
12

08/09/2016 - Personal
Information
redacted by the -old male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.

The referral was marked Urgent by the GP.

The referral was not triaged on receipt.

27/01/2017 – further GP letter – please upgrade to R/F.

30/01/2017 - as part of the internal review #2, upgraded to R/F.

5.0 DESCRIPTION OF INCIDENT/CASE

06/02/2017 - seen in clinic on day 152.

11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

Conclusions

Resultant 8-month delay in obtaining diagnosis.

Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Patient 15 30/08/2015 - Personal Information redacted by the -old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.

The referral was marked Routine by the GP.

The referral was not triaged on receipt.

29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Patient 15 was added to W/L R/F following this referral.

As part of the internal look back #2, the referral was noted.

Patient 15 had already received an appointment and was seen in clinic on day 153. Therefore, 1st GP referral was incorrect; the 2nd was a correct GP referral.

11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.

Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.

7.0 CONCLUSIONS

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

“Very significant”. Very high up the list in terms of importance”.

“It is fundamental people are seen in the appropriate time”.

“Very important” ... “Important for the patient”.

“Vital” ... “Very significant .. patients are often anxious and depend on the system to work”.

Cons1 replied,

“It is a serious issue, very important”..... “Number one ranking in overall scheme of things”

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 (Patient 13) there probably was a significant delay.

Consideration of the causative factors to the patients’ delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

7.1 Referral letters did not have the clinical priority accurately assigned by the GP.

Contributory factors

Task Factors (policy and guidelines)

The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP’s as red flag referrals (suspected cancer) i.e. incorrect triage.

Task Factors (decision aids)

The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately

involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net, work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According to the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

NICE NG12

The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

7.2 Referral letters were not triaged following receipt by the hospital.

Contributory factor

Task Factors (policy and guidelines)

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

‘...an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.... Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first’.

The Principles for booking Cancer Pathway patients states,

“Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients”.

and,

“Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation”.

However, the IEAP states,

“...if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP’s classification of urgency”.

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICAⁿ Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

Review of Adult Urology Services in Northern Ireland

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, *“Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system”.*

Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICAⁿ Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, *“Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related*

(and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process."

Contributory factor

Staff factor

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", it was, "*a very serious matter not to be minimised, very serious*" he stated he would not triage non-red flag referrals.

When asked, "*Does triage still need done?*" Cons1 answered, "*a procedure is needed to highlight when it needs done and who does it*". When further asked, "*Who was involved in SHSCT Urology service in setting up triage?*" Cons1 answered for urological cancer, "*I was the Lead*".

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, "*I would love if we had a Trust Urology agreement on the type of triage to be conducted*". When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?*" He stated, "*It depends on how you do it*" "*Not all do advanced / enhanced triage, they compromise. It is a spectrum*"... "*They have not done it in the detail I felt it needed for routine/urgent non-red flag case*".

When questioned further, regarding his way of organising his own work load, Cons1 stated, "*....yes I did it my way – I wasn't cognisant of being unbending, I am very particular*".

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, "*I do triage entirely in my own time to allow me to do it properly*".

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system, "*Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information*".

The Review Team concluded that there was a serious inconsistency between the guideline

standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

Work load/scheduling

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

Organisational

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These

attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICA Urology guidelines at the time and was grateful to the extent that he thanked DAS2. This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

Escalation within Organisation

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed,

they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICE guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.
2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.
3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.
4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.
5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.
6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged,

and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.
8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.
9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.
10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

9.0 RECOMMENDATIONS AND ACTION PLANNING

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

**Checklist for Engagement / Communication
with Service User¹ / Family / Carer following a Serious Adverse Incident**

| | | | |
|---|-------------------------------------|-------------------------|-------------------------------------|
| Reporting Organisation SAI Ref Number: | <small>Personal Information</small> | HSCB Ref Number: | <small>Personal Information</small> |
|---|-------------------------------------|-------------------------|-------------------------------------|

| SECTION 1 | | | |
|--|---|--|----------------------------------|
| INFORMING THE SERVICE USER ¹ / FAMILY / CARER | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users. Please select as appropriate (✓) | Single Service User | | Multiple Service Users* ✓ |
| | Comment: 5 <i>*If multiple service users are involved please indicate the number involved</i> | | |
| 2) Was the Service User ¹ / Family / Carer informed the incident was being reviewed as a SAI? Please select as appropriate (✓) | YES | ✓ | NO |
| | If YES , insert date informed : 19.2.18 | | |
| | If NO , please select only one rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being reviewed as a SAI | | |
| | a) No contact or Next of Kin details or Unable to contact | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | |
| | d) Case involved suspected or actual abuse by family | | |
| | e) Case identified as a result of review exercise | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | |
| | g) Other rationale | | |
| | If you selected c), d), e), f) or g) above please provide further details: | | |
| 3) Was this SAI also a Never Event? Please select as appropriate (✓) | YES | | NO |
| 4) If YES , was the Service User ¹ / Family / Carer informed this was a Never Event? Please select as appropriate (✓) | YES | If YES , insert date informed : DD/MM.YY | |
| | NO | If NO , provide details: | |
| For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)) | | | |
| Content with rationale? | YES | | NO |

| SHARING THE REVIEW REPORT WITH THE SERVICE USER ¹ / FAMILY / CARER (complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI) | | | |
|---|---|--|-------------|
| 5) Has the Final Review report been shared with the Service User ¹ / Family / Carer? Please select as appropriate (✓) | YES | | NO ✓ |
| | If YES , insert date informed: | | |
| | If NO , please select only one rationale from below, for NOT SHARING the SAI Review Report with Service User / Family / Carer: | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | |
| | b) Plan to share final review report at a later date and further engagement planned | | ✓ |

SHARING THE REVIEW REPORT WITH THE SERVICE USER¹ / FAMILY / CARER

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

| | | |
|---|---|----|
| | c) Report not shared but contents discussed (if you select this option please also complete 'I' below) | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | (if you select any of the options below please also complete 'I' below) | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user ¹ family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| l) If you have selected c), h), i), j), or k) above please provide further details: | | |
| For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)) | | |
| Content with rationale? | YES | NO |

SECTION 2

INFORMING THE CORONERS OFFICE

(under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

| | | | | | | | | |
|--|------------------------------------|--|----|--|-----|--|-----------|--|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? Please select as appropriate (✓) | YES | | NO | | | | | |
| | If YES, insert date informed: | | | | | | | |
| | If NO, please provide details: | | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? Please select as appropriate (✓) | YES | | NO | | | | | |
| | If YES, insert date report shared: | | | | | | | |
| | If NO, please provide details: | | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? Please select as appropriate (✓) | YES | | NO | | N/A | | Not Known | |
| | If YES, insert date informed: | | | | | | | |
| | If NO, please provide details: | | | | | | | |

DATE CHECKLIST COMPLETED 22.5.2020

¹ Service User or their nominated representative

serious incidents

From: serious incidents
Sent: 03 June 2020 10:59
To: Denise Boulter; Brid Farrell
Cc: Mareth Campbell
Subject: RCA Report - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Attachments: RCA Report - [Personal Information].pdf; SAI Position Report - [Personal Information].pdf

Denise/Brid

Please find attached RCA Report submitted by SHSCT on 29 May 2020..

You will note from SAI Position Report attached that at the Interim Safety and Quality Bi-weekly Meeting of 14 May 2020 this SAI was not escalated to a Level 3 but the Review was to remain as a Level 1. Queries from 18 May 2020 meeting were then forwarded to the Trust on 22 May 2020.

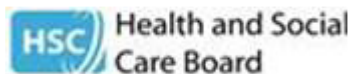
These queries remain outstanding with the Trust.

Please advise if you require a Learning Summary Report to be submitted in line with a Level 1 Review.

Regards

Ann Redpath

Ann Redpath



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information
redacted by the USI

Personal Information redacted by the USI

From: serious incidents
Sent: 19 February 2020 14:41
To: Brid Farrell; Denise Boulter
Cc: Mareth Campbell
Subject: Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Brid and Denise,

Please find attached *updated* SAI Notification and Terms of Reference & Team Membership for the above SAI.

This SAI was initially reported as a **Level 1 Review** on 21 September 2017, the Trust have now escalated to a **Level 3 Review**.

This would need to be listed for the next Acute Meeting to:

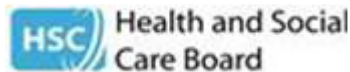
1. Agree to Level 3 Review being carried out;
2. Assign a DRO;
3. Approval / Non approval of Terms of Reference & Team Membership;
4. Submission date for Final Report;
5. Datix record to be updated.

I have also attached a Position Report for ease of reference.

Many Thanks

Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [<mailto:> Personal Information redacted by the USI]
Sent: 18 February 2020 16:44
To: serious incidents
Subject: Urology SAI Personal Inform - Trust Ref: SHSCT SAI Personal Inform HSCB Ref: Personal Informa

Roisin,

Please see attached updated SAI notification and ToR, this was the SAI I discussed with you.

Kind Regards

Diane

From: serious incidents [<mailto:seriousincidents@hscni.net>]
Sent: 21 September 2017 14:54
To: Corporate.Governance
Subject: Acknowledgement - Trust Ref: SHSCT SAI Personal Inform HSCB Ref: Personal Informa

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI Personal Informa

HSCB Ref: Personal Information

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Róisín

Róisín Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 21 September 2017 12:49
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI].

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: Margaret McNally HSCB
Sent: 04 June 2020 11:14
To: Mareth Campbell; Elaine Hamilton (HSCB)
Cc: serious incidents
Subject: SAI Ref: [Personal Information] – ToR and membership / Amended Notification

Categories: Roisin

Mareth/Elaine

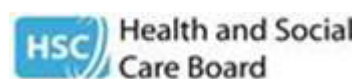
Please see below extract from Mondays interim Safety and Quality meeting in respect of the above SAI where it was agreed to close this from the action log as Denise has confirmed she has responded via email in relation to the action from the group. This is to be closed from the log as this is to be taken forward via the relevant Acute group.

Extract from interim Safety and Quality meeting:

| Date of 1 st Review | Item No | Subject | Person Responsible | Status |
|--------------------------------|---------|--|--------------------|--|
| 04.05.20 | 8.0 | <p>Any other business</p> <p>SAI Ref: [Personal Information] – ToR and membership / Amended Notification – It was noted the proposed ToR does not reflect a level 3 SAI as there is no independent person included within the membership. Following discussion it was agreed D Boulter will discuss the possibility of a thematic review with B Farrell.</p> <p>Update 18 May 2020 – D Boulter to discuss the possibility of a thematic review with B Farrell and report back to the next meeting.</p> <p>Update 1 June 2020 – Denise confirmed she has responded via email to the Governance Team following her discussions with B Farrell. Therefore as this will be taken forward by the relevant Acute Group it was agreed to close this from the action log.</p> | D Boulter | Mark Closed – refer to Acute Group to take forward |

Many thanks
 Margaret

Margaret McNally



HSCB - Southern Office | Governance Department | Tower Hill | Armagh | BT61 9DR
 DDI [Personal Information redacted by the USI] | Email: [Personal Information redacted by the USI] | Web: www.hscboard.hscni.net/

serious incidents

From: Denise Boulter
Sent: 05 June 2020 13:27
To: serious incidents
Subject: RE: RCA Report - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Categories: Roisin

Yes please Ann

From: serious incidents
Sent: 03 June 2020 11:00
To: Denise Boulter; Brid Farrell
Cc: Mareth Campbell
Subject: RCA Report - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Denise/Brid

Please find attached RCA Report submitted by SHSCT on 29 May 2020..

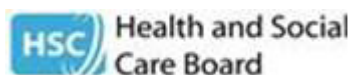
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These queries remain outstanding with the Trust.

Please advise if you require a Learning Summary Report to be submitted in line with a Level 1 Review.

Regards

Ann Redpath
 Ann Redpath



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information
redacted by the USI

Personal Information redacted by the USI

From: serious incidents
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Cc: Mareth Campbell
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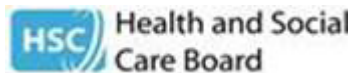
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Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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Lindsey,

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Trust Ref: SHSCT SAI Personal Informa

HSCB Ref: Personal Information

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**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Róisín

Róisín Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

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Please find attached SAI Notification ID [Personal Information redacted by the USI]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: serious incidents
Sent: 09 June 2020 12:23
To: 'Corporate.Governance'
Subject: Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Attachments: Review level: Urology SAI [Personal Information] - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Diane,

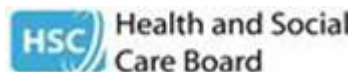
Thank you for receipt of the RCA Report in relation to the above SAI. As this was initially reported as a Level 1 SAI, can you please submit the Learning Summary Report?

Also, please find attached queries sent to the Trust on 22 May 2020. No response has been received. Can you please submit a response to seriousincidents@hscni.net mailbox **as soon as possible?**

Many Thanks

Roísín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 29 May 2020 15:02
To: serious incidents
Subject: SAI Report & Checklist for ID [Personal Information] [Personal Information]

Good Afternoon,

Please find attached SAI report and checklist for ID [Personal Information] / [Personal Information].

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: serious incidents
Sent: 01 July 2020 13:52
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: Reminder: Trust Ref: SHSCT SAI (Personal Inform) HSCB Ref: (Personal Informat)
Attachments: Review level: Urology SAI (Personal Inform) - Trust Ref: SHSCT SAI (Personal Inform) HSCB Ref: (Personal Informat)
Importance: High

Diane,

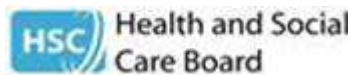
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Many Thanks

Roísín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI — Personal Information redacted by the USI

From: serious incidents
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To: 'Corporate.Governance'
Subject: Trust Ref: SHSCT SAI (Personal Inform) HSCB Ref: (Personal Informat)

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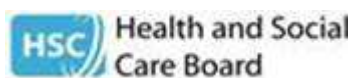
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Many Thanks

Roísín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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Subject: SAI Report & Checklist for ID [Personal Inform](#) / [Personal Informa](#)

Good Afternoon,

Please find attached SAI report and checklist for ID [Personal Informa](#) / [Personal Information](#)

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
 Corporate Governance Assistant
 Beechfield House
 Craigavon Area Hospital Site
 Telephone [Personal Information redacted
by the USI](#)



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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI](#)

serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 02 July 2020 17:36
To: serious incidents
Subject: FW: Review level: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

Categories: Work in progress

Donna

Sorry for the delay in responding. I have also requested the Level 1 Learning Summary as per last night's email.

Kind regards
Nicole

- 1. Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented.**

The origins of the review was following the completion of an SAI –Datix [Personal Inform] chaired by Mr Glackin and the recommendations contained within, which brought about this review into delay in triage for urology patients.

- 2. Can the Trust review and ensure required changes have been made in light of these cases.**

Yes . The trust have implemented e triage which automatically records the referral electronically to ensure they are triaged according to their clinical priority. These happened in 2017 so therefore changes should have been put in place when these were identified.

- 3. These happened in 2017 so therefore changes should have been put in place when these were identified**

Yes as above.

From: Donna Britton [mailto:[Personal Information redacted by the USI]]
Sent: 22 May 2020 17:02
To: Corporate.Governance
Subject: Review level: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

Diane

HSCB/PHA officers have reviewed this case and based on the information provided believe this case does not meet the requirements of a Level 3 SAI Review and would request further information as follows:

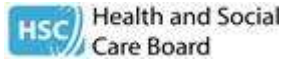
- Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented
- Can the Trust review and ensure required changes have been made in light of these cases

- These happened in 2017 so therefore changes should have been put in place when these were identified

I would welcome your response by 5 June 2020.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [mailto:Personal Information redacted by the USI]

Sent: 18 February 2020 16:44

To: serious incidents

Subject: Urology SAI Personal Information - Trust Ref: SHSCT SAI Personal Information HSCB Ref: Personal Information

Roisin,

Please see attached updated SAI notification and ToR, this was the SAI I discussed with you.

Kind Regards

Diane

From: serious incidents [mailto:seriousincidents@hscni.net]

Sent: 21 September 2017 14:54

To: Corporate.Governance

Subject: Acknowledgement - Trust Ref: SHSCT SAI Personal Information HSCB Ref: Personal Information

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI Personal Information

HSCB Ref: Personal Information

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Roisin

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 21 September 2017 12:49

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI].

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: serious incidents
Sent: 06 July 2020 09:28
To: Denise Boulter; Brid Farrell
Subject: FW: Review level: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]

Denise/Brid,

Please see below response to queries received from the SHSCT.

They have advised that the Learning Summary Report has been requested. We will forward to you upon receipt.

Regards,
John

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 02 July 2020 17:36
To: serious incidents
Subject: FW: Review level: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]

Donna

Sorry for the delay in responding. I have also requested the Level 1 Learning Summary as per last night's email.

Kind regards
Nicole

1. **Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented.**

The origins of the review was following the completion of an SAI –Datix [Personal Inform] chaired by Mr Glackin and the recommendations contained within, which brought about this review into delay in triage for urology patients.

2. **Can the Trust review and ensure required changes have been made in light of these cases.**

Yes . The trust have implemented e triage which automatically records the referral electronically to ensure they are triaged according to their clinical priority. These happened in 2017 so therefore changes should have been put in place when these were identified.

3. **These happened in 2017 so therefore changes should have been put in place when these were identified**

Yes as above.

From: Donna Britton [mailto:[Personal Information redacted by the USI]]
Sent: 22 May 2020 17:02

To: Corporate.Governance

Subject: Review level: Urology SAI [Personal Informa] - Trust Ref: SHSCT SAI [Personal Informa] HSCB Ref: [Personal Informa]

Diane

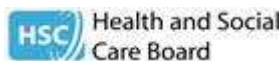
HSCB/PHA officers have reviewed this case and based on the information provided believe this case does not meet the requirements of a Level 3 SAI Review and would request further information as follows:

- Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented
- Can the Trust review and ensure required changes have been made in light of these cases
- These happened in 2017 so therefore changes should have been put in place when these were identified

I would welcome your response by 5 June 2020.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI | Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 18 February 2020 16:44

To: serious incidents

Subject: Urology SAI [Personal Informa] - Trust Ref: SHSCT SAI [Personal Informa] HSCB Ref: [Personal Informa]

Roisin,

Please see attached updated SAI notification and ToR, this was the SAI I discussed with you.

Kind Regards

Diane

From: serious incidents [mailto:seriousincidents@hscni.net]

Sent: 21 September 2017 14:54

To: Corporate.Governance

Subject: Acknowledgement - Trust Ref: SHSCT SAI [Personal Informa] HSCB Ref: [Personal Informa]

"This email is covered by the disclaimer found at the end of the message."

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT SAI Personal Informa

HSCB Ref: Personal Information

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **16 November 2017** and forward directly to seriousincidents@hscni.net.

**The DRO for this SAI is Dr Joanne McClean*

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

Regards

Roisin

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 21 September 2017 12:49

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION [Personal Information redacted by the USI]

Please find attached SAI Notification ID [Personal Information redacted by the USI].

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 03 July 2020 13:14
To: Roisin Hughes (Corporate Services)
Subject: FW: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]
Attachments: Review level: Urology SAI [Personal Inform] - Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]
Importance: High
Follow Up Flag: Follow up
Flag Status: Completed

Hi Roisin

The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.

Thanks
Nicole

From: serious incidents [<mailto:serious.incidents@hscni.net>]
Sent: 01 July 2020 13:52
To: Corporate.Governance
Subject: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]
Importance: High

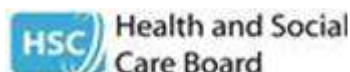
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Diane,

Thank you for receipt of the RCA Report in relation to the above SAI. As this was initially reported as a Level 1 SAI, can you please submit the Learning Summary Report?

Also, please find attached queries sent to the Trust on 22 May 2020. No response has been received. Can you please submit a response to seriousincidents@hscni.net mailbox **as soon as possible?**

Many Thanks
Roisin
Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI — Personal Information redacted by the USI

From: serious incidents
Sent: 09 June 2020 12:23
To: 'Corporate.Governance'
Subject: Trust Ref: SHSCT SAI [Personal Information redacted] HSCB Ref: [Personal Information redacted]

Diane,

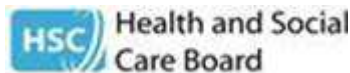
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Many Thanks

Roisin

Roisin Hughes



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Personal Information redacted by the USI — Personal Information redacted by the USI

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 29 May 2020 15:02
To: serious incidents
Subject: SAI Report & Checklist for ID [Personal Information redacted] / [Personal Information redacted]

Good Afternoon,

Please find attached SAI report and checklist for ID [Personal Information redacted] / [Personal Information redacted].

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department Personal Information redacted by the USJ

serious incidents

From: serious incidents
Sent: 06 July 2020 10:11
To: Denise Boulter; Brid Farrell
Cc: Elaine Hamilton (HSCB)
Subject: Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Attachments: Position Report [Personal Information].pdf
Importance: High

Denise/Brid,

Please see email below, in relation to the above SAI.

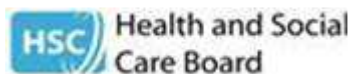
The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.

Can you please advise if you still require the Learning Summary Report and if so the reason for requesting it?

Many Thanks

Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI — Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 03 July 2020 13:14
To: Roisin Hughes (Corporate Services)
Subject: FW: Reminder: Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Importance: High

Hi Roisin

The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.

Thanks
Nicole

From: serious incidents [mailto:serious.incidents@hscni.net]
Sent: 01 July 2020 13:52

To: Corporate.Governance

Subject: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]

Importance: High

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Diane,

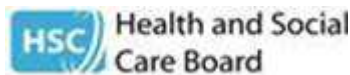
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Many Thanks

Roisin

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: serious incidents

Sent: 09 June 2020 12:23

To: 'Corporate.Governance'

Subject: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]

Diane,

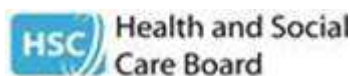
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Many Thanks

Roisin

Roisin Hughes



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From: Corporate.Governance [mailto:Personal Information redacted by the USI]
Sent: 29 May 2020 15:02
To: serious incidents
Subject: SAI Report & Checklist for ID Personal Inform / Personal Informat

Good Afternoon,

Please find attached SAI report and checklist for ID Personal Informat / Personal Information.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone Personal Information redacted by the USI



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serious incidents

From: Elaine Hamilton (HSCB)
Sent: 09 July 2020 16:19
To: serious incidents
Cc: Brid Farrell; Anne-Marie Phillips; Denise Boulter
Subject: RE: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]

Roisin,

This SAI was discussed at the Acute Group and the log is with Denise/Brid for approval. You may not receive the log for a few days so in the meantime can you advise the Trust the Level 1 Report is not required.

Thanks

Elaine

From: serious incidents
Sent: 06 July 2020 10:11
To: Denise Boulter; Brid Farrell
Cc: Elaine Hamilton (HSCB)
Subject: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]
Importance: High

Denise/Brid,

Please see email below, in relation to the above SAI.

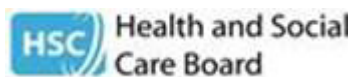
The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.

Can you please advise if you still require the Learning Summary Report and if so the reason for requesting it?

Many Thanks

Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 03 July 2020 13:14
To: Roisin Hughes (Corporate Services)
Subject: FW: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Inform]
Importance: High

Hi Roisin

The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.

Thanks
Nicole

From: serious incidents [mailto:serious.incidents@hscni.net]
Sent: 01 July 2020 13:52
To: Corporate.Governance
Subject: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]
Importance: High

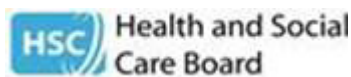
"This email is covered by the disclaimer found at the end of the message."

Diane,

Thank you for receipt of the RCA Report in relation to the above SAI. As this was initially reported as a Level 1 SAI, can you please submit the Learning Summary Report?

Also, please find attached queries sent to the Trust on 22 May 2020. No response has been received. Can you please submit a response to seriousincidents@hscni.net mailbox **as soon as possible?**

Many Thanks
Roisin
Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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From: serious incidents
Sent: 09 June 2020 12:23
To: 'Corporate.Governance'
Subject: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informa]

Diane,

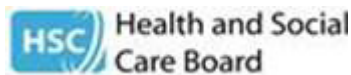
Thank you for receipt of the RCA Report in relation to the above SAI. As this was initially reported as a Level 1 SAI, can you please submit the Learning Summary Report?

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Many Thanks

Roisin

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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Sent: 29 May 2020 15:02

To: serious incidents

Subject: SAI Report & Checklist for ID Personal Inform / Personal Inform

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Kind Regards

Diane

Corporate Clinical & Social Care Governance Office

Corporate Governance Assistant

Beechfield House

Craigavon Area Hospital Site

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serious incidents

From: serious incidents
Sent: 09 July 2020 19:43
To: 'Corporate.Governance'
Subject: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]

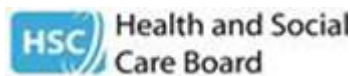
Nicole,

Please be advised that the Level 1 report is not required for the above SAI.

Regards

Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 03 July 2020 13:14
To: Roisin Hughes (Corporate Services)
Subject: FW: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]
Importance: High

Hi Roisin

The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.

Thanks
 Nicole

From: serious incidents [mailto:serious.incidents@hscni.net]
Sent: 01 July 2020 13:52
To: Corporate.Governance
Subject: Reminder: Trust Ref: SHSCT SAI [Personal Inform] HSCB Ref: [Personal Informat]
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Diane,

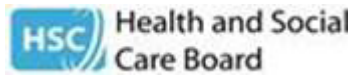
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Also, please find attached queries sent to the Trust on 22 May 2020. No response has been received. Can you please submit a response to seriousincidents@hscni.net mailbox **as soon as possible**?

Many Thanks

Roisin

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

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Personal Information redacted by the USI

From: serious incidents

Sent: 09 June 2020 12:23

To: 'Corporate.Governance'

Subject: Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Diane,

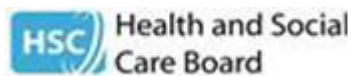
Thank you for receipt of the RCA Report in relation to the above SAI. As this was initially reported as a Level 1 SAI, can you please submit the Learning Summary Report?

Also, please find attached queries sent to the Trust on 22 May 2020. No response has been received. Can you please submit a response to seriousincidents@hscni.net mailbox **as soon as possible**?

Many Thanks

Roisin

Roisin Hughes



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From: Corporate.Governance [mailto:[Personal Information]]

Sent: 29 May 2020 15:02

To: serious incidents

Subject: SAI Report & Checklist for ID [Personal Information] / [Personal Information]

Good Afternoon,

Please find attached SAI report and checklist for ID [Personal Information] / [Personal Information].

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
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Mareth Campbell

From: patricia kingsnorth (SHSCT)
Sent: 15 October 2020 17:08
To: Anne Kane
Cc: Denise Boulter; Anne-Marie Phillips; Elaine Hamilton (SPPG); Mareth Campbell
Subject: RE: Action plan [Personal Information redacted]

Follow Up Flag: Follow up
Flag Status: Flagged

Anne
Many thanks, I'll discuss it with them tomorrow.

Kind regards
Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital

Personal Information redacted by the USI



From: Anne Kane [[mailto:](#) [Personal Information redacted by the USI]]
Sent: 15 October 2020 17:03
To: Kingsnorth, Patricia
Cc: Denise Boulter; Anne-Marie Phillips; Elaine Hamilton (HSCB); Mareth Campbell
Subject: RE: Action plan [Personal Information redacted]

"This email is covered by the disclaimer found at the end of the message."

Patricia

I know we spoke about this hence the rationale for why this was put on the Regional Gov Leads meeting. To seek consistency about regional recommendations and the fact that they need to be realistic and potentially agreed with the Board in the first instance. This is particularly important given the report will have been shared with the family.

I know Denise and Anne Marie are meeting with you next regarding a similar issue so perhaps the specific action plan you are referring to can be discussed at that meeting as it is also an Acute SAI.

Regards
Anne

From: Kingsnorth, Patricia [[mailto:](#) [Personal Information redacted by the USI]]
Sent: 15 October 2020 16:24

To: Anne Kane
Cc: serious incidents; Denise Boulter
Subject: Action plan [Personal Information redacted]

Good afternoon Anne

We had a discussion some time ago about closing the loop on action plans. Can you advise re: the attached action plan please.

Many thanks
Patricia
Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital

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Action Plan Urology

Personal Information

| Reference number | Recommendations | Designated responsible person | Action required | Date for completion / timescale | Date recommendation completed with evidence |
|------------------|--|-------------------------------|----------------------|---------------------------------|---|
| 1 | HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory. | HSCB | See recommendation 5 | | |
| 2 | HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices | HSCB | | | |
| 3 | HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients. | HSCB | | | |
| 4 | GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields. | HSCB | | | |

| | | | | | |
|---|--|----------------------------------|---|----------|---|
| 5 | <p>TRUST</p> <p>Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.</p> | AD surgical/ AMD Primary Care | The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care. | | <p>NiCan pathway.</p> <p> Bladder Cancer Pathway March 2020.</p> <p> Revised Prostate Diagnostic Pathway C</p> <p> Female Lower Urinary Tract Sympto</p> <p> Female Urinary Tract Infection.docx</p> <p> Male Lower Urinary Tract Symptoms.docx</p> <p> male urinary tract infections.docx</p> |
| 6 | The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. | AD Surgery/ AMD Surgery | Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD | Jan 2021 | |

| | | | | | |
|----|--|------------|--|----------|---|
| 7 | The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner. | AD surgery | Currently the IEAP protocol is followed The current regional protocol is being updated. | Jan 2021 |  Integrated Elective Access Protocol - Apr  Integrated Elective Access Protocol Draft  FW IEAP referral.msg  Booking Centre SOP manual.doc  TRIAGE PROCESS 2. Imca.docx |
| 8 | The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list. | AD Surgery | | Nov 2020 | |
| 9 | Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10. | AD surgery | Reports will be sent to AD and AMD/ CD | Nov 2020 | |
| 10 | The Trust must set in place a robust system within its medical management hierarchy for highlighting | MD | | | |

| | | | | | |
|----|--|----|--|--|--|
| | and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence. | | | | |
| 11 | Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner. | MD | | | |
| 12 | Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6. | MD | | | |

serious incidents

From: serious incidents
Sent: 20 October 2020 10:49
To: Elaine Hamilton (HSCB)
Subject: FW: Action plan [Personal Information]
Attachments: Action plan ([Personal Information]).pdf

Morning Elaine

Please see below email from SHSCT to Anne enclosing Action Plan for SAI [Personal Information].

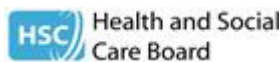
I note from record this SAI was discussed on Acute meeting on 9 July 2020 and the outcome was as follows;

- It was agreed the LSR is not required as the RCA has been received.
- Further consideration of this report is required. Integrated Care may need to be notified.
- Governance Team to advise the Southern Trust the LSR is not required as RCA is sufficient.
- Governance Team to search Datix for other Urology related cases and forward to Elaine Hamilton.

I wanted to forward Action Plan for your consideration for relisting for next meeting.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information
redacted by the USI

Personal Information redacted by the USI

From: Kingsnorth, Patricia [mailto:[Personal Information redacted by the USI]]

Sent: 15 October 2020 16:24

To: Anne Kane

Cc: serious incidents; Denise Boulter

Subject: Action plan [Personal Information]

Good afternoon Anne

We had a discussion some time ago about closing the loop on action plans. Can you advise re: the attached action plan please.

Many thanks

Patricia

Patricia Kingsnorth

Acting Acute Clinical Governance Coordinator

Governance Office

Room 53

The Rowans Craigavon Area Hospital

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Ann Redpath

From: Mareth Campbell
Sent: 15 October 2020 21:45
To: Denise Boulter; Anne-Marie Phillips; Anne Kane
Cc: Elaine Hamilton (HSCB); Geraldine McArdle
Subject: RE: Action plan [Personal Informa]
Attachments: Position Report - [Personal Informa] (SHSCT SAI [Personal Informa]).docx; RCA Report - [Personal Informa].pdf; FW: Action plan [Personal Informa]

Denise/Anne-Marie

Please find attached a position report for SAI [Personal Informa] (SHSCT SAI [Personal Informa]). This is a **Level 1** SAI (reported as a Level 1 in September 2017 but SHSCT submitted an updated notification form in February 2020 upgrading the SAI to a Level 3 and also attached Terms of Reference and Team Membership which were considered at an interim Acute meeting on 1 May 2020 where it was felt the ToR didn't reflect a Level 3). The SAI is recorded on Datix as a Level 1 and has been discussed at the Level 1 Acute Group. **Note** Trust submitted a RCA report.

For ease of reference, I have also attached the RCA report.

Anne – I have reviewed the Datix record and the Action Plan has not been received until today (email from Patricia Kingsnorth) but the 12 recommendations are incorporated within the RCA report (pages 22 – 25).

Mareth

From: Anne Kane
Sent: 15 October 2020 19:47
To: Anne-Marie Phillips; Mareth Campbell
Cc: Denise Boulter; Geraldine McArdle
Subject: RE: Action plan [Personal Informa]

AnneMarie

The reference number I think is the SHSCT reference Mareth or Geraldine will be able to pick this up in the morning. What time is your meeting?

Regards
Anne

From: Anne-Marie Phillips
Sent: 15 October 2020 18:44
To: Anne Kane; Mareth Campbell
Cc: Denise Boulter
Subject: RE: Action plan [Personal Informa]

Thank you Anne, if we could get the SAI report and position report please, as you have said for tomorrow, as I did search Datix there but unable to find it.

Though looking at the Action Plan Denise and I do know about this case and the recommendations set by the SHSCT.

Thanks
Anne-Marie

From: Anne Kane
Sent: 15 October 2020 18:27
To: Mareth Campbell
Cc: Denise Boulter; Anne-Marie Phillips
Subject: RE: Action plan [Personal Inform]

Mareth

If you get a chance can you forward to Denise and Annemarie in the morning their meeting with SHSCT is tomorrow.

Regards
Anne

From: Anne Kane
Sent: 15 October 2020 17:06
To: Mareth Campbell
Cc: Denise Boulter; Anne-Marie Phillips
Subject: FW: Action plan [Personal Inform]

Mareth

This is the action plan sent to me today – did we actually get this or were the actions just incorporate within the report.

Regards
Anne

From: Kingsnorth, Patricia [mailto: [Personal Information redacted by the USI]]
Sent: 15 October 2020 16:24
To: Anne Kane
Cc: serious incidents; Denise Boulter
Subject: Action plan [Personal Inform]

Good afternoon Anne

We had a discussion some time ago about closing the loop on action plans. Can you advise re: the attached action plan please.

Many thanks
Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital

[Personal Information redacted by the USI]



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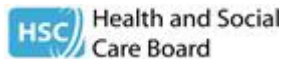
serious incidents

From: serious incidents
Sent: 05 November 2020 09:30
To: 'Corporate.Governance'
Subject: RE: Level 3 SAI review draft Terms of Reference – [Personal Information redacted]

Good morning Diane

Please advise if SHSCT SAI [Personal Information redacted] (HSCB Ref: [Personal Information redacted]) will be included in the overarching level 3 investigation as it is a urology related SAI.

Warm Regards
Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 30 October 2020 09:33
To: serious incidents
Subject: Level 3 SAI review draft Terms of Reference

Good Morning,

Please find attached overarching terms of reference in relation to the urology SAI's below:

Personal Information redacted by the USI

A large black rectangular box redacts the content of the email body, covering the list of urology SAI's mentioned in the text above.

Please be advised that there will be 1 additional notification to follow which will also relate to these SAIs.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone Personal Information redacted by the USI

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

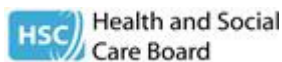
From: serious incidents
Sent: 18 November 2020 14:08
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: FW: Level 3 SAI review draft Terms of Reference - (Personal Information redacted by the USI)

Diane

I refer to email below and wished to enquire if have you received a response.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

(Personal Information redacted by the USI)

(Personal Information redacted by the USI)

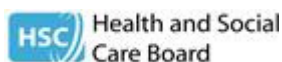
From: serious incidents
Sent: 05 November 2020 09:30
To: 'Corporate.Governance'
Subject: RE: Level 3 SAI review draft Terms of Reference - (Personal Information redacted by the USI)

Good morning Diane

Please advise if SHSCT SAI (Personal Information redacted by the USI) (HSCB Ref: (Personal Information redacted by the USI)) will be included in the overarching level 3 investigation as it is a urology related SAI.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

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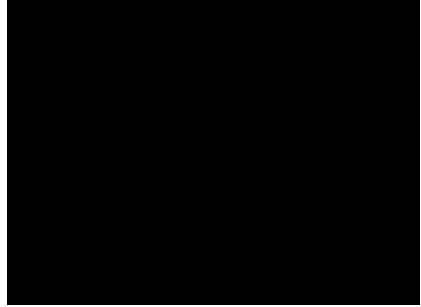
(Personal Information redacted by the USI)

From: Corporate.Governance [[\(mailto:\(Personal Information redacted by the USI\)\)](mailto:(Personal Information redacted by the USI))]
Sent: 30 October 2020 09:33
To: serious incidents
Subject: Level 3 SAI review draft Terms of Reference

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Corporate Governance Assistant
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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

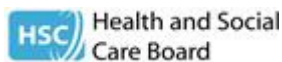
serious incidents

From: serious incidents
Sent: 03 December 2020 14:50
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: FW: Level 3 SAI review draft Terms of Reference - (Personal Information redacted by the USI)

Hi Diane

Just following up on the email below to check if you have any response.

Warm Regards
Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

(Personal Information redacted by the USI)

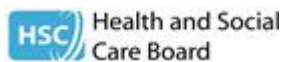
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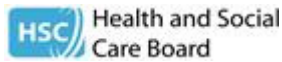
From: serious incidents
Sent: 05 November 2020 09:30
To: 'Corporate.Governance'
Subject: RE: Level 3 SAI review draft Terms of Reference - (Personal Information redacted by the USI)

Good morning Diane

Please advise if SHSCT SAI [Personal Information redacted by the USI] (HSCB Ref: [Personal Information redacted by the USI]) will be included in the overarching level 3 investigation as it is a urology related SAI.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]

Sent: 30 October 2020 09:33

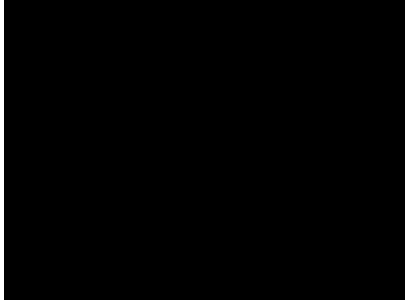
To: serious incidents

Subject: Level 3 SAI review draft Terms of Reference

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[Personal Information redacted by the USI]



Please be advised that there will be 1 additional notification to follow which will also relate to these SAIs.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office

Corporate Governance Assistant

Beechfield House

Craigavon Area Hospital Site

Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

serious incidents

From: Corporate.Governance [Personal Information redacted by the USI] >
Sent: 03 December 2020 16:46
To: serious incidents
Subject: FW: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]
Categories: Donna

Donna,

Please be advised that SAI [Personal Information redacted by the USI] will not be included in the over arching review for the new SAI investigation.

Kind Regards
Diane

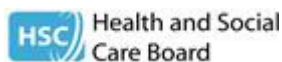
From: serious incidents [mailto:serious.incidents@hscni.net]
Sent: 05 November 2020 09:30
To: Corporate.Governance
Subject: RE: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

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Good morning Diane

Please advise if SHSCT SAI [Personal Information redacted by the USI] (HSCB Ref: [Personal Information redacted by the USI]) will be included in the overarching level 3 investigation as it is a urology related SAI.

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[Personal Information redacted by the USI]

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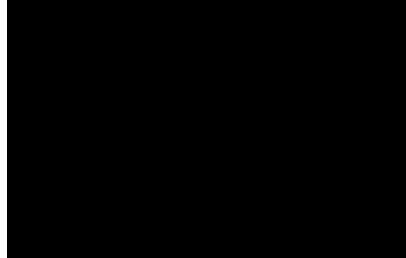
From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 30 October 2020 09:33
To: serious incidents
Subject: Level 3 SAI review draft Terms of Reference

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[Personal Information redacted by the USI]

Personal Information redacted by the USI



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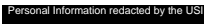
Diane

Corporate Clinical & Social Care Governance Office
 Corporate Governance Assistant
 Beechfield House
 Craigavon Area Hospital Site
 Telephone 

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serious incidents

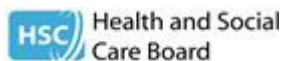
From: serious incidents
Sent: 08 December 2020 10:30
To: Brid Farrell; Denise Boulter; Anne-Marie Phillips
Subject: FW: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]
Attachments: Position report [Personal Information redacted by the USI] 8.12.20.docx

Acute Group

Please see email below from SHSCT confirming the above SAI will not be included in the Urology overarching review for the new SAI investigation.

Denise I note from Acute SAI Review Team Meeting Action Log for 30 November 2020 you were due to meet with Southern Trust.

Warm Regards
Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 03 December 2020 16:46
To: serious incidents
Subject: FW: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

Donna,

Please be advised that SAI [Personal Information redacted by the USI] /SAI [Personal Information redacted by the USI] will not be included in the overarching review for the new SAI investigation.

Kind Regards
Diane

From: serious incidents [mailto:serious.incidents@hscni.net]
Sent: 05 November 2020 09:30
To: Corporate.Governance
Subject: RE: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

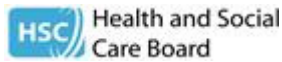
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Good morning Diane

Please advise if SHSCT SAI [Personal Information redacted by the USI] (HSCB Ref: [Personal Information redacted by the USI]) will be included in the overarching level 3 investigation as it is a urology related SAI.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 30 October 2020 09:33

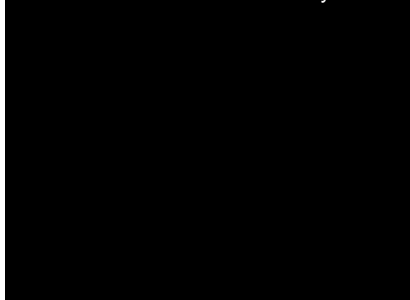
To: serious incidents

Subject: Level 3 SAI review draft Terms of Reference

Good Morning,

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[Personal Information redacted by the USI]



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Kind Regards

Diane

Corporate Clinical & Social Care Governance Office

Corporate Governance Assistant

Beechfield House

Craigavon Area Hospital Site

Telephone [Personal Information redacted by the USI]

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serious incidents

From: serious incidents
Sent: 20 January 2021 11:40
To: 'Corporate.Governance'
Subject: Query: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

Hi Diane

Following discussion of the above SAI at the Acute SAI Review Team members noted this SAI is not part of the overarching Urology SAI [Personal Information] but can the Trust confirm if this case will form part of the Independent Urology Review.

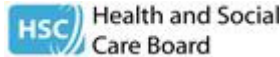
Also how has service user / family engagement been completed as the Report refers to multiple service users.

I would welcome your response by 4 February 2021.

The HSCB recognise this is a particularly challenging time for all HSC staff and will continue to work closely with colleagues during this period.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 03 December 2020 16:46

To: serious incidents

Subject: FW: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

Donna,

Please be advised that SAI [Personal Information] /SAI [Personal Information] will not be included in the over arching review for the new SAI investigation.

Kind Regards

Diane

From: serious incidents [mailto:serious.incidents@hscni.net]

Sent: 05 November 2020 09:30

To: Corporate.Governance

Subject: RE: Level 3 SAI review draft Terms of Reference - [Personal Information]

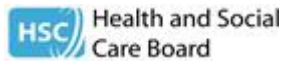
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[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 30 October 2020 09:33

To: serious incidents

Subject: Level 3 SAI review draft Terms of Reference

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Corporate Governance Assistant

Beechfield House

Craigavon Area Hospital Site

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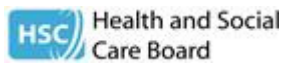
serious incidents

From: serious incidents
Sent: 29 March 2021 12:39
To: Corporate.Governance (Personal Information redacted by the USI)
Subject: FW: Query: Level 3 SAI review draft Terms of Reference - (Personal Information redacted by the USI)

Diane

I wish to follow up on response to request below.

Warm Regards
Donna Britton



Governance Office | HSCB | Tower Hill | Armagh | BT61 9DR

(Personal Information redacted by the USI)

(Personal Information redacted by the USI)

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Hi Diane

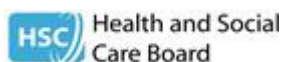
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Personal Information
redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [<mailto:> Personal Information redacted by the USI]
Sent: 03 December 2020 16:46
To: serious incidents
Subject: FW: Level 3 SAI review draft Terms of Reference - Personal Information redacted by the USI

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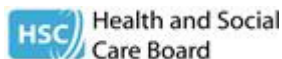
From: serious incidents [<mailto:serious.incidents@hscni.net>]
Sent: 05 November 2020 09:30
To: Corporate.Governance
Subject: RE: Level 3 SAI review draft Terms of Reference - Personal Information

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Good morning Diane

Please advise if SHSCT SAI Personal Information (HSCB Ref: Personal Information) will be included in the overarching level 3 investigation as it is a urology related SAI.

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redacted by the USI

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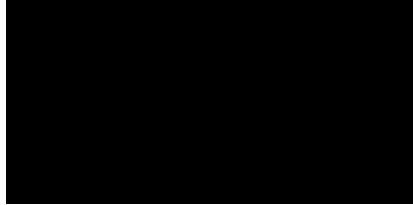
Good Morning,

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Personal Information redacted by the USI

A large black rectangular box redacting the content of the email.

Personal Information redacted by the USI



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Kind Regards

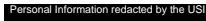
Diane

Corporate Clinical & Social Care Governance Office
 Corporate Governance Assistant
 Beechfield House
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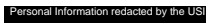
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Southern Health & Social Care Trust IT Department 

serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 31 March 2021 10:02
To: serious incidents
Subject: FW: Query: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]
Categories: Work in progress

Dear Donna,

Please see response from Governance Team: whilst this case is not part of the new urology review (9 patients) it was part of the initial urology review involving 5 patients approved in 2020.

Kind regards

Lauren

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
[Personal Information redacted by the USI]

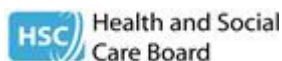
From: serious incidents [mailto:serious.incidents@hscni.net]
Sent: 29 March 2021 12:39
To: Corporate.Governance
Subject: FW: Query: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

"This email is covered by the disclaimer found at the end of the message."

Diane

I wish to follow up on response to request below.

Warm Regards
Donna Britton



Governance Office | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

From: serious incidents
Sent: 20 January 2021 11:40
To: 'Corporate.Governance'
Subject: Query: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

Hi Diane

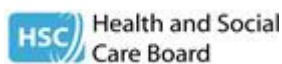
Following discussion of the above SAI at the Acute SAI Review Team members noted this SAI is not part of the overarching Urology SAI [Personal Information] but can the Trust confirm if this case will form part of the Independent Urology Review.

Also how has service user / family engagement been completed as the Report refers to multiple service users.

I would welcome your response by 4 February 2021.

The HSCB recognise this is a particularly challenging time for all HSC staff and will continue to work closely with colleagues during this period.

Warm Regards
Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR
[Personal Information redacted by the USI] | [Personal Information redacted by the USI]

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]
Sent: 03 December 2020 16:46
To: serious incidents
Subject: FW: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

Donna,

Please be advised that SAI [Personal Information]/SAI [Personal Information] will not be included in the over arching review for the new SAI investigation.

Kind Regards
Diane

From: serious incidents [<mailto:serious.incidents@hscni.net>]
Sent: 05 November 2020 09:30
To: Corporate.Governance
Subject: RE: Level 3 SAI review draft Terms of Reference [Personal Information]

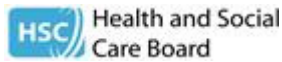
"This email is covered by the disclaimer found at the end of the message."

Good morning Diane

Please advise if SHSCT SAI [Personal Information] (HSCB Ref: [Personal Information]) will be included in the overarching level 3 investigation as it is a urology related SAI.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [[mailto:\[Personal Information redacted by the USI\]](mailto:[Personal Information redacted by the USI])]

Sent: 30 October 2020 09:33

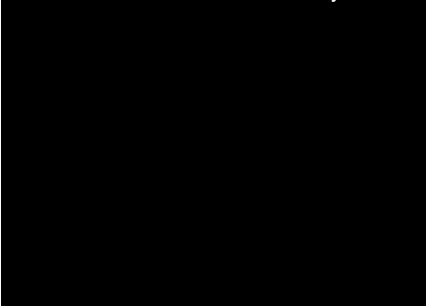
To: serious incidents

Subject: Level 3 SAI review draft Terms of Reference

Good Morning,

Please find attached overarching terms of reference in relation to the urology SAI's below:

Personal Information redacted by the USI



Please be advised that there will be 1 additional notification to follow which will also relate to these SAIs.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office

Corporate Governance Assistant

Beechfield House

Craigavon Area Hospital Site

Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

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serious incidents

From: serious incidents
Sent: 07 April 2021 16:44
To: Brid Farrell; Denise Boulter; Jackie McCall
Subject: Response to Query: Level 3 SAI review draft Terms of Reference - [Personal Information redacted by the USI]

Good afternoon

The query below was raised at the Acute SAI Review Team Meeting on 13 January 2021;

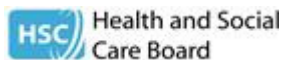
We are aware this SAI is not part of the overarching Urology SAI [Personal Information redacted by the USI] but can the Trust confirm if this case will form part of the Independent Urology Review.

How has service user / family engagement been completed as the Report refers to multiple service users

The SHSCT have submitted the following response;

whilst this case is not part of the new urology review (9 patients) it was part of the initial urology review involving 5 patients approved in 2020.

Warm Regards
Donna Britton



Governance Office | HSCB | Tower Hill | Armagh | BT61 9DR

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

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Lauren

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site

[Personal Information redacted by the USI]

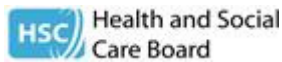
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Diane

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Donna Britton



Governance Office | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: serious incidents
Sent: 20 January 2021 11:40
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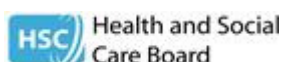
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Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information
redacted by the USI

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From: Corporate.Governance [<mailto:> Personal Information redacted by the USI]

Sent: 03 December 2020 16:46

To: serious incidents

Subject: FW: Level 3 SAI review draft Terms of Reference - Personal Information redacted by the USI

Donna,

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Kind Regards

Diane

From: serious incidents [<mailto:serious.incidents@hscni.net>]

Sent: 05 November 2020 09:30

To: Corporate.Governance

Subject: RE: Level 3 SAI review draft Terms of Reference Personal Information

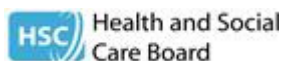
"This email is covered by the disclaimer found at the end of the message."

Good morning Diane

Please advise if SHSCT SA Personal Information (HSCB Ref: Personal Information) will be included in the overarching level 3 investigation as it is a urology related SAI.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information
redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [<mailto:> Personal Information redacted by the USI]

Sent: 30 October 2020 09:33


To: serious incidents

Subject: Level 3 SAI review draft Terms of Reference

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Kind Regards

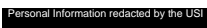
Diane

Corporate Clinical & Social Care Governance Office
 Corporate Governance Assistant
 Beechfield House
 Craigavon Area Hospital Site
 Telephone 

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Southern Health & Social Care Trust IT Department 

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serious incidents

From: serious incidents
Sent: 22 April 2021 15:01
To: Corporate.Governance (Personal Information redacted by the USI)
Cc: 'Stephen.Wallace' (Personal Information redacted by the USI)
Subject: Closure of SAI - Trust Ref: SHSCT SAI (Personal Inform / HSCB Ref: (Personal Informat

Lauren

The DRO and other relevant officers, having reviewed the Learning Summary Report/Review Report and any other information, are satisfied based on the information provided that this incident can be closed from their perspective. However, if further information is made available to the reporting organisation (for example the Coroner's Report), which impacts on the outcome of the initial review it should be communicated to the HSCB / PHA DRO via the serious incidents mailbox.

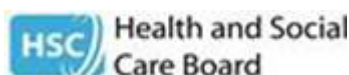
In line with the Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016), please note that it is the responsibility of the Trust to take forward any recommendations or further actions identified (*including, where appropriate, on-going or further liaison with service users or families*) and monitor these through the Trust's internal governance arrangements. This is an essential element in reassuring the public that lessons learned, where appropriate have been embedded in practice.

Stephen

You had advised family engagement had been completed. I shold be grateful if you could confirm dates of same at your earliest opportunity.

Regards

Ann Redpath
Ann Redpath



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

(Personal Information redacted by the USI)

(Personal Information redacted by the USI)

serious incidents

From: /O=HSCNI/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=SERIOUS INCIDENTS on behalf of serious incidents

Sent: 04 May 2021 13:28

To: Corporate.Governance (Personal Information redacted by the USI)

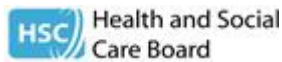
Cc: 'Stephen.Wallace' (Personal Information redacted by the USI)

Subject: Reminder: Engagement Trust Ref: SHSCT (Personal Information redacted) / HSCB Ref: (Personal Information redacted)

Good afternoon

I wish to follow up on response to email below regarding family engagement.

Warm Regards
Donna Britton



Governance Office | HSCB | Tower Hill | Armagh | BT61 9DR

(Personal Information redacted by the USI)

(Personal Information redacted by the USI)

From: serious incidents

Sent: 22 April 2021 15:01

To: Corporate.Governance (Personal Information redacted by the USI)

Cc: 'Stephen.Wallace' (Personal Information redacted by the USI)

Subject: Closure of SAI - Trust Ref: SHSCT SA (Personal Information redacted) / HSCB Ref: (Personal Information redacted)

Lauren

The DRO and other relevant officers, having reviewed the Learning Summary Report/Review Report and any other information, are satisfied based on the information provided that this incident can be closed from their perspective. However, if further information is made available to the reporting organisation (for example the Coroner's Report), which impacts on the outcome of the initial review it should be communicated to the HSCB / PHA DRO via the serious incidents mailbox.

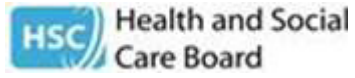
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Regards

Ann Redpath
Ann Redpath



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information
redacted by the USI

Personal Information redacted by the USI

serious incidents

From: Elaine Hamilton (HSCB)
Sent: 13 April 2022 14:33
To: serious incidents
Subject: Personal Information Urology 2016 SAI Recommendations

Can you please record this email from Denise to Sophie onto record Personal Information

Thanks

Elaine

From: Denise Boulter
Sent: 13 April 2022 13:02
To: Sophie Lusby; Louise Herron
Cc: Elaine Hamilton (HSCB)
Subject: RE: Urology 2016 SAI Recommendations

Hi Sophie

Apologies for the delay in responding and I understand you have since had a chat with Louise

We closed this SAI in April 2021 with no regional learning and at that stage advised the Trust through a telephone call that the first 4 recommendations on their action plan should be taken forward by themselves in conjunction with NiCAN re NG12. There was some correspondence with Cara who outlined this was complicated as NG12 was not fully implemented. The acute SAI group and the DRO are responsible for identification of regional learning but not for monitoring of action plans if no learning is identified. We have discussed at length on many occasions with the Trust that they should not make recommendations for any other organisation (including HSCB) before discussing with them first and these discussions were had with them regarding this particular SAI.

Therefore we do not continue to ask for updates on this action plan I would suggest you potentially contact Cara for any updates re implementation of NG12 or the ST for an update of their action plan

Thanks and happy to discuss

Denise

From: Sophie Lusby
Sent: 01 April 2022 12:14
To: Louise Herron; Denise Boulter
Subject: Urology 2016 SAI Recommendations

Dear Louise and Denise,

I understand that progress on implementation of these recommendations was halted due to the pandemic. I am picking this up now as part of the overall urology portfolio. Are we able to move forward now?

Very happy to discuss. We expect to have a urology assurance group with the DH by end of April but I would like to report back to the oversight group on 14 April. I am very happy to support in whatever way might be needed.

Best wishes,

Sophie Lusby

Assistant Director of Commissioning
Southern LCG

Tel no: Personal Information
redacted by the USI

HSCB / PHA SAI POSITION REPORT

| | | |
|---|-------------------------|-----------------------------------|
| UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: | | HSCB REFERENCE NUMBER |
| SHSCT SAI [Personal Informant] | | [Personal Informant] |
| DATE SAI NOTIFIED | CURRENT LEVEL OF REVIEW | ORGANISATIONS NOTIFIED (EXTERNAL) |
| 21 September 2017 | SAILV1 | |
| DATE SAI OCCURRED: | DRO: | LSR/RCA REPORT DUE: |
| 12 May 2017 | ACUTE GROUP | 16 November 2017 |
| CORONER'S REPORT: | DRO SUPPORT OFFICER/S | PROGRAMME OF CARE |
| | | Acute Services |

| | |
|-----------|---------------------------|
| KEY WORDS | HSCB / PHA Generic Coding |
| | |

| DATIX COMMON CLASSIFICATION SYSTEM CCS CODING | | |
|---|--|-----------------------------|
| STAGE OF CARE | DETAILS | ADVERSE EVENT |
| Access, Appointment, Admission, Transfer, Discharge | Problem with the referral from primary to secondary care | Failure in referral process |

| DATIX COMMON CLASSIFICATION SYSTEM CCS2 CODING | | |
|--|--------|--------|
| TIER 1 | TIER 2 | TIER 3 |
| | | |

| DESCRIPTION OF INCIDENT |
|---|
| <p>**DRO advises this is similar incident to [Personal Informant] and [Personal Informant]**</p> <p>Patient [Personal Informant] old male referred to urology following an episode of haematuria on 28 July 2016, it appears the letter was not triaged and the patient was placed on a routine waiting list on 30 September 16. As part of an internal review this patient's referral letter was upgraded to a red flag referral and was reviewed at OPD on 31/01/17. Subsequent investigations diagnosed a pT4 TCC of bladder and prostate. Patient has locally advance bladder cancer (G3T4a). Datix - [Personal Informant]</p> <p>2. Patient [Personal Informant] old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 151, on day 197 the patient had a confirmed cancer diagnosis T3a with no nodal metastases. Datix - [Personal Informant]</p> <p>3. Patient [Personal Informant] old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice raised PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and was seen in clinic on day 246, on day 304 the patient had a confirmed cancer diagnosis. There has been a resultant 10 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay he has decided to opt for active surveillance treatment. Datix - [Personal Informant]</p> <p>4. Patient [Personal Informant] old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice elevated PSA. Referral was marked urgent by the GP. Referral was not triaged on receipt. As part of an internal review the referral was upgraded to red flag and patient was seen in clinic on day 217, on day 270 the patient had a confirmed cancer diagnosis. There has been a resultant 9 month delay in OP review and recommendation of treatment for a prostate cancer. Patient is aware of diagnosis but not delay and has is currently thinking about his options for treatment. Datix [Personal Informant]</p> <p>The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning relating to this incident.</p> <p>WHY IS THIS INCIDENT CONSIDERED SERIOUS?: serious injury to, or the unexpected/unexplained death of: a service user</p> <p>HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? - No - Patients to be informed by Chair of SAI group following first meeting.</p> |

IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:

Notified to the Medical Director.

What action has been taken to prevent further referrals slipping through processes like this. Has the Trust assured itself that there are no other urology referrals have slipped through. Have they considered if this is likely to be a problem in other specialities

| | | | |
|--|-------------------------|--|--------------------|
| | | | |
| | 19 February 2020 | | 29 May 2020 |
| | | | |
| | 12 April 2021 | | |

| | | |
|-------------------------|--------------------|---------------------|
| | | |
| 19 February 2018 | 29 May 2020 | 15 July 2020 |
| | | |
| | | |

RATIONALE NOT INFORMING the S/User / Family / Carer that the incident was being reviewed as a SAI**RATIONALE FOR NOT SHARING LSR/SEA/RCA****HSCB PHA ACTION TAKEN:**

21/09/17: Incident acknowledged and DRO Assigned.

21/09/17: Email from DRO - 'Can you please ask the Trust the following for an urgent response:

1. What action has been taken to prevent further referrals slipping through processes like this
2. Has the Trust assured itself that there are no other urology referrals have slipped through
3. Have they considered if this is likely to be a problem in other specialities.'

Can you please also draw the Trust's attention to the attached SAI (Personal Information) and check if the cases below were found following a review prompted by this SAI as the case is not on the list of new ones.'

21/09/17: DRO Qs fwdd to Trust.

29/09/17: Email from Trust - 'Response to DRO queries:

1. What action has been taken to prevent further referrals slipping through processes like this?
 - a. Electronic referral process is being piloted which make triage more accessible and timely. It allows easy identification of referrals that have not been triaged & reporting of same
2. Has the Trust assured itself that there are no other urology referrals have slipped through?
 - a. There has been a look back exercise within urology to identify any other referrals which were not triaged, this review is complete.
3. Have they considered if this is likely to be a problem in other specialities?
 - a. If Consultants fail to comply with the IEAP process and there are delays in triaging this is escalated to the HoS & AD for action

Can you please also draw the Trust's attention to the attached SAI (Personal Information) and check if the cases below were found following a review prompted by this SAI as the case is not on the list of new ones.'

SAI (Personal Information) was identified from review of a complaint sent by his family.'

29/09/17: Trust response fwdd to DRO.

01/11/17: Email from E Hamilton to DRO - 'At the Acute meeting on 25 September 2017 (during discussion of (Personal Information)) it was agreed Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI (Personal Information re) and (Personal Information) and to seek assurance processes have been put in place to prevent reoccurrence. Can you advise if this meeting will take place in Dr Farrell's absence or if any further action is required in the interim period?'

Extract from Action Log:

Update 25 September 2017: FURTHER ACTION REQUIRED. Dr Farrell and Dr McClean along with Lisa McWilliams PMSI will arrange a meeting with SHSCT to discuss this SAI and (Personal Information) and to seek

HSCB PHA ACTION TAKEN:

assurance processes have been put in place to prevent reoccurrence.

SAI to be reviewed following meeting with SHSCT

Action: Dr Farrell / Dr McClean.

16/11/17: Email from E Hamilton to DRO 'As per email below can you advise what action is required to be taken in relation to this SAI (Personal Information) and (Personal Information). Will I relist for the Acute meeting on 20 November for another discussion or will the meeting go ahead with SHSCT?

16/11/17: Email from J McClean - Brid was following this up and I do not think anything has happened in her absence. Can you please send me the position reports and re-list for Monday?

16/11/17: Email from Trust showing internal email trail with update on outstanding report - Good afternoon the first formal SAI meeting was on the 24th October 2017. The next meeting is planned for 28th November 2017, I don't anticipate the report being completed before Christmas.

17/11/17: Trust's update forwarded to DRO.

17/01/18 : Letter from HSCB CX to Trust attaching status report highlighting all review reports that remain outstanding as at 31 December 2017.

17/04/18 - Letter from HSCB CX to Trust attaching status report highlighting all review reports that remain outstanding as at 31 March 2018.

27/07/18 - Letter from HSCB CX to Trust attaching status report highlighting all review reports that remain outstanding as at 30 June 2018.

12/12/18: Letter from HSCB Cx to Trust Cx attaching status report highlighting all review reports that remain outstanding as at 30 September 2018. In order to support the process, it was suggested that a meeting would be arranged between the HSCB and Trust to discuss any concerns. The Trust have been asked to forward the name of a representative(s) to Geraldine McArdle for a meeting to be arranged.

17 September 2018: Trust Update - Writing report for October finalizing.

08/02/19: Letter from HSCB Cx to Trust Cx attaching status report highlighting all review reports that remain outstanding as at 31 December 2018.

21/05/19: Letter from HSCB Cx to Trust Cx attaching status report highlighting all review reports that remain outstanding as at 31 March 2019.

11/07/19: Letter from HSCB Cx to Trust Cx attaching status report highlighting all review reports that remain outstanding as at 30 June 2019.

SHSCT Outstanding / Overdue SAI Review Reports – Position at 30th September 2019

This report is being checked for factual accuracy. Will be shared with family and HSCB by the end of December 2019.

30/10/19: Letter from HSCB CX to Trust attaching status report highlighting all review reports that remain outstanding as at 30 September 2019.

19/11/19: It was agreed at the Nursing and Governance Learning Meeting on 6th November 2019 that all Acute Level 1 SAIs are to be reassigned to the Acute Professional Group'.

10/02/20: Letter from HSCT Cx to Trust Cx attaching status report highlighting all review reports that remain outstanding as at 31 December 2019.

18/02/20: Email from Trust with attached updated Level 3 Notification and ToR.

19/02/20: Fwdd to Denise and Brid cc Mareth. To be listed for discussion at the next Acute Meeting.

*LV02 Acute Meeting cancelled. Await new date.

01/05/20: INTERIM POC 1 TEAM - NURSING SAFETY AND QUALITY TEAM REVIEW OF POC 1 (LEVEL 2 and 3) SAI REVIEW REPORTS RECEIVED – 1 MAY 2020 - ACTION LOG - SAI relating to urology in CAH (4 patients) was initially reported as a Level 1. SHSCT have submitted an amended notification form and Terms of Reference and Team Membership indicating they will review as a Level 3. Following review of the Team Membership and Terms of Reference, it was felt they don't reflect a Level 3 as there is no independent person included in the Team Membership and perhaps the Trust could carry out a thematic review of urology cases. It was agreed the Terms of Reference would be listed for discussion at the Interim Quality and Safety Bi-weekly Review Group on 4 May 2020.

Action:

•SAI to be listed for review at the Interim Quality and Safety Bi-weekly Review Group on 4 May 2020. M Campbell

04/05/20: INTERIM SAFETY AND QUALITY BI-WEEKLY MEETING – Action Log as at 04.05.20

ToR and membership / Amended Notification – It was noted the proposed ToR does not reflect a level 3 SAI as there is no independent person included within the membership. Following discussion it was agreed D Boulter will discuss the possibility of a thematic review with B Farrell.

Person Responsible - D Boulter

HSCB PHA ACTION TAKEN:

Review 18.05.20

14-05-20 – INTERIM REVIEW by Safety and Quality Nursing Team (D Boulter, A Phillips, C Garland) with input from the Governance Team (A Kane, J Burns):

Members agreed the review level should not be revised - TOR membership does not reflect a Level 3 Review. FURTHER PROFESSIONAL INPUT: D Boulter to discuss with Dr Farrell and this case will be considered by the Acute Group - ACTION D Boulter

Review Level to be updated on this record to Level 1- ACTION GOVERNANCE TEAM

This case will be considered by Acute Group

Interim Safety and Quality Bi-weekly Meeting – Action Log as at 18.05.20

Update 18 May 2020 – D Boulter to discuss the possibility of a thematic review with B Farrell and report back to the next meeting.

22/05/20: Email to SHSCT - HSCB/PHA officers have reviewed this case and based on the information provided believe this case does not meet the requirements of a Level 3 SAI Review and would request further information as follows:

- Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented
- Can the Trust review and ensure required changes have been made in light of these cases
- These happened in 2017 so therefore changes should have been put in place when these were identified

29/05/20: Email from Trust - Please find attached SAI report and checklist for ID [Personal Information redacted by the USI]

03/06/20: Email to DRO - Please find attached RCA Report submitted by SHSCT on 29 May 2020.

You will note from SAI Position Report attached that at the Interim Safety and Quality Bi-weekly Meeting of 14 May 2020 this SAI was not escalated to a Level 3 but the Review was to remain as a Level 1. Queries from 18 May 2020 meeting were then forwarded to the Trust on 22 May 2020.

These queries remain outstanding with the Trust. Please advise if you require a Learning Summary Report to be submitted in line with a Level 1 Review.

04/06/20: Email from MMcN to Mareth & Elaine - 'Please see below extract from Mondays interim Safety and Quality meeting in respect of the above SAI where it was agreed to close this from the action log as Denise has confirmed she has responded via email in relation to the action from the group. This is to be closed from the log as this is to be taken forward via the relevant Acute group.

Extract from interim Safety and Quality meeting:

Update 1 June 2020 – Denise confirmed she has responded via email to the Governance Team following her discussions with B Farrell. Therefore as this will be taken forward by the relevant Acute Group it was agreed to close this from the action log.

Person Responsible - D Boulter

Status - Mark Closed – refer to Acute Group to take forward.

Interim Safety and Quality Bi-weekly Meeting – Action Log as at 01.06.20

Update 1 June 2020 –Denise confirmed she has responded via email to the Governance Team following her discussions with B Farrell. Therefore as this will be taken forward by the relevant Acute Group it was agreed to close this from the action log.

05/06/20: Email from Denise confirming LSR still required.

09/06/20: Email to Trust requesting LSR & response to o/s Qs.

01/07/20: Email to Trust re outstanding LSR & response to Qs.

02/07/20: Response from Trust - Sorry for the delay in responding. I have also requested the Level 1 Learning Summary as per last night's email.

1. Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented.

The origins of the review was following the completion of an SAI –Datix [Personal Informa] chaired by Mr Glackin and the recommendations contained within, which brought about this review into delay in triage for urology patients.

2.Can the Trust review and ensure required changes have been made in light of these cases.

Yes . The trust have implemented e triage which automatically records the referral electronically to ensure they are triaged according to their clinical priority. These happened in 2017 so therefore changes should have been put in place when these were identified.

3.These happened in 2017 so therefore changes should have been put in place when these were identified

Yes as above.

HSCB PHA ACTION TAKEN:

06/07/20: Trust response fwdd to DRO.

06/07/20: Email from Trust - 'The team have asked why the HSCB requires a Level 1 report? The investigation produced an RCA report which details the learning within it.'

06/07/20: Trust Q fwdd to Denise and Brid.

09/07/20: Email from E Hamilton - 'This SAI was discussed at the Acute Group and the log is with Denise/Brid for approval. You may not receive the log for a few days so in the meantime can you advise the Trust the Level 1 Report is not required.'

09/07/20: Trust advised.

*Await Action Log. Re ToR approval. RCA already received.

Level 1 Acute SAI Review Team Meeting on 9 July 2020 which was approved by Dr Farrell on 03 August 2020.

First Review 9 July 2020. It was agreed the LSR is not required as the RCA has been received.

Further consideration of this report is required. Integrated Care may need to be notified.

Governance Team to advise the Southern Trust the LSR is not required as RCA is sufficient.

Governance Team to search Datix for other Urology related cases and forward to Elaine Hamilton.

15/10/20: Email from PKingsnorth SHSCT to AKane - We had a discussion some time ago about closing the loop on action plans. Can you advise re: the attached action plan please.

Forwarded to EHmailton to query relisting

15/10/20: Email from A Kane to M Campbell (cc: D Boulter; A M Phillips) - This is the action plan sent to me today – did we actually get this or were the actions just incorporate within the report.

15/10/20: Email from A Kane to M Campbell (cc: D Boulter; A M Phillips) - If you get a chance can you forward to Denise and Annemarie in the morning their meeting with SHSCT is tomorrow.

15/10/20: Email from A M Phillips to A Kane; M Campbell (cc: D Boulter) - Thank you. If we could get the SAI report and position report please, as you have said for tomorrow, as I did search Datix there but unable to find it. Though looking at the Action Plan Denise and I do know about this case and the recommendations set by the SHSCT.

15/10/20: Email from A Kane to A M Phillips; M Campbell (cc: D Boulter; G McArdle) - The reference number I think is the SHSCT reference Mareth or Geraldine will be able to pick this up in the morning. What time is your meeting?

15/10/20: Email from M Campbell to D Boulter, AM Phillips, A Kane (cc: E Hamilton, G McArdle) - Please find attached a position report for SAI [Personal Information] (SHSCT SAI [Personal Information]). This is a Level 1 SAI (reported as a Level 1 in September 2017 but SHSCT submitted an updated notification form in February 2020 upgrading the SAI to a Level 3 and also attached Terms of Reference and Team Membership which were considered at an interim Acute meeting on 1 May 2020 where it was felt the ToR didn't reflect a Level 3). The SAI is recorded on Datix as a Level 1 and has been discussed at the Level 1 Acute Group. Note Trust submitted a RCA report.

For ease of reference, I have also attached the RCA report.

Anne – I have reviewed the Datix record and the Action Plan has not been received until today (email from Patricia Kingsnorth) but the 12 recommendations are incorporated within the RCA report (pages 22 – 25).

Acute SAI Review Team Level 1 Action Log Updated 8 October 2020 agreed 28/10/20

Update 8 October 2020: The SHSCT have advised that all previously submitted SAIs for urology will be subject to one overarching level 3 investigation. This has been discussed with Denise Boulter. Level 3 TOR to follow. This will include the following SAIs.

Personal Information redacted by the U

08/10/20: Level 1 Acute SAI Review Team Meeting on 8 October 2020 - Further Discussion Required. Denise will discuss all Urology cases with Dr Farrell to agree action required.

The following SAIs will also be considered along with this SAI.

Personal Information redacted by the U

HSCB PHA ACTION TAKEN:

05/11/20: Email to SHSCT - Please advise if SHSCT SAI [Personal Information] (HSCB Ref: [Personal Information]) will be included in the overarching level 3 investigation as it is a urology related SAI.

Acute SAI Review Team Level 1 Action Log

Update 12 November 2020: Governance Team have asked Trust to confirm if this SAI will be considered as part of the Level 3 Urology Review. Denise will also follow up with Patricia Kingsnorth.

18/11/20: Email to SHSCT reminder requesting response to above query

Action Log level 1 Acute SAI Review Team Meeting 30 November 2020

Meeting with Southern Trust hasn't taken place yet. Denise will update following the meeting.

03/12/20: Email from SHSCT - Please be advised that SAI [Personal Information] /SAI [Personal Information] will not be included in the over arching review for the new SAI investigation.

Forwarded to APG

Action Log level 1 Acute SAI Review Team Meeting 13 January 2021

Update 13 January 2021: Governance Team mark SAI as deferred until the Report for the overarching SAI Ref: [Personal Information] is received as members would like to view both reports together.

Governance Team to include the following in the email to the Trust.

- We are aware this SAI is not part of the overarching Urology SAI [Personal Information] but can the Trust confirm if this case will form part of the Independent Urology Review.
- How has service user / family engagement been completed as the Report refers to multiple service users

20/01/21: Email to SHSCT enc APG Query

10/02/21: Tel call from SWallace SHSCT re query, he advised family engagement been completed and he will confirm dates of same via email

11/03/21: Reminder email to SHSCT re APG queries

29/03/21: Reminder email to SHSCT req response to APG Queries

31/03/21: Email from SHSCT -

Please see response from Governance Team: whilst this case is not part of the new urology review (9 patients) it was part of the initial urology review involving 5 patients approved in 2020.

Forwarded to APG

Acute Level 1 SAI Review Team Meeting – Updated 12 April 2021

Update 12 April 2021: CLOSE based on the information provided including the engagement checklist. No new regional learning was identified in relation to this SAI.

Southern Trust have confirmed whilst this case is not part of the new urology review (9 patients) it was part of the initial urology review involving 5 patients approved in 2020.

Stephen Wallace (SHSCT) advised family engagement been completed and he will confirm dates of same via email.

Governance team to follow up response from Stephen Wallace.

22/04/21: Closure email to Trust. Request to S Wallace to to confirm family engagement dates.

SAI closed

04/05/21: Reminder email to SHSCT re family engagement dates

Update from Touchpoint meeting on 28.06.21 provided via email on 16 July 2021.

Letters were delivered to each patient advising the outcome of the review.

Patient 11 15/07/2020

Patient 12 09/10/2020

Patient 14 22/09/2020.

2 patients met with the review team

Patient 13 25/11/2020/15.

Patient 15 25/05/2021

11/06/21: Email from D Boulter to C Anderson (cc: Anne Kane) - Hi Cara, Hope you are well. On the attached document (Action Plan) are a number of recommendations for the HSCB (page 1) which while we have informed the Trust they should progress with the HSCB themselves Lisa Mc Williams has advised that some progress on these areas have been progress via NICAN. Would you be able to give me an update on any of these as to whether there is progress against them or not. Happy to discuss if needed

11/06/21: Email from C Anderson to DB (cc: AK and L Herron) – Denise, This is the first time I am seeing these. They appear to be premised on the fact that NG12 has been implemented, which it has not. This is quite a complex issue. It might be helpful for you, Louise and I to have a quick call sometime next week to fill you in.

HSCB PHA ACTION TAKEN:

14/06/21: Thanks Cara that would be very helpful. Is there a time that suits?

29/06/21: Update on engagement received from Trust.

ACUTE SERVICES SAI REVIEW TEAM MEETING - ACTION LOG UPDATED 5 APRIL 2022

5 April 2022: Denise and Elaine will search for any information in relation to the 2016 Urology recommendations and Denise will respond to Sophie Lusby's email.

13/04/22: D.Boulter email to S.Lusby - Apologies for the delay in responding and I understand you have since had a chat with Louise

We closed this SAI in April 2021 with no regional learning and at that stage advised the Trust through a telephone call that the first 4 recommendations on their action plan should be taken forward by themselves in conjunction with NiCAN re NG12. There was some correspondence with Cara who outlined this was complicated as NG12 was not fully implemented. The acute SAI group and the DRO are responsible for identification of regional learning but not for monitoring of action plans if no learning is identified. We have discussed at length on many occasions with the Trust that they should not make recommendations for any other organisation (including HSCB) before discussing with them first and these discussions were had with them regarding this particular SAI.

Therefore we do not continue to ask for updates on this action plan I would suggest you potentially contact Cara for any updates re implementation of NG12 or the ST for an update of their action plan
Thanks and happy to discuss

Ann Redpath

From: Anne Kane
Sent: 01 August 2022 20:57
To: Geraldine McArdle
Subject: FW: recommendations

From: Denise Boulter
Sent: 14 June 2021 08:23
To: Cara Anderson
Cc: Anne Kane; Louise Herron
Subject: RE: recommendations

Thanks Cara that would be very helpful

Is there a time that suits?

Denise

From: Cara Anderson
Sent: 11 June 2021 14:03
To: Denise Boulter
Cc: Anne Kane; Louise Herron
Subject: RE: recommendations

Denise

This is the first time I am seeing these. They appear to be premised on the fact that NG12 has been implemented, which it has not. This is quite a complex issue. It might be helpful for you, Louise and I to have a quick call sometime next week to fill you in.

Cara

Cara Anderson
Assistant Director of Commissioning
HSCB
12-22 Linenhall Street
Belfast

Tel. Personal Information
redacted by the USI



From: Denise Boulter
Sent: 11 June 2021 11:51
To: Cara Anderson
Cc: Anne Kane
Subject: recommendations

Hi Cara

Hope you are well

On the attached document are a number of recommendations for the HSCB (page 1) which while we have informed the Trust they should progress with the HSCB themselves Lisa Mc Williams has advised that some progress on these areas have been progress via NICAN

Would you be able to give me an update on any of these as to whether there is progress against them or not

Happy to discuss if needed

Denise

Denise Boulter

Assistant Director Nursing Quality, Safety and Patient Experience (Interim)

4th Floor

Linenhall Street

Belfast

Personal Information
redacted by the USI

Personal Information
redacted by the USI



serious incidents

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 22 September 2017 12:02
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION ID [Personal Information]
Attachments: 20170922_ SAI Notification [Personal Information].pdf
Categories: New SAI notification

Please find attached SAI Notification ID [Personal Information]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | | | |
|--|--|---|---|
| 1. ORGANISATION: Southern Health and Social Care Trust | | 2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE Personal Information | |
| 3. HOSPITAL / FACILITY / COMMUNITY LOCATION Craigavon Area Hospital | | 4. DATE OF INCIDENT: 10/07/2016 | |
| 5. DEPARTMENT / WARD / LOCATION EXACT Urology | | | |
| 6. CONTACT PERSON: Mrs Connie Connolly | | 7. PROGRAMME OF CARE: <i>Acute Services</i> | |
| 8. DESCRIPTION OF INCIDENT: Personal Information redacted by the old patient had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient was considered for palliative pelvic radiotherapy in January 2016, but the urology stents insitu required renewal prior to radiotherapy. There was a long and protracted delay in the management of stents. In December 2016 radiotherapy was no longer considered an option for patient due to disease progression. Patient died Personal Information redacted by the Personal Information redacted by the USI The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning relating to this incident DOB: Personal Information redacted by the USI GENDER: M AGE: Personal Information redacted by the USI | | | |
| 9. IS THIS INCIDENT A NEVER EVENT? | | If 'YES' provide further detail on which never event - refer to DoH link below https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars | |
| YES | | NO | x |
| DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING | | | |
| STAGE OF CARE: Management of Deterioration | | DETAIL: (refer to Guidance Notes) | ADVERSE EVENT: (refer to Guidance Notes) |
| 10. <u>IMMEDIATE</u> ACTION TAKEN TO PREVENT RECURRENCE: n/a | | | |
| 11. CURRENT CONDITION OF SERVICE USER: Deceased | | | |
| 12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? (please select) | | | NO |
| 13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? (please specify where relevant) | | YES | |
| 14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: (please select relevant criteria below) | | | |
| serious injury to, or the unexpected/unexplained death of: | | | |
| - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) | | | x |
| - a staff member in the course of their work | | | |
| - a member of the public whilst visiting a HSC facility. | | | |

| SERIOUS ADVERSE INCIDENT NOTIFICATION FORM | | | | |
|---|-----|--------------------------|---|----------|
| - | | | | |
| unexpected serious risk to a service user and/or staff member and/or member of the public | | | | |
| unexpected or significant threat to provide service and/or maintain business continuity | | | | |
| serious self-harm or serious assault (<i>including attempted suicide, homicide and sexual assaults</i>) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service | | | | |
| serious self-harm or serious assault (<i>including homicide and sexual assaults</i>) <ul style="list-style-type: none"> - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (<i>as defined within the Mental Health (NI) Order 1986</i>) and/or known to/referred to mental health and related services (<i>including CAMHS, psychiatry of old age or leaving and aftercare services</i>) and/or learning disability services, in the 12 months prior to the incident | | | | |
| suspected suicide of a service user who has a mental illness or disorder (<i>as defined within the Mental Health (NI) Order 1986</i>) and/or known to/referred to mental health and related services (<i>including CAMHS, psychiatry of old age or leaving and aftercare services</i>) and/or learning disability services, in the 12 months prior to the incident | | | | |
| serious incidents of public interest or concern relating to: <ul style="list-style-type: none"> - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner | | | | |
| 15. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: (<i>please select</i>) | | | | NO |
| if 'YES' (<i>full details should be submitted</i>): | | | | |
| 16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? | YES | DATE INFORMED: 19.4.2017 | | |
| | | specify reason: | | |
| 17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? (<i>refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.</i>) please specify where relevant | | | | NO |
| if 'YES' (<i>full details should be submitted including the date notified</i>): | | | | |
| 18. OTHER ORGANISATION/PERSONS INFORMED: (<i>please select</i>) | | DATE INFORMED: | OTHERS: (<i>please specify where relevant, including date notified</i>) | |
| DoH EARLY ALERT | | | | |
| HM CORONER | | | | |
| INFORMATION COMMISSIONER OFFICE (ICO) | | | | |
| NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC) | | | | |
| HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI) | | | | |
| POLICE SERVICE FOR NORTHERN IRELAND (PSNI) | | | | |
| REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA) | | | | |
| SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI) | | | | |
| NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP) | | | | |
| 19. LEVEL OF REVIEW REQUIRED: (<i>please select</i>) | | LEVEL 1 | LEVEL 2* | LEVEL 3* |
| * FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6 | | | | |
| 20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (<i>delete as appropriate</i>) | | | | |

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

Report submitted by: Mrs Connie ConnollyDesignation: Lead Nurse Acute Governance

Email:

Personal Information redacted by the USI

Telephone:

Personal Information redacted by the USI

Date: 22/09/2017

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

Additional information submitted by: _____

Designation: _____

Email:

Telephone:

Date: DD / MM / YYYY

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

serious incidents

From: serious incidents
Sent: 22 September 2017 14:06
To: 'Corporate.Governance'
Subject: Acknowledgement - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: S [Personal Information]

Lindsey,

This communication acknowledges receipt of the Serious Adverse Incident Notification made to the HSCB seriousincidents@hscni.net mail box and confirms that the **Southern Trust** will complete a **LEVEL 1** Significant Event Audit (SEA) review relating to this SAI.

Trust Ref: SHSCT [Personal Information redacted by the USI]

HSCB Ref: [Personal Information]

In line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016, please provide a copy of the redacted **Learning Summary Report** by **17 November 2017** and forward directly to seriousincidents@hscni.net.

****The DRO for this SAI is Dr Joanne McClean***

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

Regards

Róisín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 22 September 2017 12:02
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION ID [Personal Information]

Please find attached SAI Notification ID [Personal Information]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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Southern Health & Social Care Trust IT Department 028 [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 22 September 2017 14:09
To: Joanne McClean
Cc: Carolyn Harper; Brid Farrell; Mary Hinds; Lynne Charlton; Mary McElroy; Oriel Brown; Michael Bloomfield; Anne Kane; Jacqui Burns; Margaret McNally; Mareth Campbell; Elaine Hamilton (HSCB); Elaine Hyde; Geraldine McArdle
Subject: DRO Assigned - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Attachments: SAI Notification Form [Personal Information].pdf

Joanne,

You have been identified as the DRO for the above SAI.

Please can you advise by email to seriousincidents@hscni.net on any immediate action you have taken or action required; the governance team will update the Datix record for this incident accordingly.

If you require advice in relation to medication related issues please contact Angela Carrington, email:

[Personal Information redacted by the USI]. Please ensure all correspondence to Angela is copied to seriousincidents@hscni.net.

I attach the Serious Adverse Incident Notification from the **Southern Trust** received on 22 September 2017. This notification confirms that a **Level 1** Significant Event Audit (SEA) review will be undertaken.

This incident has been reported to the HSCB in line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference: SHSCT SAI [Personal Information]

HSCB Reference: [Personal Information]

Programme of Care: Acute

An acknowledgement of receipt of this notification has been forwarded to the **Southern Trust**, requesting the redacted **Learning Summary Report** by no later than **17 November 2017**.

If you require any further information, please do not hesitate to contact me.

Regards

Róisín

Roisin Hughes

Governance Support Officer
 Corporate Services Department
 Health & Social Care Board
 Tower Hill
 Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto: [redacted]]
Sent: 22 September 2017 12:02
To: serious incidents
Subject: ENCRYPTION: SAI NOTIFICATION ID [redacted]

Please find attached SAI Notification ID [redacted]

Kind regards

Lindsey

Lindsey Liggett
Southern Health & Social Care Trust
Corporate Governance Assistant
Corporate Clinical & Social Care Governance Office
Beechfield House
Craigavon Area Hospital Site
68 Lurgan Road
PORTADOWN BT63 5QQ

Telephone [redacted]

Ext [redacted]



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Southern Health & Social Care Trust IT Department [redacted]

serious incidents

From: Michele Clawson
Sent: 22 September 2017 11:49
To: serious incidents
Subject: SHSCT April SAI [Personal Information] Complaint Ref [Personal Information]

Categories: Work in progress

We have received a complaint within the Southern Trust complaints reports for April advising that it was being investigated under SAI procedures.

Can you please confirm that you have received SAI ID [Personal Information]

Thanks

Michele

Michele Clawson | Complaints Officer | Corporate Services | Health and Social Care Board | 12-22 Linenhall Street | Belfast BT2 8BS | Tel: [Personal Information redacted by the USI]

serious incidents

From: serious incidents
Sent: 22 September 2017 15:30
To: Michele Clawson
Subject: RE: SHSCT April SAI [Personal Information] (Complaint Ref [Personal Information])

Michele

I can confirm that a SAI Notification has been received in respect of this reference.

Regards

AERedpath

Ann Redpath
Governance Support Officer
Health and Social Care Board - Southern Office
Tower Hill
Armagh
BT61 9DR

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

www.hscboard.hscni.net

From: Michele Clawson
Sent: 22 September 2017 11:49
To: serious incidents
Subject: SHSCT April SAI [Personal Information] (Complaint Ref [Personal Information])

We have received a complaint within the Southern Trust complaints reports for April advising that it was being investigated under SAI procedures.

Can you please confirm that you have received SAI ID [Personal Information]

Thanks

Michele

Michele Clawson | Complaints Officer | Corporate Services | Health and Social Care Board | 12-22 Linenhall Street | Belfast BT2 8BS | Tel: [Personal Information redacted by the USI]

serious incidents

From: Joanne McClean
Sent: 22 September 2017 14:29
To: serious incidents
Subject: RE: DRO Assigned - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]
Categories: Work in progress

Roisin,

This is the third SAI related to urology in CAH. Can you please link it with [Personal Information] and [Personal Information]? Thanks

I will speak to their medical director about these as it is unusual to get three like this in one service area.

Joanne

From: serious incidents
Sent: 22 September 2017 14:09
To: Joanne McClean
Cc: Carolyn Harper; Brid Farrell; Mary Hinds; Lynne Charlton; Mary McElroy; Oriel Brown; Michael Bloomfield; Anne Kane; Jacqui Burns; Margaret McNally; Mareth Campbell; Elaine Hamilton (HSCB); Elaine Hyde; Geraldine McArdle
Subject: DRO Assigned - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Joanne,

You have been identified as the DRO for the above SAI.

Please can you advise by email to seriousincidents@hscni.net on any immediate action you have taken or action required; the governance team will update the Datix record for this incident accordingly.

If you require advice in relation to medication related issues please contact Angela Carrington, email: [Personal Information redacted by the USI]. Please ensure all correspondence to Angela is copied to seriousincidents@hscni.net.

I attach the Serious Adverse Incident Notification from the **Southern Trust** received on 22 September 2017. This notification confirms that a **Level 1** Significant Event Audit (SEA) review will be undertaken.

This incident has been reported to the HSCB in line with the HSCB Procedure for the Reporting and Follow up of SAIs, November 2016.

Trust Reference: SHSCT SAI [Personal Information]
HSCB Reference: [Personal Information]
Programme of Care: Acute

An acknowledgement of receipt of this notification has been forwarded to the **Southern Trust**, requesting the redacted **Learning Summary Report** by no later than **17 November 2017**.

If you require any further information, please do not hesitate to contact me.

Regards

Róisín

Róisín Hughes

Governance Support Officer

Corporate Services Department

Health & Social Care Board

Tower Hill

Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]

Sent: 22 September 2017 12:02

To: serious incidents

Subject: ENCRYPTION: SAI NOTIFICATION ID [Personal Information]

Please find attached SAI Notification ID [Personal Information]

Kind regards

Lindsey

Lindsey Liggett

Southern Health & Social Care Trust

Corporate Governance Assistant

Corporate Clinical & Social Care Governance Office

Beechfield House

Craigavon Area Hospital Site

68 Lurgan Road

PORTADOWN BT63 5QQ

Telephone [Personal Information redacted by the USI]

Ext [Personal Information redacted by the USI]



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

Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

SHSCT Outstanding / Overdue SAI Review Reports (As at 30 June 2018)

OUTLIERS – Position at 15 August 2018

| Current Level of Review | POC 1 | POC 2 | TOTAL |
|-------------------------|----------|----------|----------|
| SAI Report Level 1 | 6 | 0 | 6 |
| SAI Report Level 2 | 0 | 1 | 1 |
| Total | 6 | 1 | 7 |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | POC | Review Report due | Number of Weeks Overdue | Update |
|--|----------|---------------|-------------------------|------|-------------------|-------------------------|---|
| Personal Information redacted by the USI | | 25-Apr-2017 | SAI Report Level 1 | POC1 | 20-Jun-2017 | 54 | Learning Summary Report received 24 July 2018 |
| | | 1-Aug-2017 | SAI Report Level 1 | POC1 | 26-Sep-2017 | 40 | 29/06/18 – Update from Trust There was some difficulty in organising the meetings due to a change of Chairperson. Report is complete however the Chair wishes to speak with the Consultants involved prior to issue. It is anticipated the report will be finalised by early July. Update 15 August 2018 – The report was due to be presented at the Acute Clinical Governance meeting, but due to annual leave the report will not now be presented at the September Acute Clinical Governance meeting. Update 17/09/18 Within 2 weeks for submission |
| | | 15-Aug-2017 | SAI Report Level 2 | POC2 | 7-Nov-2017 | 34 | ToR And TM approved 28 September 2017 |

| | | | | | | | |
|--|--|-------------|--------------------|------|-------------|----|---|
| | | | | | | | Update 17/09/18 Is completed and being finalised. This SAI was an interface investigation with the Belfast Trust, It is anticipated to have it completed for submission by the end of October |
| Personal Information redacted by the USI | | 21-Sep-2017 | SAI Report Level 1 | POC1 | 16-Nov-2017 | 32 | 16/11/17 – Update from Trust The first formal SAI meeting was on the 24 th October 2017. The next meeting is planned for 28 th November 2017, I don't anticipate the report being completed before Christmas Update September 2018 Writing report for October finalizing |
| | | 22-Sep-2017 | SAI Report Level 1 | POC1 | 17-Nov-2017 | 32 | Update September 2018 Within 2 weeks for submission |
| | | 22-Jul-2017 | SAI Report Level 1 | POC1 | 17-Nov-2017 | 32 | Update September 2018 Writing report for October finalizing |
| | | 22-Sep-2017 | SAI Report Level 1 | POC1 | 17-Nov-2017 | 32 | Update September 2018 Within 2 weeks for submission |

SHSCT Outstanding / Overdue SAI Review Reports – Position at 30th September 2019

| Level of Review | Number of Review Reports Outstanding |
|--------------------|--------------------------------------|
| SAI Report Level 1 | 23 |
| SAI Report Level 2 | 26 |
| SAI Report Level 3 | 2 |
| Total | 51 |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|---------------|-------------------------|------------------------|-------------------------|--------------|--|
| SEA/LSR LEVEL ONE | | | | | | | |
| Personal Information redacted by the USI | | 21/09/2017 | Level 1 | 16/11/2017 | 98 | Acute | This report is being checked for factual accuracy. Will be shared with family and HSCB by the end of December 2019 |
| | | 22/07/2017 | Level 1 | 17/11/2017 | 98 | Acute | This report is being checked for factual accuracy. Will be shared with family and HSCB by the end of December 2019 |
| | | 22/09/2017 | Level 1 | 17/11/2017 | 98 | Acute | 05/12/19 SAI Report submitted to HSCB |
| | | 23/11/2017 | Level 1 | 18/01/2018 | 89 | Acute | 22/10/19 - SAI Report submitted to HSCB |
| | | 27/11/2017 | Level 1 | 22/01/2018 | 89 | Acute | 25/10/19 - SAI Report & Checklist submitted to HSCB |
| | | 11/05/2018 | Level 1 | 06/07/2018 | 65 | Acute | 11/12/19 This report is being checked for factual accuracy. |
| | | 06/07/2018 | Level 1 | 31/08/2018 | 57 | Acute | 05/12/19 SAI report submitted to HSCB |
| | | 27/12/2018 | Level 1 | 21/02/2019 | 32 | Acute | This report is ready for ACG presentation January 2020 |
| | | 09/01/2019 | Level 1 | 06/03/2019 | 31 | MHD | Report sent to HSCB and offered to family on 19-11-19. Meeting to be set up with family in New Year at their request and as agreed in discussion with them 27/11/19. |
| | | 23/01/2019 | Level 1 | 20/03/2019 | 29 | Acute | 02/12/19 SAI report submitted to HSCB |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|---------------|-------------------------|------------------------|-------------------------|--------------|--|
| Personal Information redacted by the USI | | | | | | | |
| | | 29/01/2019 | Level 1 | 26/03/2019 | 28 | Acute | 05/11/19 SAI report submitted to HSCB and shared with family |
| | | 30/01/2019 | Level 1 | 27/03/2019 | 28 | Acute | This report is in final draft and will be ready for presentation at January 2020 ACG |
| | | 19/02/2019 | Level 1 | 17/04/2019 | 25 | MHD | Report sent to HSCB 19/11/19 and sent to family on 25-11-19. Family do not wish to meet Trust. Family contacted 18/12/19 to ask if they have any comments to make. Further bereavement support also offered. |
| | | 12/04/2019 | Level 1 | 07/06/2019 | 17 | MHD | SAI Review held and Report being drafted for circulation to review team for approval. |
| | | 19/04/2019 | Level 1 | 14/06/2019 | 16 | OPPC | 13/11/19 CGO - SEA Report submitted. |
| | | 15/05/2019 | Level 1 | 10/07/2019 | 13 | CYP | SAI submitted to HSCB |
| | | 03/06/2019 | Level 1 | 29/07/2019 | 10 | MHD | SAI meeting to take place 19 Dec 19 |
| | | 05/06/2019 | Level 1 | 31/07/2019 | 10 | Acute | 1 st meeting has taken place and draft report is complete. Will be ready for presentation at January 202 ACG |
| | | 09/07/2019 | Level 1 | 03/09/2019 | 5 | MHD | SAI Review held. Report Drafted and with review team for approval. |
| | | 24/07/2019 | Level 1 | 18/09/2019 | 3 | Acute | Meeting to finalise report on 27/11/19. Will be ready for presentation to January 2020 ACG |
| | | 25/07/2019 | Level 1 | 19/09/2019 | 2 | Acute | 27/12/19 SAI report submitted |
| | | 29/07/2019 | Level 1 | 23/09/2019 | 2 | MHD | SAI Review held. Report Drafted and with review team for approval |
| | | 01/08/2019 | Level 1 | 26/09/2019 | 1 | CYP | 05/12/19 SAI report submitted |
| | | RCA LEVEL TWO | | | | | |
| | | 05/04/2018 | Level 2 | 28/06/2018 | 66 | Acute | 14/11/19 SAI report submitted |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|---------------|-------------------------|------------------------|-------------------------|--------------|---|
| Personal Information redacted by the USI | | 22/05/2018 | Level 2 | 14/08/2018 | 60 | MHD | Report sent to HSCB 12/11/19 and sent to family on 19-11-19. |
| | | 07/06/2018 | Level 2 | 30/08/2018 | 57 | MHD | Report sent to HSCB 12/12/2019 and offered to family same day |
| | | 01/08/2018 | Level 2 | 24/10/2018 | 50 | MHD | SAI submitted to HSCB |
| | | 31/10/2017 | Level 2 | 03/12/2018 | 44 | MHD | Safeguarding report received on 12-09-19. SAI report then drafted and with assistant director for approval. |
| | | 21/09/2018 | Level 2 | 14/12/2018 | 42 | MHD | SAI Review held. Report Drafted and with review team for approval. External chair has advised that he wishes to discuss report with external medical rep on the review team and has requested that the timescale for completion is adjusted to the end of March 2020. |
| | | 15/10/2018 | Level 2 | 07/01/2019 | 39 | Acute | 17/12/19 – ACG meeting December 2019 |
| | | 24/10/2018 | Level 2 | 16/01/2019 | 38 | Acute | Comments with Chairperson for approval before finalising |
| | | 02/11/2018 | Level 2 | 25/01/2019 | 36 | MHD | 10/12/19 Draft SAI report and checklist submitted. Family contacted Trust to advise they do not wish to receive the report.. 16/12/19 – 16/12/2019 Final SAI Report submitted to Coroner, HSCB and RQIA |
| | | 15/01/2019 | Level 2 | 09/04/2019 | 26 | MHD | SAI review held. Report drafted awaiting additional information |
| | | 21/01/2019 | Level 2 | 15/04/2019 | 25 | Acute | 12/11/19 SAI Report submitted to HSCB |
| | | 27/12/2018 | Level 2 | 03/05/2019 | 22 | Acute | 04/12/19 SAI report submitted |
| | | 13/02/2019 | Level 2 | 08/05/2019 | 22 | Acute | 18/10/19 CGO - Terms of Reference and Membership has been approved by HSCB |
| | | 19/02/2019 | Level 2 | 14/05/2019 | 21 | MHD | 16/12/2019 Draft report provided to family. Draft report to HSCB 18/12/2019 pending family engagement. |
| | | 22/02/2019 | Level 2 | 17/05/2019 | 20 | Acute | 05/11/19 RCA report was submitted |

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review | SEA/LSR/RCA Report due | Number of weeks overdue | Direct orate | Comment |
|--|----------|-----------------|-------------------------|------------------------|-------------------------|--------------|--|
| Personal Information redacted by the USI | | 26/02/2019 | Level 2 | 21/05/2019 | 20 | MHD | Review held. Report being drafted. Review meeting had to be rescheduled. |
| | | 08/03/2019 | Level 2 | 31/05/2019 | 18 | MHD | 11/11/19 Closure of SAI email received from HSCB |
| | | 14/03/2019 | Level 2 | 06/06/2019 | 17 | MHD | ToR and Membership approved by HSCB. Review meeting being set up. |
| | | 20/03/2019 | Level 2 | 12/06/2019 | 17 | MHD | Draft report to HSCB 17/12/2019 pending family engagement. Report to be offered to family post-Christmas period. |
| | | 09/04/2019 | Level 2 | 02/07/2019 | 14 | Acute | 18/10/19- SAI report submitted |
| | | 15/05/2019 | Level 2 | 07/08/2019 | 9 | Acute | 04/10/19 SAI report sent |
| | | 15/05/2019 | Level 2 | 07/08/2019 | 9 | MHD | SAI Review held. Report Drafted and with review team for approval. |
| | | 17/05/2019 | Level 2 | 09/08/2019 | 8 | MHD | SAI Review held. Report Drafted and with review team for approval. |
| | | 14/06/2019 | Level 2 | 06/09/2019 | 4 | MHD | 10/01/2020 Draft SAI report sent |
| | | 19/06/2019 | Level 2 | 11/09/2019 | 4 | MHD | SAI meeting to take place. Provisional date Jan 2020 due to diary commitments. |
| | | 19/06/2019 | Level 2 | 11/09/2019 | 4 | Acute | 27/12/2019 SAI report submitted |
| | | RCA LEVEL THREE | | | | | |
| | | 23/04/2018 | Level 3 | 02/11/2018 | 48 | Acute | 14/11/19 SAI report submitted |
| | | 06/12/2018 | Level 3 | 05/06/2019 | 4 | MHD | Draft report received from External Chair 18-12-2019. |

* Indicates level of review has changed since initial notification

In addition to the above, the completion of the following SAI review report has been deferred pending the outcome of other HSC investigation/review processes or another statutory agency/external body review.

| HSC Trust Reference | HSCB Ref | Reported date | Current Level of Review |
|--|----------|---------------|---|
| Personal Information redacted by the USI | | 19/06/2019 | Level 1 |
| | | 07/05/2019 | Level 1 |
| | | 14/01/2019 | Level 2 Awaiting outcome of BHST independent review |

Donna Britton

From: Corporate.Governance <[Personal Information redacted by the USI]>
Sent: 06 February 2020 14:58
To: serious incidents
Subject: SAI Report (Final Learning Report/RCA Report) & Checklist [Personal Information]
Attachments: [Personal Information] SAI Report.pdf; TOR and Membership [Personal Information] pdf; SAI Notification [Personal Information] pdf

Good Afternoon,

Please find attached RCA Report and checklist for your attention. I have also attached a copy of the Terms of Reference and amended SAI notification.

This SAI was first notified as a level 1, the Southern Trust conducted a level 3 as they wanted to involve an independent person in the investigation.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | | | |
|---|--|--|--|
| 1. ORGANISATION: Southern Health and Social Care Trust | | 2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE Personal Information | |
| 3. HOSPITAL / FACILITY / COMMUNITY LOCATION Craigavon Area Hospital | | 4. DATE OF INCIDENT: 10/07/2016 | |
| 5. DEPARTMENT / WARD / LOCATION EXACT Urology | | | |
| 6. CONTACT PERSON: Mrs Connie Connolly | | 7. PROGRAMME OF CARE: <i>Acute Services</i> | |
| 8. DESCRIPTION OF INCIDENT: Personal Information redacted by the USI old patient had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient was considered for palliative pelvic radiotherapy in January 2016, but the urology stents insitu required renewal prior to radiotherapy. There was a long and protracted delay in the management of stents. In December 2016 radiotherapy was no longer considered an option for patient due to disease progression. Patient died Personal Information redacted by the USI . The SHSCT wish to submit this incident as an SAI in order to establish any areas of learning relating to this incident DOB: Personal Information redacted by the USI GENDER: M AGE: Personal Information redacted by the USI | | | |
| 9. IS THIS INCIDENT A NEVER EVENT? If 'YES' provide further detail on which never event - refer to DoH link below https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars | | | |
| YES | | NO | x |
| DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING | | | |
| STAGE OF CARE: AD0700 | | DETAIL: (refer to Guidance Notes) AD0703 | ADVERSE EVENT: (refer to Guidance Notes) A0900 |
| 10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE: n/a | | | |
| 11. CURRENT CONDITION OF SERVICE USER: Deceased | | | |
| 12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? (please select) | | | NO |
| 13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? (please specify where relevant) | | YES | |
| 14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: (please select relevant criteria below) | | | |
| serious injury to, or the unexpected/unexplained death of: | | | |
| - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) | | | x |
| - a staff member in the course of their work | | | |
| - a member of the public whilst visiting a HSC facility. | | | |

| SERIOUS ADVERSE INCIDENT NOTIFICATION FORM | | | |
|---|----------------|---|---------------|
| - | | | |
| unexpected serious risk to a service user and/or staff member and/or member of the public | | | |
| unexpected or significant threat to provide service and/or maintain business continuity | | | |
| serious self-harm or serious assault (<i>including attempted suicide, homicide and sexual assaults</i>) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service | | | |
| serious self-harm or serious assault (<i>including homicide and sexual assaults</i>) <ul style="list-style-type: none"> - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (<i>as defined within the Mental Health (NI) Order 1986</i>) and/or known to/referred to mental health and related services (<i>including CAMHS, psychiatry of old age or leaving and aftercare services</i>) and/or learning disability services, in the 12 months prior to the incident | | | |
| suspected suicide of a service user who has a mental illness or disorder (<i>as defined within the Mental Health (NI) Order 1986</i>) and/or known to/referred to mental health and related services (<i>including CAMHS, psychiatry of old age or leaving and aftercare services</i>) and/or learning disability services, in the 12 months prior to the incident | | | |
| serious incidents of public interest or concern relating to: <ul style="list-style-type: none"> - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner | | | |
| 15. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED: (<i>please select</i>) | | | NO |
| if 'YES' (<i>full details should be submitted</i>): | | | |
| 16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? | YES | DATE INFORMED: 19.4.2017 | |
| | | specify reason: | |
| 17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? (<i>refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.</i>) please specify where relevant | | | NO |
| if 'YES' (<i>full details should be submitted including the date notified</i>): | | | |
| 18. OTHER ORGANISATION/PERSONS INFORMED: (<i>please select</i>) | DATE INFORMED: | OTHERS: (<i>please specify where relevant, including date notified</i>) | |
| DoH EARLY ALERT | | | |
| HM CORONER | | | |
| INFORMATION COMMISSIONER OFFICE (ICO) | | | |
| NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC) | | | |
| HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI) | | | |
| POLICE SERVICE FOR NORTHERN IRELAND (PSNI) | | | |
| REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA) | | | |
| SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI) | | | |
| NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP) | | | |
| 19. LEVEL OF REVIEW REQUIRED: (<i>please select</i>) | LEVEL 1 | LEVEL 2* | LEVEL 3* x |
| * FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6 | | | |
| 20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (<i>delete as appropriate</i>) | | | |

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

Report submitted by: Patricia Kingsnorth Designation: Acting Acute Governance Co-ordinator

Email: Personal Information redacted by the USI Telephone: Personal Information redacted by the USI Date: 06/02/2020

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

Additional information submitted by: _____ Designation: _____

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

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

APPENDIX 6

Revised November 2016 (Version 1.1)

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

Organisation's Unique Case Identifier:

Personal Information redacted
by the USI

Date of Incident/Event: 10/07/2016

HSCB Unique Case Identifier:

Personal Information redacted by the
USI

Service User Details: (*complete where relevant*)

D.O.B:

Personal Information redacted by the
USI

Gender: (M)

Age:

(
Personal
Information
redacted by the USI
)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 27 January 2020

1.0 EXECUTIVE SUMMARY

Patient 16 was a Personal Information redacted by the -old man who had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient 16 was considered for palliative pelvic radiotherapy in January 2016, but urology stents already in-situ required renewal prior to radiotherapy. There was a protracted delay in the management of the stents. In December 2016, due to disease progression, palliative radiotherapy was no longer considered an option for Patient 16. Patient 16 died on the Personal Information redacted by the USI.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser
Mr M Haynes - Consultant Urologist
Mrs K Robinson - Booking & Contact Centre Manager
Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of Patient 16 in the period after referral to the SHSCT urology service using National Patient Safety Agency root cause analysis methodology.
2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 16 that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

APPENDIX 6

Revised November 2016 (Version 1.1)

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

Organisation's Unique Case Identifier:

Personal Information redacted
by the USI

Date of Incident/Event: 10/07/2016

HSCB Unique Case Identifier:

Personal Information redacted by the
USI

Service User Details: (*complete where relevant*)

D.O.B:

Personal Information redacted by the
USI

Gender: (M)

Age:

(Personal
Information
redacted by the USI)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 27 January 2020

1.0 EXECUTIVE SUMMARY

Patient 16 was a Personal Information redacted by the -old man who had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient 16 was considered for palliative pelvic radiotherapy in January 2016, but urology stents already in-situ required renewal prior to radiotherapy. There was a protracted delay in the management of the stents. In December 2016, due to disease progression, palliative radiotherapy was no longer considered an option for Patient 16. Patient 16 died on the Personal Information redacted by the USI.

Causative Factor(s)

There was a treatment and care delay - specifically, to the changing of ureteric stents, due to,

1. Lack of effective communication systems and processes; and
2. Long Waiting Lists leading to delay.

The Review Team consider that the delay was probably significant in terms of,

- an easier progression through the process of having the stents removed and replaced;
- reduction in the level of pain and discomfort reported towards the end of life.

However, in relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental.

Recommendations

TRUST

Recommendation 1

The Trust will explore and evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR.

Recommendation 2

The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter.

Recommendation 3

The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff.

This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4

The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB

Recommendation 5

In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6

The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

2.0 THE REVIEW TEAM



Dr J R Johnston - Consultant Medical Adviser

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of  in the period after referral to the SHSCT urology service using National Patient Safety Agency root cause analysis methodology.
2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to  that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute

3.0 SAI REVIEW TERMS OF REFERENCE

Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.

4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

Mr Patient 16. DOB = Personal Information redacted by the USI
Previous history of traumatic C5/6 (? C6/7) spinal injury due to fall, spinal surgery circa Personal Information redacted by the USI, requiring intermittent self-catheterisation. Personal Information redacted by the USI.

July 2012 - diagnosed with colon cancer. Following admission to Daisy Hill Hospital (DHH), with a large bowel obstruction underwent an emergency sigmoid colectomy on 2 July 2012.

September 2012 – first referral to Oncology outpatient services.

25 October 2012 - attended the Oncology clinic where, following discussion, Patient 16 opted not to proceed with chemotherapy, with concerns regarding potential urinary sepsis considered as

5.0 DESCRIPTION OF INCIDENT/CASE

a significant factor in the decision.

03 August 2014 - attended DHH ED with severe abdominal pain. Admitted to DHH and had resection of a recurrence of a small bowel tumour; discharged 2 September 2014.

September 2014 - referred back to the Oncology service. After further discussion, it was agreed that, rather than proceeding with palliative chemotherapy, he would be kept under surgical review, and treatment considered in the event of progressive disease.

15 December 2014 - attended Colorectal Consultant Surgeon 9 (ConsSurg9) who planned to review Patient 16 in 4 months.

02 March 2015 - Patient 16's review appointment brought forward at the request of his daughter. Patient 16 was reviewed at surgical outpatient clinic. He reported abdominal pain and his carcinoembryonic antigen (CEA) test (blood test used to help diagnose and manage certain types of cancer) was increasing.

11 March 2015 - CT scan detected a left sided pelvic mass, causing hydronephrosis (a swelling of a kidney due to a build-up of urine). It happens when urine cannot drain out from the kidney to the bladder from a blockage or obstruction), and a new lung nodule.

12 March 2015 – Discussed at Cancer Multidisciplinary Team (MDT) meeting. ConsSurg9 wrote to Consultant Urologist 11 (ConsUrol11) referring for consideration of a ureteric stent to relieve the blockage. ***Red Flag*** label. Patient 16 was also referred back to Oncology (ConsOnc10).

12 March 2015 – letter from ConsSurg9 to patient and copied to GP, “ *I have referred you to kidney specialist to see about placing a little tube to relieve that blockage.*”

26 March 2015 - reviewed at Consultant Urology 15's (ConsUrol15) clinic. The clinic letter notes, ‘*He was seen by the Oncologists today and is planned for chemotherapy. As such we have arranged for him to be admitted electively on 31st March for insertion of a left ureteric stent. Pre-op assessment has been completed at the clinic today*’

26 March 2015 - at the Oncology clinic, decided to proceed with palliative Oxaliplatin and Capecitabine chemotherapy, (treatment began on 23 April 2015).

31 March 2015 - admitted to CAH presumed to be under care of ConsUrol13 and had cystoscopy + optical urethrotomy + ureteroscopy + insertion of ureteric stent. Performed by ST4Urol12 with assistance by ConsUrol13. Operation note, “*Oncologists to contact when chemotherapy complete for stent removal / replacement*”.

01 April 2015 – Theatre / Recovery Care Pathway. “*Pt transferred from Recovery Day 1..... A/W ConsUrol13 to R/V*”.

5.0 DESCRIPTION OF INCIDENT/CASE

02 April 2015 – Discharge Notification. “ admitted under the care of ConsUrol13.... into 3 South Elective Ward on 31/03.2015” .

02 April 2015 – handwritten in clinical notes. Ward Round ConsUrol19 / ConsUrol13 noted, “*Care taken over by ConUrol11 (referral by ConsSurg9) ConsUrol13 will keep patient.*” This is thought to mean that it was decided that care of patient remained with ConsUrol13. The previous 4 entries are taken to indicate that ConsUrol13 assumed the overall care of Patient 16 at or around the 31 March 2015.

02 April 2015 – discharged; discharge letter sent to GP and was to be copied to Mandeville Unit (CAH) stating, “*Urology to be contacted when chemotherapy is completed so that stent removal/change can be planned.*”

02 April 2015 - Patient 16 added to ConsUrol13 Urgent waiting list. Date for this (noted below) was October 2015. However, was finally admitted 29 June 2016.

10 August 2015 - reviewed by ConsSurg9; the clinic letter notes ‘*He is feeling very well. He is coming to the end of his palliative chemotherapy.*’

27 August 2015 - at Oncology clinic; noted an improvement in the CEA tumour marker, but chemotherapy was complicated by extravasation. It was decided to proceed with Capecitabine only for the final two cycles.

08 October 2015 - Chemotherapy completed. Letter from Consultant Oncologist 2 (ConsOnc2) to GP and copied to ConsSurg9, but not to a Consultant Urologist.

26 November 2015 - letter dictated (typed on 27th) by ConsOnc10 to ConsUrol13 and copied to ConsSurg9, regarding ureteric stent change, “*... has undergone a 6 month course of palliative chemotherapy I would be grateful if you could consider if this would be an appropriate time to arrange change of his stent.*”

This was date stamped in the CAH chart 11 December 2015 but there is no Consultant note/signature/handwriting evident on letter.

Copy of same letter in the DHH chart is initialled by ConsSurg9 with a hand-written note, ‘*file and ‘? review date.*’ There is an additional note in red ink, ‘*Due 02/16 already on OPD sorted.*’

30 November 2015 email to ConsUrol13 from his secretary Patient 16 was ringing this morning regarding his change of left nephrostomy drain...”

30 December 2015 – email to ConsUrol13 from his secretary, “*The above patient is on your planned w/l for removal of left ureteric stent, ureteroscopy and ? restenting – October 2015. Mr Patient 16’s daughter was ringing this am regarding a date for her father’s surgery. She advised that her father is experiencing pain and would appreciate a date for his surgery as soon as*

5.0 DESCRIPTION OF INCIDENT/CASE

possible”.

21 January 2016 – attended Oncology clinic. Letter dictated by SpROnc14 to GP; copied to ConsSurg9, but not to a Consultant Urologist. Date stamped in the SHSCT on 4 February 2016, the letter noted, *“He is still awaiting a stent change and I will re-contact the Urology team regarding this”.*

Further treatment options discussed including palliative radiotherapy – once the stent is out.

04 March 2016 – email from audiotypist to ConsUrol13 secretary, *“Patient phoned re TCI date for removal of stent.”*

24 March 2016 - further letter,
dictated by ConsOnc2 to Patient 16's GP;
copied to ConsSurg9, initialled by ConsSurg9;
not copied to a Consultant Urologist;
dictated 24 March 2016 and typed on 22 April 2016; and
date stamped as received in DHH chart on 5 May 2016.

This letter highlighted that CT on 8 February 2016 showed, *‘stable pelvic disease. However, progression of the left hydro-ureter and hydronephrosis with the development of a small right upper lobe pulmonary nodule and progression of a small left upper lobe pulmonary nodule. CEA had also risen Has heard nothing further from urology and unclear whether stent is to be removed or replaced (placed approximately 1 year ago). After discussion, the plan is not to proceed with further chemotherapy presently’.*

09 May 2016 - review by the ConsSurg9; wrote to GP and ConUrol11, to review Patient 16's *‘Please see and review Urological care’. “His main symptoms currently appear to be related to longstanding left ureteric stent which has been in now for about a year and a half. Could you perhaps review whether or not this could be removed/replaced?”*

10 May 2016 - email to ConsUrol13 from his secretary, *“This patient was ringing to advise that he had an appointment with ConsSurg9 yesterday and was told that all of his current symptoms are related to his stent which should have been removed last year Patient 16 would appreciate if you could give him a date very soon to have his stent removed.”*

02 June 2016 - letter dictated/typed following Oncology clinic from SpROnc14 to GP and copied to ConsSurg9, but not to a Consultant Urologist. Date stamped as being received in the DHH chart on 8 June 2016, signed by ConsSurg9. The letter documents, *“I have recommended that we will re-contact the urology team for review and whenever his stent is changed and if his urinary symptoms are stable and creatinine is satisfactory that we could consider palliative IMDG chemotherapy. We will aim to review him back in 10 weeks’ time and will write a letter to ConUrol11 in the meantime”.*

02 June 2016 - letter dictated/typed from SpROnc14 to ConUrol11, requesting *‘your intervention to facilitate his ongoing oncological management’.*

5.0 DESCRIPTION OF INCIDENT/CASE

date stamped in SHSCT on 8 June 2016.

Hand-written note (black ink) stating, *"known to ConsUrol15, stented 3/2015, review imaging, ? 'NT required"*.

Another hand-written note (blue ink), *"very probably. email ConsUrol15 to discuss mane, 22.6.16"*.

24 June 2016 – email from ConsUro13 to his secretary, *"Please send letters of admission admission on 29 June 2016 as follows Patient 16 for Left Ureterography, Ureteroscopy and Removal / Replacement of Left Ureteric stent"*.

The Oncologists continued to review Patient 16 regularly as an outpatient and highlighted at each appointment. *'Options for progressive symptomatic disease were discussed at each of those appointments, which included second line palliative chemotherapy, or palliative pelvic radiotherapy. The timing and choice of modality would depend on a number of factors, including radiological and biochemical indications of progression, performance status, symptomatology, relative risk of urosepsis and patient preference'*. [evidence = Oncology complaint response]

.....however, he was pre-admitted on the 24 June 2016 for 29 June 2016.

29 June 2016 - Admitted for surgery. Note that Mr Patient 16 was added to the waiting list 02 April 2015 with first request by ConsOnc10 to ConsUrol13 made on the 26 November 2015 that chemotherapy had finished i.e. provides evidence for delay.

29 June 2016 – admission. Operated in theatre for elective optical urethrotomy, left sided stent removal and laser to encrustation to distal end and left ureteroscopy under the care of ConsUrol13. Postoperatively, Patient 16 developed Urosepsis and was commenced on antibiotics (Tazocin and Gentamicin post procedure and then Metronidazole).

30 June 2016 – Further procedure, left nephrostomy tube inserted.

06 July 2016 – FY1 note in Clinical record, *"Discuss with ConsUrol13 re long term plan."*

08 July 2016 – email from ConsUrol13 to secretary to place Patient 16 on W/L for stenting.

09 July 2016 - discharged. Discharge letter, Follow-up arrangements were, ConsUrol13, Nephrogram as o/p scan requested.
Please CC discharge letter to ConsUro13 secretary to arranged follow up appointment once nephrogram performed'.

10 July 2016 - added to ConsUrol13's urgent waiting list. Pre-admitted on the 27 July 2016 for 10 August 2016.

22 July 2016 - Oncology review appointment ConsOnc10. Therapeutic options were again

5.0 DESCRIPTION OF INCIDENT/CASE

discussed, with palliative pelvic radiotherapy being the preferred treatment choice, dependent on any further planned urology intervention.

ConsOnc10 notes, the following day he spoke to ConsUrol13, who requested that radiotherapy be postponed until after a further attempt at ureteric stent insertion, which was scheduled to take place in August.

23 July 2016 - letter was dictated to GP; typed on 27 July 2016 (date stamped in SHSCT 04 August 2016 signed by ConsSurg9); copied to the ConsSurg9 and ConsUrol13.

10 August 2016 - admitted to CAH and had uteroscopy (sic) and ureteric stenting.

10 August 2016 - email from ConsUrol13 to secretary to place Patient
16 on W/L for replacement of stent – February 2017.

12 August 2016 - discharged.

Discharge letter arrangements for Follow-up were, *"Neph tube removal in 2/52, Stents changed in 6/12 - ConsUrol13"*.

12 August 2016 - request to radiology by ConUrol11; performed on 1 September 2016. Radiology report documented *"Nephrostomy tube was exchanged in the usual fashion. No immediate complications"*.

13 October 2016 - CT scan showed progression of both pelvic and pulmonary disease, as well as new hepatic metastatic disease.

30 November 2016 – email from ConsUrol13 secretary to ConsUrol13. *"Patient ringing this am regarding change of left nephrostomy drain. He had it changed in September and was due to have it changed again in 12 weeks however he is not on a waiting list for this. Can you please advise."*

01 December 2016 – attended ConsOnc2 clinic; noted Patient
16 was suffering from a urinary tract infection and had problems related to his nephrostomy. CT scan reveals bigger pelvic mass, 2 lung nodules which are bigger and 2 liver metastases.

Note on the 2 December 2016, *"regarding wife and daughter very unhappy with management primarily related to Urology. But also feeling that a lack of liaison between Urology and Oncology has left an opportunity for pelvic radiotherapy being missed..... Whilst I apologised for any delay within our service, the main areas of concern appear to be elsewhere."*

ConsOnc2 spoke with ConsUrol13's secretary and noted, *"arrangements are already in place for nephrostomy tube replacement and ureteric stent removal in Craigavon on 6 December 2016"*.

01 December 2016 – email from ConsUrol13 to secretary requesting formal notification for admission for removal of stent.

5.0 DESCRIPTION OF INCIDENT/CASE

06 December 2016 - admitted to CAH; had an exchange of left nephrostomy tube, flexible cystoscopy, dilation of urethral stricture and removal of left ureteric stent by ConsUrol11 and was discharged on 8 December 2016.

Discharge letter to GP dictated by ConUrol11; copied to ConsUrol13.

09 December 2016 - admitted to DHH with a small bowel obstruction. His care was managed conservatively; he refused surgical intervention and following comfort care, Patient 16 died on Personal Information.

Personal Information redacted by the USI.


21 December 2016 – letter of complaint received in Governance Office, CAH from daughter; letter dated 05 December 2016. Complaint, “*centres on the poor response to communication between Oncology and Urology departments in Craigavon Hospital and the consequences of this which include; unnecessary suffering and denied access to a treatment option for cancer*”.

6.0 FINDINGS

Summary of sequence of events

| | |
|-------------------------|--|
| 11 March 2015 | CT scan detected a left sided pelvic mass, causing hydronephrosis. |
| 12 March 2015 | MDT meeting. ConsUrol11 requested to insert stent. |
| 26 March 2015 | reviewed at ConsUrol15 clinic. |
| 26 March 2015 | reviewed at Oncology clinic, proceed with Chemotherapy. |
| 31 March 2015 | admitted to CAH under care of ConsUrol13 and stent inserted. Operation note, “ <i>Oncologists to contact when chemotherapy complete for stent removal / replacement</i> ”. |
| 02 April 2015 | discharged. “ <i>Urology to be contacted when chemotherapy is completed so that stent removal/change can be planned.</i> ” |
| 02 April 2015 | added to ConsUrol13 Urgent waiting list. |
| 23 April 2015 | Chemotherapy started. |
| 08 October 2015 | Chemotherapy completed. |
| 26 November 2015 | Letter, ConsOnc10 asks ConsUrol13 to consider changing stent. |
| 11 December 2015 | date stamp letter received in Craigavon. |
| 30 December 2015 | email to ConsUrol13 from his secretary, on W/L for October 2015. Daughter rang regarding date for surgery. |
| 21 January 2106 | SpROnc14 to re-contact Urology. Copied to ConsSurg9, not Urology. |
| 04 March 2016 | email from audiotypist to ConsUrol13 secretary, query date for surgery. |
| 24 March 2016 | further letter from ConsOnc2 to ConsSurg9, not Urology. “ ... has heard nothing further from Urology”. Date stamp 5 May 2016. |
| 09 May 2016 | review by ConsSurg9; wrote to ConUrol11. “ <i>Please see and review</i> ” |

6.0 FINDINGS

| | |
|---------------------|---|
| | <i>Urological care. ...stent has been in now for about a 1½ year. Could you perhaps review whether or not this could be removed/replaced?"</i> |
| 10 May 2016 | email to ConsUrol13 from his secretary, " <i>Patient ringing....current symptoms related to stentgive him a date for removal.</i> " |
| 02 June 2016 | letter from SpROnc14 to ConUrol11 requesting, " <i>your intervention to facilitate his ongoing oncological management</i> ". |
| 24 June 2016 | email from ConsUro13 to his secretary, " <i>Please send letters of admission admission on 29 June 2016 as follows</i> "  |
| 29 June 2016 | admission. Operated on for stent removal by ConsUrol13. |

Therefore, after the original stent was inserted on the 31 March 2015 and the patient discharged on the 2nd April 2015, Chemotherapy could start, and the stent would then be removed or replaced 6-9 months later. The last dose of chemotherapy was given on the 8th October 2015 and the letter to ConsUrol13 was sent on the 26th November 2015, (typed on 27th November 2015).

The crucial period regarding any unnecessary delay in treatment and care in this case (as indicated between the entries above in bold) appears to be from the time the patient was deemed ready to have his stent removed or replaced i.e. 26th November 2015, and when he was finally admitted for his surgery i.e. 29th June 2016, a period of 217 days or 31 weeks. Also, did this delay remove a window of opportunity for a course of pelvic radiotherapy?

The 26th November 2015 letter to ConsUrol13 perhaps was not received in CAH until 11th December 2015. There is no evidence that he received and/or acknowledged the receipt of letter. The question is, "Did he ever receive i.e. see, this letter?"

A copy of the 26th November 2015 letter appears to have been received and acknowledged by ConsSurg9 who queried a review date. An entry in red ink (probably secretary) appears to indicate there was an OPD date of 02/16, presumably February 2016. No action seems to have happened following receipt of the 26th November 2015 letter.

An email was sent to ConsUrol13 on the 30th December 2015 indicating the patient was on a waiting list for October 2015 and patient's daughter rang regarding a date for surgery. There appears to be no record of a response to this email.

The next possible reminder to the Urology service was the 21/01/2016 letter. It is uncertain whether SpROnc14 contacted Urology. Letter was copied to ConsSurg9. The letter indicates that palliative radiotherapy was being considered. There is no apparent action taken at this time.

On the 4th March an email to ConsUrol13's secretary indicated the patient had requested a date to come in for removal of stent. There is no apparent action taken at this time.

6.0 FINDINGS

At Oncology clinic review on the 24th March 2016, ConsOnc2 sent another letter to ConsSurg9 indicating disease progression and that nothing further had been heard from Urology. This letter appears to have been typed almost a month later (22/04/2106) and not received in CAH until 5th May 2016. ConsSurg9 seems to have seen this letter.

ConsSurg9 reviewed Patient 16 at Surgical OPD on 9th May 2016 and has then written to ConsUrol11 on the 9th May 2016 asking him to review Patient 16's Urological care.

Then, on the 10 May 2016 a further email sent to ConsUrol13 from his secretary informing ConsUrol13 that the patient rang the office and asked for an appointment to have his stent removed. There is no apparent action taken at this time.

Further letter on the 2nd June 2016 from SpROnc14 to ConsUrol11 asking for his intervention to facilitate oncological management. Letter not copied to ConsUrol13. The Oncology team would consider IMDG chemotherapy once the stent is changed and if his urinary symptoms are stable. This letter, received on the 8 June 2016, has been acknowledged and annotated by ConsUrol11 on the 22 June 2016, which led to an expedited appointment for surgical intervention on 29 June 2016, 454 days after being listed and 217 days after chemotherapy had ceased.

Then, on 24th June 2016 email from ConsUrol13 to secretary requesting admission for Patient 16 on the 29th June 2016 for surgery.

Surgery on the 29th June 2016 proceeds with removal of the stent without replacement. The postoperative course is difficult with a period of urosepsis. Further surgery on 10th August 2016 when stent was inserted with much resistance. Followed by period of disease progression, further Urology surgery in December 2016 with terminal admission shortly afterwards. Patient died on Personal Information redacted by the USI.

In relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental. [Source = Complaint response]

Communication between Oncology service, Surgery and Urology

The Oncology medical staff copied ConsSurg9 into GP correspondence. However, the Review Team noted that Urology was not always copied into all Oncology correspondence. On occasion, there was evidence of Oncology letters sent or copied to,

- ConsUrol13 on 26 November 2015, 23 July 2016 and 2 December 2016.
- SpROnc14 sent to ConsUrol11, dictated on 2 June 2016.

but on others it was not. It appears especially odd that on the 8th October 2015, when chemotherapy was stopped, Oncology wrote to ConsSurg9 but not ConsUrol13 who should

6.0 FINDINGS

have been waiting to hear that information, prior to removal/replacement of the stent, as agreed back in March/April 2105.

Acknowledging receipt and sight of correspondence

In the medical chart, there is evidence that some Consultants signed letters from other specialties and on occasions annotated the letter with instructions including ConsSurg9 and COnsUrol11.

There is no evidence of the letters sent to ConsUrol13 being initialled to acknowledge receipt. The important 26th November 2015 letter from ConsOnc10 to ConsUrol13 initially requesting change of the stent was date stamped in the CAH chart, 11th December 2015, but there is no Consultant note/signature/handwriting evident on letter to acknowledge receipt. This calls into question whether ConsUrol13 was made aware, at that time, that the stent change was required.

However, there were several email communications received shortly afterwards that should have brought this to his attention. This series of communication issues could be characterised as indicating a lack of acknowledging, reviewing and/or actioning correspondence.

Assurance for tracking correspondence

The Review Team noted that letters to Consultants are not tracked and there is no process in place to ensure they have been reviewed and actioned by Consultants.

Correspondence on NIECR

The Oncology service is based in Belfast City Hospital Cancer Centre and the Oncology medical team visit CAH to do clinics. The Oncologists do not have access to Southern HSC Trust intranet services. The Oncologists highlighted, *'Dictated, typed, verified and recorded letters remain the preferred method of communication between disciplines, though admittedly delays can occur due to shortages of administrative staff. On occasions where was a clinical imperative for urgent communication, phone calls and emails were made from Oncologists to the Urology service'*. [Source = Complaint response]

Oncology letters were not available on the NIECR which made reviewing the full patient journey difficult for clinicians.

The Booking Centre Manager has highlighted that on occasions letters may have been filed or held in a backlog with no evidence of Consultant review. On the 4th April 2017 correspondence was sent by the Booking Centre Manager to Operation Support Leads for action by secretaries, this stated *'..... if not on NIECR, filing is a priority. Also, please ensure all your staff know that no letters or results should ever be filed in charts without a Consultant's signature. For example, Oncology letters are not on NIECR and when they are sent to Consultants here, it is up to the Consultant to read the letter, and sign before the*


6.0 FINDINGS

secretary files. It is important that these letters in particular are filed because they are not on NIECR.'

Waiting List

Patients with urological conditions which affect the normal functioning of the upper urinary tract are at risk of losing kidney function and consequently renal failure. The duration of Urology waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting is associated with progressively increasing risk of urosepsis, and its associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months.

Waiting times in Urology are long due to a demand & capacity mismatch. In June 2016, ConsUrol13 had 273 patients on his inpatient day case waiting list, with 158 on his urgent waiting list, 75 of these patients had been waiting over 52 weeks.

When  was added to the urgent Urology waiting list in April 2015, the Urgent Urology Waiting list patients position on 30 June 2016 was,

| 0-13 Wks | 13-17 Wks | 17-21 Wks | 21-26 Wks | 26-31 Wks | 31-36 Wks | 36-41 Wks | 41-46 Wks | 46-52 Wks | Over 52 Wks |
|-------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|----------------|
| 202 | 32 | 36 | 46 | 28 | 25 | 21 | 13 | 11 | 106 |

The longest patient waiting was for over 127 weeks with 6 patients waiting over 114 weeks and 18 patients over 100 weeks.

7.0 CONCLUSIONS

There was a treatment and care delay – specifically, to the changing of ureteric stents, due to,

1. Lack of effective communication systems and processes; and
2. Long Waiting Lists leading to delay.

The Review Team consider that the delay probably was significant in terms of,

- an easier progression through the process of having the stents removed and replaced;
- reduction in the level of pain and discomfort reported towards the end of life.

However, in relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental.

1. Lack of effective communication systems and processes

Contributory factors

Task Factors (policy and guidelines) / Communication

Communication between Oncology and other services can be by telephone in urgent situations but is mostly by letter which can lead to delay or omission in communication in relation to patient care. There were gaps of weeks to over a month between dictation, typing, sending, receipt and acknowledging of letters with action, such as addition to a waiting list, taking further time; followed by time actually waiting while on the waiting list.

Oncology letters were not on NIECR (Note: possibly this has now been rectified) and thus not accessible outside of patients' clinical notes for other clinical teams to access and use when planning treatment.

The Trust has no formal process for tracking letters or emails and ensuring they have been received, acknowledged, reviewed and actioned.

There were also many occasions when letters from Oncology which contained urological issues were not copied to Urology. On some occasions, when they did copy to Urology it was to ConsUrol11 and not the Urologist in charge i.e. ConsUrol13.

Contributory factor

Staff factor

The Review Team noted, throughout this case, the number of times that communication opportunities involving ConsUrol13 appeared to have been missed, resulting in Patient 16's stent not being removed and/or replaced in a timely manner. Throughout this case, there were letters not received or acknowledged, emails not actioned and phone messages from the patient and family that also did not result in action.

2. Long Waiting Lists leading to delay

Contributory factor

Workload/scheduling

The Review Team noted that the long waiting times for Routine and Urgent Urology inpatient and day case treatment contributed in the delay in Patient 16 having his stent changed, and therefore a delay in decisions regarding palliative treatment.

8.0 LESSONS LEARNED

1. Communication between the Oncologists from the Belfast Trust and the Clinicians in the SHSCT was mostly by letter. This appears to be too inefficient with respect to timeliness, especially for potential cancer patients being investigated and cancer patients already on a treatment pathway. Correspondence can also become misplaced or lost especially if it comes in from another Trust.

2. There is no formal Trust guidance/process on what is expected of clinicians when dealing with clinical matters using paper correspondence; particularly for recording receipt, acknowledgement, reviewed and actioned. This should include what is expected of clinicians when triaging referral letters including Consultant to Consultant written documentation. This includes letters where the action required could be the addition to either inpatient or outpatient waiting lists by clinical priority.
3. The SHSCT does not have formal guidance on managing letters e.g. by tracking, to ensure they are managed in a consistent, timely and appropriate way by all clinicians. Good practice was noted by some clinicians.
4. The above lessons learnt also applies to the use of correspondence by email.
5. Correspondence and communication between clinical teams, especially when they involve 'visiting' clinical teams, should include all the SHSCT teams/clinicians directly involved in the patient's care, particularly when they are referred to in the correspondence.
6. Long Urology waiting lists mean that some patients are often unable to be treated in a clinically appropriate time, leading to delay in treatment and care and possible adverse outcomes.

9.0 RECOMMENDATIONS AND ACTION PLANNING

TRUST

Recommendation 1

The Trust will explore and evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR.

Recommendation 2

The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter.

Recommendation 3

The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff.

This guidance will outline the systems and processes required to ensure that all clinical

9.0 RECOMMENDATIONS AND ACTION PLANNING

correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4

The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB

Recommendation 5

In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6

The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.


Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Melanie McClements, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

 family

**Checklist for Engagement / Communication
with Service User¹ / Family / Carer following a Serious Adverse Incident**

| | | | |
|---|---|-------------------------|--|
| Reporting Organisation SAI Ref Number: | <small>Personal Information redacted by the</small> | HSCB Ref Number: | |
|---|---|-------------------------|--|

| SECTION 1 | | | |
|---|----------------------------|--|--------------------------------|
| INFORMING THE SERVICE USER ¹ / FAMILY / CARER | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users. Please select as appropriate (✓) | Single Service User | X | Multiple Service Users* |
| Comment: <i>*If multiple service users are involved please indicate the number involved</i> | | | |
| 2) Was the Service User ¹ / Family / Carer informed the incident was being reviewed as a SAI? Please select as appropriate (✓) | YES | X | NO |
| If YES , insert date informed : 19/04/2017 | | | |
| If NO , please select only one rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being reviewed as a SAI | | | |
| a) No contact or Next of Kin details or Unable to contact | | | |
| b) Not applicable as this SAI is not 'patient/service user' related | | | |
| c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | |
| d) Case involved suspected or actual abuse by family | | | |
| e) Case identified as a result of review exercise | | | |
| f) Case is environmental or infrastructure related with no harm to patient/service user | | | |
| g) Other rationale | | | |
| If you selected c), d), e), f) or g) above please provide further details: | | | |
| 3) Was this SAI also a Never Event? Please select as appropriate (✓) | YES | NO | X |
| 4) If YES , was the Service User ¹ / Family / Carer informed this was a Never Event? Please select as appropriate (✓) | YES | If YES , insert date informed : DD/MM.YY | |
| | NO | If NO , provide details: | |
| For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)) | | | |
| Content with rationale? | YES | NO | |

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

SHARING THE REVIEW REPORT WITH THE SERVICE USER¹ / FAMILY / CARER

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

| | | | |
|---|---|--|-----------|
| | engagement planned to share final report | | |
| | b) Plan to share final review report at a later date and further engagement planned | | X |
| | c) Report not shared but contents discussed (if you select this option please also complete 'I' below) | | |
| | d) No contact or Next of Kin or Unable to contact | | |
| | e) No response to correspondence | | |
| | f) Withdrew fully from the SAI process | | |
| | g) Participated in SAI process but declined review report | | |
| | (if you select any of the options below please also complete 'I' below) | | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user ¹ family/ carer | | |
| | i) case involved suspected or actual abuse by family | | |
| | j) identified as a result of review exercise | | |
| | k) other rationale | | |
| l) If you have selected c), h), i), j), or k) above please provide further details: | | | |
| For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)) | | | |
| Content with rationale? | YES | | NO |

SECTION 2

INFORMING THE CORONERS OFFICE

(under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

| | | | | |
|--|--|-----|----|-----------|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? Please select as appropriate (✓) | YES | | NO | X |
| | If YES, insert date informed : | | | |
| | If NO, please provide details: | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? Please select as appropriate (✓) | YES | | NO | |
| | If YES, insert date report shared : | | | |
| | If NO, please provide details: | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? Please select as appropriate (✓) | YES | | NO | |
| | | N/A | | Not Known |
| | If YES, insert date informed : | | | |
| | If NO, please provide details: | | | |

| | |
|---------------------------------|-------------------|
| DATE CHECKLIST COMPLETED | 31/01/2019 |
|---------------------------------|-------------------|

Service User or their nominated representative

Donna Britton

From: serious incidents
Sent: 07 February 2020 10:10
To: Denise Boulter; Brid Farrell
Cc: Mareth Campbell
Subject: Amended SAI Notification, ToR & Team Membership and RCA Report & Checklist - Trust Ref: SHSCT SAI [Personal Information redacted by the USI] HSCB Ref: [Personal Information redacted by the USI]
Attachments: Amended SAI Notification Form ([Personal Information redacted by the USI]).pdf; TOR & Team Membership [Personal Information redacted by the USI].pdf; RCA Report & Checklist ([Personal Information redacted by the USI]).pdf; Position Report ([Personal Information redacted by the USI]).pdf

Denise and Brid,

Please find attached an **amended** SAI Notification Form, Terms of Reference & Team Membership and RCA Report & Checklist from the **Southern Trust** in relation to:

Trust Ref: SHSCT SAI [Personal Information redacted by the USI]

HSCB Ref: [Personal Information redacted by the USI]

**Please be advised that this was initially reported as a Level 1. The Southern Trust have now carried out a Level 3 Review as they wanted to involve an independent person in the investigation.*

Also attached is a Position Report detailing all activity in relation to this incident.

If you require advice in relation to **medication related issues** please contact:

- Caitlin Bradley, email: [Personal Information redacted by the USI] (*relating secondary care issues*) or;
- Brenda Bradley and copy to Matthew Dolan (*relating to Primary Care issues*).

In the case of interface incidents where there are both primary and secondary care issues, all three above people should be contacted.

This SAI will be listed for the next Professional SAI Review Team Meeting for:

1. Discussion re Level of Review
2. Approval / non approval of Terms of Reference & Team Membership
3. Review of RCA Report & Checklist

However, please advise if any action is required prior to the meeting.

Many Thanks

Róisín

Róisín Hughes

Governance Support Officer
 Corporate Services Department
 Health & Social Care Board
 Tower Hill
 Armagh

E: [Personal Information redacted by the USI]

T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto: [Personal Information redacted by the USI]]
Sent: 06 February 2020 14:58
To: serious incidents
Subject: SAI Report (Final Learning Report/RCA Report) & Checklist [Personal Information]

Good Afternoon,

Please find attached RCA Report and checklist for your attention. I have also attached a copy of the Terms of Reference and amended SAI notification.

This SAI was first notified as a level 1, the Southern Trust conducted a level 3 as they wanted to involve an independent person in the investigation.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]

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

Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Donna Britton

From: serious incidents
Sent: 07 February 2020 10:29
To: 'Corporate.Governance'
Subject: Acknowledgement of Amended Notification, ToR & Team Membership and RCA Report & Checklist - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Diane,

Trust Ref: SHSCT SAI [Personal Information]

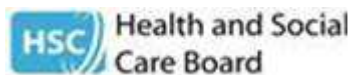
HSCB Ref: [Personal Information]

This communication acknowledges receipt of the Amended Notification, Terms of Reference & Team Membership and RCA Report submitted to the HSCB seriousincidents@hscni.net mail box in respect of the above Incident.

Many Thanks

Róisín

Roisin Hughes



Governance Office - HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 06 February 2020 14:58
To: serious incidents
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Kind Regards

Diane

Corporate Clinical & Social Care Governance Office

Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone Personal Information redacted
by the USI

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Donna Britton

From: Brid Farrell
Sent: 10 February 2020 13:13
To: serious incidents; Denise Boulter
Cc: Mareth Campbell
Subject: RE: Amended SAI Notification, ToR & Team Membership and RCA Report & Checklist - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

This is a level 2 report

This should be considered by the acute SAI team

From: serious incidents
Sent: 07 February 2020 10:10
To: Denise Boulter; Brid Farrell
Cc: Mareth Campbell
Subject: Amended SAI Notification, ToR & Team Membership and RCA Report & Checklist - Trust Ref: SHSCT SAI [Personal Information] HSCB Ref: [Personal Information]

Denise and Brid,

Please find attached an **amended** SAI Notification Form, Terms of Reference & Team Membership and RCA Report & Checklist from the **Southern Trust** in relation to:

Trust Ref: SHSCT SAI [Personal Information]
HSCB Ref: [Personal Information]

**Please be advised that this was initially reported as a Level 1. The Southern Trust have now carried out a Level 3 Review as they wanted to involve an independent person in the investigation.*

Also attached is a Position Report detailing all activity in relation to this incident.

If you require advice in relation to **medication related issues** please contact:

- Caitlin Bradley, email: [Personal Information redacted by the USI] (*relating secondary care issues*) or;
- Brenda Bradley and copy to Matthew Dolan (*relating to Primary Care issues*).

In the case of interface incidents where there are both primary and secondary care issues, all three above people should be contacted.

This SAI will be listed for the next Professional SAI Review Team Meeting for:

1. Discussion re Level of Review
2. Approval / non approval of Terms of Reference & Team Membership
3. Review of RCA Report & Checklist

However, please advise if any action is required prior to the meeting.

Many Thanks

Roísín

Roisin Hughes

Governance Support Officer
Corporate Services Department
Health & Social Care Board
Tower Hill
Armagh

E: [Personal Information redacted by the USI]
T: [Personal Information redacted by the USI]

From: Corporate.Governance [mailto:[Personal Information redacted by the USI]]
Sent: 06 February 2020 14:58
To: serious incidents
Subject: SAI Report (Final Learning Report/RCA Report) & Checklist [Personal Information]

Good Afternoon,

Please find attached RCA Report and checklist for your attention. I have also attached a copy of the Terms of Reference and amended SAI notification.

This SAI was first notified as a level 1, the Southern Trust conducted a level 3 as they wanted to involve an independent person in the investigation.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office
Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Donna Britton

From: Donna Britton
Sent: 15 May 2020 16:54
To: 'Corporate.Governance'
Subject: Review level: SAI Report (Final Learning Report/RCA Report) & Checklist

Personal Information

Diane

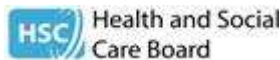
Members of the Safety and Quality Review Team agreed the Terms of Reference and Membership submitted for the above SAI does not meet the requirements of a Level 3 SAI Review.

However this case will be considered as a SAI Level 2 Review by the HSCB / PHA Acute Group at their next meeting.

I will provide outcome in due course.

Warm Regards

Donna Britton



Governance Support Officer | HSCB | Tower Hill | Armagh | BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

From: Corporate.Governance [mailto:[Personal Information redacted by the USI](#)]
Sent: 06 February 2020 14:58
To: serious incidents
Subject: SAI Report (Final Learning Report/RCA Report) & Checklist

Personal Information

Good Afternoon,

Please find attached RCA Report and checklist for your attention. I have also attached a copy of the Terms of Reference and amended SAI notification.

This SAI was first notified as a level 1, the Southern Trust conducted a level 3 as they wanted to involve an independent person in the investigation.

Kind Regards

Diane

Corporate Clinical & Social Care Governance Office

Corporate Governance Assistant
Beechfield House
Craigavon Area Hospital Site
Telephone [Personal Information redacted by the USI]

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Donna Britton

From: Louise Herron
Sent: 30 June 2020 13:18
To: Cara Anderson; David McCormick
Cc: Mareth Campbell
Subject: SAI
Attachments: RCA Report and Checklist (Personal Information).pdf

Hi both,

For information but not for sharing.

We reviewed this SAI report today and I agreed that I would send on to you for information re urology waiting lists. Please note the date of the SAI was 2016.

Password to follow

Thanks,

Louise

Dr Louise Herron

*Consultant in Service Development and Screening
Public Health Agency
12-22 Linenhall Street
Belfast
BT2 8BS*

Personal Information
redacted by the USI

Please note I work Monday, Tuesdays and Fridays

Sarah McClatchey

From: Hugo Van Woerden
Sent: 24 August 2020 17:07
To: Paul Cavanagh
Subject: RE: CONFIDENTIAL

Sure

From: Paul Cavanagh
Sent: 24 August 2020 17:00
To: Hugo Van Woerden; Lisa McWilliams
Cc: Valerie Watts; Brid Farrell; Olive MacLeod
Subject: RE: CONFIDENTIAL

Hugo

It would be useful that we discuss asap given Jackie's email (attached). I am in LHS tomorrow although unable to attend SMT. Perhaps after RCG?

Paul

From: Hugo Van Woerden
Sent: 24 August 2020 10:13
To: Paul Cavanagh; Lisa McWilliams
Cc: Valerie Watts; Brid Farrell; Olive MacLeod
Subject: CONFIDENTIAL

Dear Paul

I have suggested to Maria that:

1. There may be a case for a QI piece of work to develop learning for the trust, perhaps using tools such as the five whys and undertaking process mapping of the patient flow. I do wonder if the focus at present is too much on one individual, whereas my experience is that things are often more 'system level issues'.
2. There are three ways forward:
 - a. Internal review led by the Trust – if seen as an internal issue
 - b. Regional review lead by HSCB/PHA – if affecting several organisations
 - c. DoH led review – if considered of wider significance

My understanding is that Maria is considering a 5 years as the framework for a look back.

I think that there needs to be an early decision as to what level this is being taken forward – trust, regional or DoH. I have copied Brid in, as I would require support from her team if there is a regional component.

Best wishes

Hugo

From: Paul Cavanagh
Sent: 24 August 2020 09:35
To: Lisa McWilliams; Hugo Van Woerden
Cc: Valerie Watts
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Lisa, Hugo

I have spoken to Aldrina Magwood about this. The issue is largely related to record-keeping and there are concerns of delayed care due to this. The consultant concerned has retired. To date there have been 3 SAs raised and there may be more. There are no plans for further lookbacks.

The pressures facing ST urology could be alleviated somewhat by WT accelerating taking on Fermanagh patients as the additional staff are in place to facilitate this. I will follow up on this. ST is also recruiting 2 consultant urologist posts at present.

I have asked Aldrina to speak to Maria O'Kane and that it may be useful for Maria to contact me. Aldrina suggested that Maria has been in contact with PHA and DoH but this may not be the case.

I would like to go back to DoH with an update asap and would appreciate if you would let me know if there is anything you wish to add.

Paul

From: Johnston, Jackie (DoH) [<mailto:Personal Information redacted by the USI>]
Sent: 21 August 2020 16:07
To: Paul Cavanagh; Olive MacLeod
Cc: [michael.mcbride](mailto:michael.mcbride@usl.nhs.uk) Personal Information redacted by the USI; Wilson, Ryan (DoH)
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Paul and Olive

I'm unsighted as to the extent to which the Southern Trust has involved HSCB and PHA colleagues in this matter. I've attached the EA notification. Ryan is on leave so I've replied that I could meet at 2pm on Monday. HSCB and PHA would need to be involved as the Department will look to you to provide advice on assessing the need for a recall/lookback and if required submit this to the Minister for approval. We would also look to HSCB/PHA to oversee the governance and process if a lookback/recall is required.

Regards

Jackie

From: Wallace, Stephen [<mailto:Personal Information redacted by the USI>]
Sent: 21 August 2020 15:29
To: Wilson, Ryan (DoH) <Personal Information redacted by the USI>
Cc: Johnston, Jackie (DoH) <Personal Information redacted by the USI>; OKane, Maria <Personal Information redacted by the USI>; Geoghegan, Lourda <Personal Information redacted by the USI>; Chada, Naresh <Personal Information redacted by the USI>; Greenwood, Victoria <Personal Information redacted by the USI>; Campbell, Emma <Personal Information redacted by the USI>; OKane, Maria <Personal Information redacted by the USI>
Subject: RE: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Dear Ryan,

Further to the CMO's email below can you advise if you are available to take a call / zoom meeting on Monday (24th) anytime between 1pm-3pm with Dr O'Kane in the first instance.

To date discussions have been held to date with Dr Chada, Dr Brid Farrell and Professor Von Woerden, NHS Resolution, the GMC and we have had a number of discussions with the Royal College of Surgeons. Following on from the early alert notification and further to these discussions on behalf of the Trust we require advice on how to

proceed in relation to any potential lookback required. This is in keeping with the 2007 DOH lookback guidance which highlights the key role of the DOH in this process.

The Trust is processing SAls in relation to these concerns and the discussions are being held locally with patients and families. If you wish to discuss further you can reach me on [redacted] .

Best Regards
Stephen

Stephen Wallace
Interim Assistant Director of Clinical and Social Care Governance
Mob: [redacted]

From: Gordon, Lesley [mailto:[redacted]]
Sent: 21 August 2020 08:46
To: OKane, Maria
Cc: Johnston, Jackie (DoH); Wilson, Ryan (DoH); OKane, Maria; Geoghegan, Lourda; Chada, Naresh; Wallace, Stephen; Greenwood, Victoria
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Maria

As Trust Medical Director grateful if you could liaise/discuss with PHA/HSCB in the first instance and thereafter the relevant Departmental Policy Lead. CMO group will provide all necessary professional advice.

Many thanks.

Lesley

Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21
Castle Buildings
Stormont
BELFAST BT4 3SQ
Tel: [redacted]



Stay Home Stay Safe

From: OKane, Maria [mailto:[redacted]]
Sent: 20 August 2020 23:46
To: Lesley.Gordon [redacted]
Cc: Wallace, Stephen <[redacted]>
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Dear Michael,

I wonder would it be possible to have a phonecall to discuss please?

I would welcome your thought about whether the Department of Health wishes to consider a Patient Service Review / Look Back Exercise in keeping with the DOH 2007 or other guidance please and the extent of this potentially?

Finally Dr Dermot Hughes previously MD Western Trust has agreed to independently chair the 3 initial SAs that have come to the Trust's attention since June 2020. He has recommended including an expert service user which I would welcome but your thoughts on this would be very helpful please.

Kindest regards, Maria

From: McBride, Michael [<mailto:> Personal Information redacted by the USI]
Sent: 19 August 2020 11:09
To: OKane, Maria; Wilson, Ryan (DoH)
Cc: Johnston, Jackie (DoH); Geoghegan, Lourda; Chada, Naresh; DoH Early Alert
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Maria,

Thank you for forwarding

I write to acknowledge receipt and to advise that I forwarded to the relevant policy lead Ryan Wilson.

Please keep Ryan and secondary care colleagues updated.

Michael

Sent with BlackBerry Work
(www.blackberry.com)

From: Gordon, Lesley <Personal Information redacted by the USI>
Date: Wednesday, 19 Aug 2020, 8:40 am
To: McBride, Michael <Personal Information redacted by the USI>, Geoghegan, Lourda <Personal Information redacted by the USI>, Chada, Naresh <Personal Information redacted by the USI>
Subject: FW: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Please see update below received from Mara's O'Kane.

Many thanks

Lesley

Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21

Castle Buildings
Stormont
BELFAST BT4 3SQ

Tel: Personal Information
redacted by the USI



Stay Home Stay Safe

From: Wallace, Stephen [[mailto:](#)Personal Information
redacted by the USI] **On Behalf Of** OKane, Maria
Sent: 18 August 2020 22:23
To: Gordon, Lesley Personal Information
redacted by the USI >
Subject: HPRM: MM/0121/2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology

Dear Michael,

I hope you have had a well-earned break, further to the attached I would like to update you on some aspects of this early alert. The doctor involved has now retired and we are in contact with him through his legal representative. Following on from the advice of NHS Resolutions and the GMC he has agreed not to see private patients. I do not have an oversight of his previous private patients. To the best of my local knowledge he is not working for another Trust and is not registered with the Medical Council of Ireland. We are concerned about patients who were under the doctor's care.

I spoke to Dr Naresh Chada when you were on leave and Dr Brid Farrell and have made contact with Professor Hugo Van Woerden regarding the HSCB / PHA role. We are continuing to liaise with the GMC regarding professional matters and in tandem have continued to consider any potential quality of care issues. We have spoken to the IRS of the RCS to engage with BAUS to consider the import and extent of our findings and to access subject matter experts in relation to SAIs.

Given our information to date I feel we are at a point where we need to make a decision on the requirement for a formal look back exercise and what the nature and scope of such a process would look like. You are familiar with the Department of Health 2007 Guidance *'Conducting Patient Service Reviews / Lookback Exercises'* which states that any decision to progress with a lookback exercise will be taken jointly by the HSCB and Department of Health (Introduction - Section 1.4).

I would appreciate guidance on the following:

- The information required by the Department of Health to allow for a determination to be made on the requirement for a look back
- If there is a requirement by the Department of Health to issue an Alert letter regarding the clinician
- Any other actions the Trust should be taking currently

Though clinical necessity and in the spirit of openness and candour, one of the consultants has met with a patient and his relatives recently to explain that the patient's care has been impacted by clinician delays.

We are preparing to contact the service users impacted as part of the SAI process, we are keen to ensure that our initial contact provides the service users with full information regarding the circumstances of the identified incidents therefore a determination on the scope of this work will help inform our discussions.

I am happy to discuss the details of this case via phone call if this would be suitable

Kindest Regards Maria

Personal Information
redacted by the USI

From: Gordon, Lesley [<mailto:> Personal Information redacted by the USI]
Sent: 17 August 2020 10:53
To: Wallace, Stephen
Subject: RE: CONFIDENTIAL EARLY ALERT

Stephen

I have spoken to Dr McBride and he has asked if Mara could email him with an update.

Many thanks

Lesley

Lesley Gordon
Personal Secretary to:
Dr Naresh Chada (DCMO) &
Dr Lourda Geoghegan (DCMO)
Department of Health
Room C5.21
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Stay Home Stay Safe

From: Wallace, Stephen [<mailto:> Personal Information redacted by the USI]
Sent: 17 August 2020 09:57
To: Gordon, Lesley <Personal Information redacted by the USI>
Subject: CONFIDENTIAL EARLY ALERT

Lesley, please find attached as discussed

Thanks
Stephen

Stephen Wallace
Assistant Director of Clinical and Social Care Governance
Mob: Personal Information redacted by the USI

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