		1st Feb am, pm (no ENP) 2nd Feb am 9th Feb am, pm 14th Feb am, pm 21st Feb pm 22nd Feb pm 24th Feb am, pm (no cover) 25th Feb am 4th Mar am 7th Mar am, pm 12th Mar am 16th Mar am, pm 17th Mar am, pm 20th Mar pm 22nd Mar am, pm 24th Mar am, pm 27th Mar am, pm (no max, min temps) 30th Mar am, pm 31st Mar am, pm				• of Feb into early Mar were between 0 and 2°C, with no record of action. • Current temperature on 3rd Mar am and pm 1.5°C and 1.4°C respectively. • 6 dates missed in a month is Datix reportable. Submitted by CCrom for Jan, Feb and Mar respectively.	
AMU	317882		Email sent to LC, no response as of 18/05/22 Medicine's Fri follow-up audi				

OPD CAH-ENT	331623		Unable to see.			• Current temperature on the 3rd and 7th Feb was 8.3°C and 8.8°C respectively; no record of action having been taken.	Email sent to JP.
OPD CAH-Ramone	043724	Dates missed:- 7th Mar pm 24th Mar pm 31st Mar pm (no time stated)	Nutrient drink on top shelf.			• On a few occasions in March the max temperature exceeded 8°C, no record of action having been taken or line manager informed.	
OPD CAH-Neurology			X1 item stored in door.			• Evidence of weekly cleaning schedule. • Ensure that "closed" is written in space on days when clinic is off.	

Thorndale	331813						
Trauma ward	171220	Dates missed:- 3rd Feb pm 8th Feb pm 9th Feb pm					Spoken to LC.
Ortho ward	C53025	Dates missed:- 13th Jan pm 23rd Jan am, pm 24th Jan am, pm 27th Jan pm 11th Feb am 19th Feb pm 4th Mar am 7th Mar am 23rd Mar pm 24th Mar am	Items stored at bottom and near top fan.			6 dates missed in a month is Datix reportable. To be submitted by CCrom for Jan 2022.	Spoken to JO.
DPU	333006		Items stored at bottom of fridge.		Key left in lock.		Email sent to UG.

Elective admissions	326901	Dates missed:- 16th Jan am 28th Jan pm (no signature) 30th Jan pm (no signature) 9th Feb am 13th Feb pm 16th Feb am 19th Feb am 27th Feb am 2nd Mar am 4th Mar pm 10th Mar pm				• From 26th Feb pm to 28th Feb pm current temperatures were >8°C; no recorded action taken. • 1st Mar am, pm Ward manger was then notified!	Spoken to BO'N
3 south	325952	Dates missed:- 8th Jan pm 1st Feb am 14th Feb pm 23rd Feb pm 1st Mar pm 10th Mar am 31st Mar am	Items stored at bottom of fridge. EQA samples also stored in fridge.	Unable to see.		• Query thermometer not being reset as max temperatures in Jan at around 14° on numerous occasions. • Max temperatures frequently >8°C with no record of action being taken. • Max temperature on 2nd Feb was 20°C!	Spoken to LW.

4 north	29229	Dates missed:- 29th Jan pm 5th Feb am, pm 6th Feb am 13th Feb pm 14th Feb am 15th Feb am 5th Mar am 7th Mar am 28th Mar am (no time recorded) 30th Mar pm (no time recorded)	Antibiotics and TPN stored at bottom of fridge.			• Max temperatures frequently >8°C and occasions when <2°C with no evidence of action taken on logs. • Current temperatures on 12th and 13th Jan was 8.4 and 8.9°C respectively (no action recorded). EMcC states that she intends to order a bigger fridge. • 6 dates missed in a month is Datix reportable. To be submitted by CCrom	Spoken to EMcC.

						for Feb 2022.	
4 south				Unable to see.			Spoken to KW who will pass onto AK.
ICU (TPN Fridge)	320104		(see email attachment)		(see email attachment)	Medicine's Fridge Follow-up audit Apı	
ICU (Fridge 2)	319960		(see email attachment)		(see email attachment)	Medicine's Fridge Audit.msg	
Recovery	41210	Date missed:- 8th Feb am		Label on plug.	Fridge located in main Recovery; Restricted Area.	Medicine's Fridge Audit.msg	Spoken to AS.

Recovery Pharmacy Fridge	317315	Dates missed:- 8th Feb am 15th Mar pm 26th Mar am		Label on plug.	Fridge located in locked room which required fob access.	Medicine's Fridge Audit.msg	
Theatre 1		Dates missed:- 10th Jan pm 26th Mar pm (no min temperature) 27th Mar am				• Max temperature consistently above 8°C! Query issue with fridge as comment "pulled out" frequently used. Occasionally current temperature >8°C • Please ensure signature of line manager recorded on logs. Medicine's Frid Audit.msg	Email sent to PJ and other Theatre staff. RE Theatre's 1 to Medicine's Fridge

Theatre 2		Dates missed:- 24th Feb pm 25th Feb am				• Max temperatures frequently above 8°C with no record of action taken.  Medicine's Frid Audit.msg	
Theatre 3		Date missed:- 28th Mar am (no max temperature)				• Occasions at beginning of Jan 22 when max temperature was >8°C with no record of action taken. • Query as to whether pharmacy was contacted on 19th, 20th Jan regarding integrity of drugs as fridge	

						temperature had reached 22.4°C. • Logs very difficult to read!  Medicine's Frid Audit.msg	
Theatre 4						**No medicine's fridge in this area!**	
Endoscopy		Dates missed:- 10th Jan pm 12th Jan pm 20th Jan pm 21st Jan pm 22nd Jan pm 25th Jan pm 26th Jan am 15th Feb pm 23rd Feb pm 1st Mar pm 13th Mar am 13th Mar pm				• Max temperature consistently above 8°C with no record of action taken! • Current temperature on 8th Feb pm was 8.5°C with no record of action taken! • 6 dates missed in a	

						month is Datix reportable. To be submitted by CCrom for Jan 2022.  Medicine's Frid Audit.msg	
Theatre 5	C58890	Dates missed:- 10th Feb am 11th Feb pm	A few items stored at bottom.		Restricted Area (Fridges opened every morning and locked again at night)	• JO'H informed me that a new fridge has been ordered for this area. • Max temperature on 19th Feb 10.5°C; no record of action taken.  Medicine's Frid Audit.msg	Spoken to JO'H.

Theatre 6	300774	Dates missed:- 10th Jan pm 15th Jan am 17th Mar pm 26th Mar am 29th Mar pm			Restricted Area (Fridges opened every morning and locked again at night)	• Multiple occasions when max temperatures were >8°C; no evidence on logs of Line Manager being informed.  Medicine's Frid Audit.msg	
Theatre 7	C57863	Dates missed:- 15th Jan pm 16th Jan pm			Restricted Area (Fridges opened every morning and locked again at night)	• Two occasions when max temperatures were >8°C; no evidence on logs of Line Manager being informed.  Medicine's Frid Audit.msg	

Theatre 8	C59748	Dates missed:- 15th Jan pm 2nd Feb pm			Restricted Area (Fridges opened every morning and locked again at night)	• Occasions when max temperatures were >8°C; no evidence on logs of Line Manager being informed.  Medicine's Frid Audit.msg	
Theatre 5-8 (Store)	C53027	Dates missed:- 17th Jan pm 2nd Feb am 10th Feb am	Bone cement was stored at bottom of fridge, however this has no requirement to be refrigerated.	Plug with label.	Fridge was opened, however store room locked at night.	• X1 occasion when max temp was >8°C; no evidence on logs of Line Manager being informed.  Medicine's Frid Audit.msg	

Current % compliance	**88%**	**24%**	**47%**	**93%**	**55%**	
October 2021 % Compliance	83%	15%	18%	75%	58%	
June 2021 % Compliance	79%	14%	17%	57%	62%	
February 2020 % compliance		32%	59%	74%	71%	
November 2019 % Compliance		16%	39%	67%	69%	
August 2019 % Compliance		21%	31%	59%	77%	
April 2019 % Compliance		15%	8%	63%	61%	
January 2019 % Compliance		20%	17%	61%	76%	

Divisional Percentage Compliance for each Audit Standard

Division	Is there an Asset ID sticker on the fridge?	Has the fridge temperature been checked twice daily on working days in January, February and March?	Is the Fridge stocked as per SOP?	If fridge is not spurred into wall is there a sign advising fridge should never be disconnected?	Is fridge locked?
ATICS and SEC	90%	29%	59%	100%	46%
IMWH	90%	30%	20%	78%	40%
Medicine	100%	25%	43%	83%	63%
Unscheduled Care	100%	17%	20%	100%	60%
CCS	50%	0%	83%	100%	67%

Compliant	Partly Compliant/In-Progress	Non-Compliant

Auditee(s): Personal Information redacted by the USI

Medicine

Audit Questions	CAH 1 South RAG Rating	CAH 1 South Evidence/Observations	CAH Cath Lab RAG Rating	CAH Cath Lab Evidence/Observations	DHH Renal Unit RAG Rating	DHH Renal Unit Evidence/Observations
Date Audit Began	30/05/2022		21/04/2022		26/04/2022	
Is there a trained equipment controller and deputy in the ward/department?		[redacted]		[redacted]		[redacted]
Policy and Procedures						
Can you show me a copy of the Trust's most up to date Equipment Management Policy/or how to find it on Sharepoint?		[redacted]		[redacted]		[redacted]
Can you show me a copy of the Trust's most up to date Equipment Procedures Manual/or how to find it on Sharepoint?		(As above)		(As above)		(As above)
Equipment Inventory						
Is there an equipment asset list available at ward/department level?		[redacted]		Equipment folder in Sister's office.		[redacted]
Is the asset list up to date? (updated within the last 12 months)		Yes it is currently up to date.		[redacted]		[redacted]
Has any equipment which has been condemned within the last 12 months been removed from the asset register?	N/A	No equipment has been condemned within the last 12 months.	N/A	[redacted]		[redacted]
Is an asset sticker present on the pieces of equipment checked during audit? (Select x3 random pieces of equipment to check compliance and note ID's)		Syringe pump 325871, Nebuliser 335971, Syringe Driver 306545		Infusion Pump 159326, Nebuliser 326580, Suction Pump 160724		Zoll R Series Defibrillator 332613, Fesensius Dialysis Machine 330932, Covidien Genius 3 Thermometer 340009
Are there manufacturer's instructions available for equipment and/or do you know how to access them on Sharepoint?		[redacted]		Manuals etc. are stored in cupboard within the Housekeepers office. Unsure of specific manuals that are there. Also available on Sharepoint.		[redacted]
Are the instructions up to date?		(See above)		Manuals etc. are stored in cupboard within the		[redacted]
Procurement						
If there has been new equipment purchased by the ward / department within the last 12 months is there evidence that a pre purchase checklist was completed?	N/A	[redacted]	N/A	[redacted]		[redacted]
Was a TDA (Technical Design Authority) form and/or Business Case completed (if applicable) for equipment purchased within the last 12 months?	N/A	[redacted]	N/A	[redacted]	A	[redacted]
Delivery and Pre-Use Checks						
For new equipment purchased within the past 12 months is there evidence that an acceptance form has been completed?	N/A	[redacted]	N/A	[redacted]		[redacted]
If new equipment is a replacement for an older model of equipment have these manuals been removed from use?	N/A	[redacted]	N/A	[redacted]		[redacted]
Traning and Competency						
Are there training/competency records held at ward/department level for existing equipment?	Info not provided	7469764.msg		[redacted]		[redacted]
For equipment that has been purchased within the last 12 months is there evidence that all relevant staff received formal training from the supplier or authorised other?	Info not provided	7469764.msg	N/A	[redacted]		[redacted]
Have all new staff completed an induction Checklist for Equipment Management as part of their induction training?	Info not provided	7469764.msg		[redacted]		[redacted]
Is the patient safety poster on display?		[redacted]		[redacted]		[redacted]
Maintenance and Repair						
Is there evidence that good practice is adhered to for the storage of equipment?		[redacted]		Equipment stored in separate room. Area is clean and dry.		[redacted]
Select one piece of equipment with a requirement for daily pre-use checks; are the required daily checks fully completed, signed and dated for the previous full month? i.e no gaps in records. If gaps are noted (missing daily checks, signatures or dates) was appropriate action taken i.e recorded on daily check sheet; details recorded in Communications Book,: and/or Incident reported	Info not provided	7469764.msg		Checked Daily log for Crash Trolley Defibrillator for month of March 2022.		[redacted]
Is there a designated segregation area for equipment needing decontamination or repair?		[redacted]		Items are stored in Housekeepers office. Sign on whiteboard to notify staff of where to place items.		[redacted]
Incident Reporting						
Within the past 12 months has a fault report been completed and sent to the Technical Services team / estates department for any medical equipment requiring repair?		[redacted]	N/A	None reported.		[redacted]
Prior to equipment being sent for repair in the past 12 months is there evidence that the equipment has been cleaned in accordance with manufacturer's instructions? Has a decontamination form been completed?		[redacted]	N/A	[redacted]		[redacted]
If there has been any incidents relating to medical devices / equipment within the last 12 months, have they been reported on Datix?	Info not provided	7469764.msg		[redacted]		[redacted]
Are there "do not use" labels available at ward level?		[redacted]		[redacted]		[redacted]
Decontamination						
Can you show me where to find the Trust's Decontamination Policy and supporting procedures		[redacted]		[redacted]		[redacted]
Can you show me how to find information on infectin control procedures, i.e. IPC Toolkit?		[redacted]		[redacted]		[redacted]
Is there evidence of a decontamination schedule for medical devices / equipment available at ward or department level?	Info not provided	7469764.msg		[redacted]		[redacted]

Unscheduled Care

Audit Questions	CAH ED RAG Rating	CAH ED Evidence/Observations	DHH DAU RAG Rating	DHH DAU Evidence/Observations	DHH ED RAG Rating	DHH ED Evidence/Observations
Date Audit Began	17/05/2022		26/04/2022		25/04/2022	
Is there a trained equipment controller and deputy in the ward/department?		[redacted]		[redacted]		[redacted]
Policy and Procedures						
Can you show me a copy of the Trust's most up to date Equipment Management Policy/or how to find it on Sharepoint?		[redacted]		This document was present in the Equipment folder. CC has shown how to access this on Sharepoint.		In ED Equipment Resource File. CC also stated this can be found on Sharepoint and is in the process of being updated.
Can you show me a copy of the Trust's most up to date Equipment Procedures Manual/or how to find it on Sharepoint?		(As above)		(As above)		In ED Equipment Resource File. CC also stated this can be found on Sharepoint and is in the
Equipment Inventory						
Is there an equipment asset list available at ward/department level?		[redacted]		[redacted]		[redacted]
Is the asset list up to date? (updated within the last 12 months)		[redacted]		[redacted]		[redacted]
Has any equipment which has been condemned within the last 12 months been removed from the asset register?	A	[redacted]		[redacted]		[redacted]
Is an asset sticker present on the pieces of equipment checked during audit? (Select x3 random pieces of equipment to check compliance and note ID's)		322577, Midway Vital Signs Monitor 335978, Fresensius Agilia Syringe Pump 325933		Infusion Pump Fresenius Agilia 331155, Welch Allyn Connex Vital Signs Monitor 337399, Zoll R Series Trolley Defibrillator 331145.		[redacted]
Are there manufacturer's instructions available for equipment and/or do you know how to access them on Sharepoint?		[redacted]		[redacted]		[redacted]
Are the instructions up to date?		[redacted]		[redacted]		[redacted]
Procurement						
If there has been new equipment purchased by the ward / department within the last 12 months is there evidence that a pre purchase checklist was completed?		[redacted]		[redacted]	N/A	[redacted]
Was a TDA (Technical Design Authority) form and/or Business Case completed (if applicable) for equipment purchased within the last 12 months?	N/A	[redacted]	/A	[redacted]	N/A	[redacted]
Delivery and Pre-Use Checks						
For new equipment purchased within the past 12 months is there evidence that an acceptance form has been completed?		[redacted]		[redacted]	N/A	[redacted]
If new equipment is a replacement for an older model of equipment have these manuals been removed from use?		[redacted]		[redacted]		[redacted]
Traning and Competency						
Are there training/competency records held at ward/department level for existing equipment?		[redacted]		[redacted]		[redacted]
For equipment that has been purchased within the last 12 months is there evidence that all relevant staff received formal training from the supplier or authorised other?		[redacted]	N/A	[redacted]	N/A	[redacted]
Have all new staff completed an induction Checklist for Equipment Management as part of their induction training?		[redacted]		[redacted]		[redacted]
Is the patient safety poster on display?		[redacted]		[redacted]		[redacted]
Maintenance and Repair						
Is there evidence that good practice is adhered to for the storage of equipment?		[redacted]		[redacted]		[redacted]
Select one piece of equipment with a requirement for daily pre-use checks; are the required daily checks fully completed, signed and dated for the previous full month? i.e no gaps in records. If gaps are noted (missing daily checks, signatures or dates) was appropriate action taken i.e recorded on daily check sheet; details recorded in Communications Book,: and/or Incident reported		X3 blanks in Crash Trolley (Defibrillator) record for April 2022 ED Yellow Area.	Info not provided	DF43EC5B.msg		Crash-Trolley Defibrillator. A couple of gaps present. LS will remind all staff to ensure checklists are recorded daily.
Is there a designated segregation area for equipment needing decontamination or repair?		[redacted]		[redacted]		There is no specific area however most equipment requiring repair would be left in the Sister's office.
Incident Reporting						
Within the past 12 months has a fault report been completed and sent to the Technical Services team / estates department for any medical equipment requiring repair?		Yes. Multiple records available on Backtraq system.		[redacted]		Electronic records are present for DHH ED on the EBME Helpdesk.
Prior to equipment being sent for repair in the past 12 months is there evidence that the equipment has been cleaned in accordance with manufacturer's instructions? Has a decontamination form been completed?		[redacted]		[redacted]		[redacted]
If there has been any incidents relating to medical devices / equipment within the last 12 months, have they been reported on Datix?	/A	No incidents have been recorded.	N/A	[redacted]	N/A	[redacted]
Are there "do not use" labels available at ward level?		Yes there is a supply of these.		[redacted]		[redacted]
Decontamination						
Can you show me where to find the Trust's Decontamination Policy and supporting procedures		CC has stated that this is available on Sharepoint.		[redacted]		[redacted]
Can you show me how to find information on infectin control procedures, i.e. IPC Toolkit?		[redacted]		[redacted]		[redacted]
Is there evidence of a decontamination schedule for medical devices / equipment available at ward or department level?		Yes cleaning schedule available for each area.		[redacted]		[redacted]

IMWH

Audit Questions	CAH 2 West RAG Rating	CAH 2 West Evidence/Observations	CAH Gynae Ward RAG Rating	CAH Gynae Ward Evidence/Observations	DHH Maternity Ward RAG Rating	DHH Maternity Ward Evidence/Observations
Date Audit Began	10/05/2022		29/04/2022		12/05/2022	
Is there a trained equipment controller and deputy in the ward/department?		[redacted]		[redacted]		[redacted]
Policy and Procedures						
Can you show me a copy of the Trust's most up to date Equipment Management Policy/or how to find it on Sharepoint?		[redacted]		In equipment folder. CC also stated that this can be found on Sharepoint and is in the process of being updated.		In equipment folder. CC also stated that this can be found on Sharepoint and is in the process of being updated.
Can you show me a copy of the Trust's most up to date Equipment Procedures Manual/or how to find it on Sharepoint?		[redacted]		(As above)		(As above)
Equipment Inventory						
Is there an equipment asset list available at ward/department level?		[redacted]		[redacted]		[redacted]
Is the asset list up to date? (updated within the last 12 months)		[redacted]		(As above).		(See above).
Has any equipment which has been condemned within the last 12 months been removed from the asset register?	N/A	[redacted]	N/A	No equipment has been condemned within the last 12 months.	N/A	[redacted]
Is an asset sticker present on the pieces of equipment checked during audit? (Select x3 random pieces of equipment to check compliance and note ID's)		[redacted]		Welch Allyn vital signs monitor 331320, Trolley defib zoll r series 332588, Suction Pump no asset id (RH took a note of this item).		Zoll R Series Defibrillator 332612, Vital Signs Monitor 309392, Welch Allyn Thermometer 343245.
Are there manufacturer's instructions available for equipment and/or do you know how to access them on Sharepoint?		[redacted]		Manuals not available on ward. CC has shown RH how to access Sharepoint page.		[redacted]
Are the instructions up to date?		[redacted]		(See above)		[redacted]
Procurement						
If there has been new equipment purchased by the ward / department within the last 12 months is there evidence that a pre purchase checklist was completed?		[redacted]	Info not available	705CC9D7.msg	Info not available	AE79AE0F.msg
Was a TDA (Technical Design Authority) form and/or Business Case completed (if applicable) for equipment purchased within the last 12 months?	N/A	[redacted]	N/A	[redacted]		
Delivery and Pre-Use Checks						
For new equipment purchased within the past 12 months is there evidence that an acceptance form has been completed?		[redacted]		[redacted]		[redacted]
If new equipment is a replacement for an older model of equipment have these manuals been removed from use?	N/A	[redacted]		[redacted]		[redacted]
Traning and Competency						
Are there training/competency records held at ward/department level for existing equipment?		[redacted]		[redacted]		[redacted]
For equipment that has been purchased within the last 12 months is there evidence that all relevant staff received formal training from the supplier or authorised other?	N/A	[redacted]	N/A	[redacted]		[redacted]
Have all new staff completed an induction Checklist for Equipment Management as part of their induction training?		[redacted]		[redacted]		[redacted]
Is the patient safety poster on display?		[redacted]		[redacted]		[redacted]
Maintenance and Repair						
Is there evidence that good practice is adhered to for the storage of equipment?		[redacted]		[redacted]		CC observed an equipment store however space is limited.
Select one piece of equipment with a requirement for daily pre-use checks; are the required daily checks fully completed, signed and dated for the previous full month? i.e no gaps in records. If gaps are noted (missing daily checks, signatures or dates) was appropriate action taken i.e recorded on daily check sheet; details recorded in Communications Book,: and/or Incident reported		CC checked the Daily Defib Logs for April 2022. Logs were not completed on three occasions for this month.		Crash trolley defibrillator checks completed for March 2022.		All ok. Crash trolley defibrillator checks completed for April 2022.
Is there a designated segregation area for equipment needing decontamination or repair?		Placed in equipment store with a tag.		[redacted]		[redacted]
Incident Reporting						
Within the past 12 months has a fault report been completed and sent to the Technical Services team / estates department for any medical equipment requiring repair?		[redacted]	N/A	[redacted]		Yes repair/servicing records are on Backtraq system.
Prior to equipment being sent for repair in the past 12 months is there evidence that the equipment has been cleaned in accordance with manufacturer's instructions? Has a decontamination form been completed?		[redacted]	N/A	[redacted]		[redacted]
If there has been any incidents relating to medical devices / equipment within the last 12 months, have they been reported on Datix?	N/A	[redacted]	N/A	[redacted]	/A	No device incidents recorded within the last 12 months.
Are there "do not use" labels available at ward level?		[redacted]		[redacted]		[redacted]
Decontamination						
Can you show me where to find the Trust's Decontamination Policy and supporting procedures		[redacted]		[redacted]		[redacted]
Can you show me how to find information on infectin control procedures, i.e. IPC Toolkit?		[redacted]		[redacted]		[redacted]
Is there evidence of a decontamination schedule for medical devices / equipment available at ward or department level?		[redacted]		[redacted]		[redacted]

SEC and ATICS

Audit Questions	CAH Orthopaedic Ward RAG Rating	CAH Orthopaedic Ward Evidence/Observations	CAH Trauma Ward RAG Rating	CAH Trauma Ward Evidence/Observations	DHH Female Surgical Ward RAG Rating	DHH Female Surgical Ward Evidence/Observations
Date Audit Began	28/04/2022		29/04/2022		11/05/2022	
Is there a trained equipment controller and deputy in the ward/department?		[redacted]		[redacted]		[redacted]
Policy and Procedures						
Can you show me a copy of the Trust's most up to date Equipment Management Policy/or how to find it on Sharepoint?		In equipment folder. CC also stated that this can be found on Sharepoint and is in the process of being updated.		In equipment folder. CC also stated that this can be found on Sharepoint and is in the process of being updated.		In equipment folder. CC also stated that this can be found on Sharepoint and is in the process of being updated.
Can you show me a copy of the Trust's most up to date Equipment Procedures Manual/or how to find it on Sharepoint?		(As above)		(As above)		(As above)
Equipment Inventory						
Is there an equipment asset list available at ward/department level?		[redacted]		[redacted]		[redacted]
Is the asset list up to date? (updated within the last 12 months)		[redacted]		[redacted]		(See above)
Has any equipment which has been condemned within the last 12 months been removed from the asset register?		[redacted]		[redacted]		Sit-on scales have been condemned however as there is no list that cannot be updated.
Is an asset sticker present on the pieces of equipment checked during audit? (Select x3 random pieces of equipment to check compliance and note ID's)		Infusion Pump 160289, DVT Flowtron 331477, Insulin Infusion Pump 325906		Pinit Echoson Bladder Scanner 333748, Vital Signs Monitor 321930, Thermometer 339156.		T34 Syringe Driver 333643, Vital Signs Monitor 322037, Thermometer 335881.
Are there manufacturer's instructions available for equipment and/or do you know how to access them on Sharepoint?		[redacted]		These are kept in files within the equipment store. CC has shown LC and NW how to access Sharepoint page which contains user manuals etc.		[redacted]
Are the instructions up to date?		[redacted]		[redacted]		(See above)
Procurement						
If there has been new equipment purchased by the ward / department within the last 12 months is there evidence that a pre purchase checklist was completed?		[redacted]	N/A	[redacted]	N/A	[redacted]
Was a TDA (Technical Design Authority) form and/or Business Case completed (if applicable) for equipment purchased within the last 12 months?	N/A	[redacted]	N/A	[redacted]	N/A	[redacted]
Delivery and Pre-Use Checks						
For new equipment purchased within the past 12 months is there evidence that an acceptance form has been completed?		[redacted]	N/A	[redacted]	N/A	[redacted]
If new equipment is a replacement for an older model of equipment have these manuals been removed from use?		[redacted]	N/A	[redacted]	N/A	[redacted]
Traning and Competency						
Are there training/competency records held at ward/department level for existing equipment?		[redacted]		[redacted]		[redacted]
For equipment that has been purchased within the last 12 months is there evidence that all relevant staff received formal training from the supplier or authorised other?		[redacted]	N/A	[redacted]	N/A	[redacted]
Have all new staff completed an induction Checklist for Equipment Management as part of their induction training?		[redacted]		[redacted]		[redacted]
Is the patient safety poster on display?		[redacted]		[redacted]		[redacted]
Maintenance and Repair						
Is there evidence that good practice is adhered to for the storage of equipment?		[redacted]		Ward in process of getting new equipment store however current area is of a good standard.		Items stored in equipment store room, however room is very small.
Select one piece of equipment with a requirement for daily pre-use checks; are the required daily checks fully completed, signed and dated for the previous full month? i.e no gaps in records. If gaps are noted (missing daily checks, signatures or dates) was appropriate action taken i.e recorded on daily check sheet; details recorded in Communications Book,: and/or Incident reported		Crash trolley defibrillator checks completed for March 2022.		Crash trolley defibrillator checks completed for March 2022.		Signature missing for x1 day in April.
Is there a designated segregation area for equipment needing decontamination or repair?		[redacted]		Staff are aware that there is a broken equipment cupboard in the equipment store.		[redacted]
Incident Reporting						
Within the past 12 months has a fault report been completed and sent to the Technical Services team / estates department for any medical equipment requiring repair?		Numerous items logged on Backtraq system of the past 12 months.		Yes repair/servicing records are on Backtraq system.		Yes evidence on Backtraq of issues being raised and logged.
Prior to equipment being sent for repair in the past 12 months is there evidence that the equipment has been cleaned in accordance with manufacturer's instructions? Has a decontamination form been completed?		[redacted]		[redacted]		Items are cleaned with Clinell wipes and now aware of how to find decon forms on Sharepoint.
If there has been any incidents relating to medical devices / equipment within the last 12 months, have they been reported on Datix?	N/A	[redacted]	/A	[redacted]		[redacted]
Are there "do not use" labels available at ward level?		[redacted]		[redacted]		[redacted]
Decontamination						
Can you show me where to find the Trust's Decontamination Policy and supporting procedures		[redacted]		[redacted]		[redacted]
Can you show me how to find information on infectin control procedures, i.e. IPC Toolkit?		[redacted]		[redacted]		[redacted]
Is there evidence of a decontamination schedule for medical devices / equipment available at ward or department level?		[redacted]		[redacted]		[redacted]

CCS

Audit Questions	CAH Haematology Ward RAG Rating	CAH Haematology Ward Evidence/Observations	CAH Mandeville Unit RAG Rating	CAH Mandeville Unit Evidence/Observations	CAH X-Ray (Endoscopy Intervention Nursing Service) RAG Rating	CAH X-Ray (Endoscopy Intervention Nursing Service) Evidence/Observations
Date Audit Began	01/06/2022		31/05/2022		27/05/2022	
Is there a trained equipment controller and deputy in the ward/department?		[redacted]		[redacted]		[redacted]
Policy and Procedures						
Can you show me a copy of the Trust's most up to date Equipment Management Policy/or how to find it on Sharepoint?		[redacted]		[redacted]		In equipment folder. CC also stated that this can be found on Sharepoint and is in the process of being updated.
Can you show me a copy of the Trust's most up to date Equipment Procedures Manual/or how to find it on Sharepoint?		(As above)		(As above)		[redacted]
Equipment Inventory						
Is there an equipment asset list available at ward/department level?		[redacted]		[redacted]		[redacted]
Is the asset list up to date? (updated within the last 12 months)		Folder was last updated August 2021.		(See above)		[redacted]
Has any equipment which has been condemned within the last 12 months been removed from the asset register?	N/A	[redacted]	A	[redacted]		[redacted]
Is an asset sticker present on the pieces of equipment checked during audit? (Select x3 random pieces of equipment to check compliance and note ID's)		• Chair Scales 323251, ECG Monitor 328636, Infusion Device 159364.		Fresensius Kabi Agilia Syringe Pump 159257, Welch Allyn Vital Signs Monitor 325750 and Zoll R Series Debrillator 332589.		Welch Ally Thermometer 334516, Mindray Vital Signs Monitor 306212, Fresensius Cabi Infusion Pump 160304.
Are there manufacturer's instructions available for equipment and/or do you know how to access them on Sharepoint?		Instruction manuals stored in box file, but they do need updated. CC suggested going through the hardcopies periodically and discarding/put beyond use any documents that are out of date. CC		[redacted]		[redacted]
Are the instructions up to date?		(As above)		(See above)		Yes has recently been updated.
Procurement						
If there has been new equipment purchased by the ward / department within the last 12 months is there evidence that a pre purchase checklist was completed?	N/A	[redacted]	Info not provided	31ACECCB.msg		
Was a TDA (Technical Design Authority) form and/or Business Case completed (if applicable) for equipment purchased within the last 12 months?	N/A	[redacted]	Info not provided	31ACECCB.msg	N/A	None
Delivery and Pre-Use Checks						
For new equipment purchased within the past 12 months is there evidence that an acceptance form has been completed?	N/A	[redacted]	Info not provided	31ACECCB.msg		[redacted]
If new equipment is a replacement for an older model of equipment have these manuals been removed from use?	N/A	[redacted]		[redacted]		[redacted]
Traning and Competency						
Are there training/competency records held at ward/department level for existing equipment?		[redacted]	Infor not provided	[redacted]		[redacted]
For equipment that has been purchased within the last 12 months is there evidence that all relevant staff received formal training from the supplier or authorised other?	N/A	[redacted]	N/A	[redacted]		[redacted]
Have all new staff completed an induction Checklist for Equipment Management as part of their induction training?		[redacted]		[redacted]		[redacted]
Is the patient safety poster on display?		[redacted]		[redacted]		[redacted]
Maintenance and Repair						
Is there evidence that good practice is adhered to for the storage of equipment?		[redacted]		[redacted]		Scope equipment is stored in a well organised cupboards. General equipment is kept where it is needed. No defined equipment store therefore difficult to acquire additional equipment.
Select one piece of equipment with a requirement for daily pre-use checks; are the required daily checks fully completed, signed and dated for the previous full month? i.e no gaps in records. If gaps are noted (missing daily checks, signatures or dates) was appropriate action taken i.e recorded on daily check sheet; details recorded in Communications Book,: and/or Incident reported		[redacted] May 2022. These were completed and up to date.		Defibrillator logs fully completed for May 2022.		Record on 19th April 2022 missing. Record states that this has been brought up with CT staff as this was a Public Holiday.
Is there a designated segregation area for equipment needing decontamination or repair?		No designated area in current location (Ramone Ward 2). CC advised to have a specific area to store equipment requiring repair/servicing.		Broken equipment stored in sunroom (patient area), however CC suggested having a dedicated area to store equipment requiring repair.		[redacted]
Incident Reporting						
Within the past 12 months has a fault report been completed and sent to the Technical Services team / estates department for any medical equipment requiring repair?		Yes records on Repair Portal for Haematology Ward.		Staff have recorded faults on the repair portal within the past 12 months.		[redacted]
Prior to equipment being sent for repair in the past 12 months is there evidence that the equipment has been cleaned in accordance with manufacturer's instructions? Has a decontamination form been completed?		[redacted]		Everything cleaned down before repair. Decontamination forms to be completed going forward.		[redacted]
If there has been any incidents relating to medical devices / equipment within the last 12 months, have they been reported on Datix?	N/A	[redacted]	Info not provided	31ACECCB.msg	N/A	[redacted]
Are there "do not use" labels available at ward level?		[redacted]		[redacted]		[redacted]
Decontamination						
Can you show me where to find the Trust's Decontamination Policy and supporting procedures		[redacted]		[redacted]		[redacted]
Can you show me how to find information on infectin control procedures, i.e. IPC Toolkit?		[redacted]		[redacted]		[redacted]
Is there evidence of a decontamination schedule for medical devices / equipment available at ward or department level?		[redacted]		[redacted]		[redacted]

Are decontamination processes in accordance with manufacturer's instructions?		[redacted]		Equipment is cleaned in accordance with IPC criteria.		[redacted]		[redacted]		[redacted]
Can you describe the symbol for single use equipment?		[redacted]		[redacted]		[redacted]		[redacted]		[redacted]
Loaned Equipment										
Is there an up to date register of equipment that has been loaned outside of hospital premises i.e, patient use?	Info not provided	7469764.msg	N/A	[redacted]		[redacted]	N/A	[redacted]	N/A	[redacted]
For loaned equipment do end-users have access to manufacturer's instructions?	Info not provided	7469764.msg	N/A	[redacted]	N/A	[redacted]	N/A	(See above)	N/A	[redacted]
For equipment that is being loaned from a company / other Trust is there evidence that an indemnity form has been completed?	Info not provided	7469764.msg	N/A	[redacted]	N/A	[redacted]	Info not provided.	A9FE5F05.msg	N/A	[redacted]
Condemns/Disposal										
If a medical device / equipment item has been condemned / disposed of by the ward / department within the last 12 months is there evidence that an Equipment Surplus / Condemns form has been completed?	N/A	[redacted]	Not Known	[redacted]		[redacted]	N/A	[redacted]	N/A	[redacted]
Has a waste transfer note been completed?	N/A	[redacted]		[redacted]		[redacted]	N/A	[redacted]	N/A	[redacted]
Percentage (%) Full Compliance	44		57		48		31		38	

Are decontamination processes in accordance with manufacturer's instructions?		[redacted]		[redacted]		[redacted]		[redacted]		[redacted]
Can you describe the symbol for single use equipment?		[redacted]		[redacted]		[redacted]		[redacted]		[redacted]
Loaned Equipment										
Is there an up to date register of equipment that has been loaned outside of hospital premises i.e, patient use?	N/A	[redacted]	Info not provided	ADC92221.msg	N/A	[redacted]		Breast pumps are loaned to patients. Breast Feeding Champion looks after these. Data kept in file beside pumps.		[redacted]
For loaned equipment do end-users have access to manufacturer's instructions?	N/A	[redacted]	N/A	(See above)	N/A	[redacted]		Instructions for breast pumps sent home in packet with the device.	N/A	[redacted]
For equipment that is being loaned from a company / other Trust is there evidence that an indemnity form has been completed?	N/A	[redacted]	N/A	[redacted]	N/A	[redacted]	Info not available.	[redacted] 5542B1F5.msg	N/A	[redacted]
Condemns/Disposal										
If a medical device / equipment item has been condemned / disposed of by the ward / department within the last 12 months is there evidence that an Equipment Surplus / Condemns form has been completed?		[redacted]	N/A	No eqipment has been condemned within the past year.	N/A	[redacted]	N/A	[redacted]		[redacted]
Has a waste transfer note been completed?		[redacted]	N/A	[redacted]	N/A	[redacted]	N/A	[redacted]		[redacted]
Percentage (%) Full Compliance	42		71		36		56		63	

Are decontamination processes in accordance with manufacturer's instructions?		[redacted]		[redacted]		[redacted]		[redacted]		Cleaned as per IPC.
Can you describe the symbol for single use equipment?		[redacted]		[redacted]		[redacted]		[redacted]		[redacted]
Loaned Equipment										
Is there an up to date register of equipment that has been loaned outside of hospital premises i.e, patient use?	N/A	[redacted]		[redacted]		[redacted]		[redacted]	N/A	[redacted]
For loaned equipment do end-users have access to manufacturer's instructions?	N/A		N/A	[redacted]	N/A	[redacted]	N/A	[redacted]	N/A	(See above)
For equipment that is being loaned from a company / other Trust is there evidence that an indemnity form has been completed?		Indemnity form completed for trial of M200 Falls mat.	No further update as of 22/07/2022	Vacs system Smith and Nephew from pharmacy. FAE97A2D.msg	N/A	[redacted]	Info not provided	31ACECCB.msg		[redacted]
Condemns/Disposal										
If a medical device / equipment item has been condemned / disposed of by the ward / department within the last 12 months is there evidence that an Equipment Surplus / Condemns form has been completed?		[redacted]		[redacted]	N/A	[redacted]	N/A	[redacted]		[redacted]
Has a waste transfer note been completed?		[redacted]		[redacted]	N/A		N/A	[redacted]		[redacted]
Percentage (%) Full Compliance	77		37		30		27		53	

National Patient Safety Alert

Depleted batteries in intrao

Date of Issue:	5 November 2019	Reference No:	NatPSA/2019/001/NHSPS

This alert is for action by:

Acute trusts, ambulance trusts and any other organisation providing NHS funded-care that use battery-powered intraosseous injectors.

This is a safety critical and complex National Patient Safety Alert. An e leader (or the equivalent role in organisations without executive boards) should co-ordinate its implementation, supported by the appropriate clinical resuscitation lead.

Explanation

The intraosseous (IO) route (that is, through the bone marrow) is used to access the venous system when intravenous access is not possible, often in emergency situations. IO access is most commonly achieved using a battery-powered injector[1]. The battery is sealed within the device and cannot be recharged or replaced[2]. Some models may lack a battery power indicator and the first sign a battery may be depleted will be when it does not work.

In a recent three-year period, 42 incident reports described delay in administering IO medication because an IO injector had a depleted battery. The impact of this is difficult to assess given the patients were already in cardiac arrest or critically ill, but several reports indicated the delay may have affected the effectiveness of resuscitation.

Insight from stakeholders suggest:

- IO injectors without battery indicators remain in use
- IO injectors may be kept in 'IO kits' that are sealed in opaque bags, making it difficult to routinely check their battery indicator lights
- Routine checks of battery indicators are not always in place
- Staff may not know that change in the battery power indicator light means that the device needs to be replaced
- The injector stalling might be mistaken for battery failure
- Limited awareness of how to continue IO access manually if the injector cannot be used.

For further detail, resources and supporting materials see:

improvement.nhs.uk/resources/patient-safety-alerts

Actions required

Actions to commence as soon as possible and to complete by 5 May 2020

1. Identify and replace any battery-powered IO injectors **without** a battery indicator light
2. For battery-powered IO injectors **with** a battery indicator light, ensure resuscitation equipment checklist (and 'make ready' equipment checks and replenishment in ambulance trusts) includes:
   a. how to check the device, and where to record that the indicator light shows the battery is working ie green LED[2]
   b. a prompt that a flashing red LED[2] means the IO injector must be replaced, and how to obtain a replacement
3. Review training materials [A] and competency frameworks and ensure they include how to avoid the injector stalling mid-use and what to do if this occurs

Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Additional Information:

TECHNICAL NOTES

Patient safety incident reporting

The National Reporting and Learning System (NRLS) was searched on 23 April 2019 for incidents occurring on or after 1 April 2016 with the keywords relating to battery and intraosseous, including abbreviations.

42 reports linked a delay in obtaining IO access to battery depletion, of which 32 related to patients in cardiac arrest and, the rest to other emergencies such as hypothermia or hypovolaemic shock. Most incidents occurred during ambulance service interventions in the patient's home or a public space. Patients ranged in age from newborn to over 80 years.

References

1. The battery-powered IO injectors predominantly used by NHS acute and ambulance trusts are listed on NHS Supply Chain.
2. Guidance from a leading manufacturer of battery-powered IO injectors states that "a green light indicates it is suitable for use, a flashing red light indicates there is only 10% of battery life remaining. Purchase and replace [the injector] when the red LED begins blinking".

Resources

A. Teleflex, the main supplier of battery-powered IO injectors, provide training and resource materials on its website. The training materials include techniques to avoid stalling, how to overcome stalling and how to continue the procedure manually if unable to resume use of the injector.

Stakeholder engagement

- National Patient Safety Response Advisory Panel (for a list of members and organisations represented on the panel, see improvement.nhs.uk/resources/patient-safety-alerts/)

ADVICE FOR CENTRAL ALERTING SYSTEM (CAS) OFFICERS AND RISK MANAGERS

This is a safety critical and complex National Patient Safety Alert. In response to CHT/2019/001 *The introduction of National Patient Safety Alerts* issued via CAS on 17 September 2019, your organisation should be developing new processes to ensure executive oversight and coordination of safety critical and complex National Patient Safety Alerts. CAS officers should send this Alert to the executive leader nominated in their new process to co-ordinate implementation of safety critical and complex National Patient Safety Alerts, copying in their clinical resuscitation leads. If CAS officers do not yet know which executive leader will coordinate the implementation of safety critical and complex National Patient Safety Alerts, they should send this Alert to their Chief Nurse and Executive Medical Director (or equivalent roles, including in organisations without executive boards).

This alert asks for co-ordinated implementation across the trust/organisation, and so should not be disseminated to individual teams or departments by the CAS officer.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Audit Evidence
Acute Directorate
Intraosseous Injectors
(Follow-up April 2022)

Unscheduled Care

Department/Area	Device Serial Number	Is the LED Indicator light green on the device?	Is there a record of battery life checks having been carried out on device at least every 6 months?	Feedback
CAH ICU	J08624			Personal Information redacted by the USI
CAH Theatres 1-4	K21407			
CAH Theatres 1-4	J46799			
CAH ED Red Resus	K35953	Device no longer in use.		
CAH ED Red Resus	J46798			
DHH ED Resus	K38465			
DHH ED Resus	J68851			

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Resus Training	T43092		Devices are routinely checked as they are in frequent use for training purposes.	
Resus Training	T43351		Devices are routinely checked as they are in frequent use for training purposes.	
Resus Training	T43352		Devices are routinely checked as they are in frequent use for training purposes.	
Resus Training	T43091		Devices are routinely checked as they are in frequent use for training purposes.	
Current % Compliance (April 2022)		**100%**	**70%**	
% Compliance (Dec 2021)		**92%**	**46%**	
% Compliance (Sept 2021)		**92%**	**31%**	

Urology Screening : 04/07/22 **In Attendance:** **Apologies:** **Date of Next Meeting:**

Urology screening 04/072022

Note Tamoxifen dose discussed at screening 27/06/22:Mark advised group use of Tamoxifen dose 10mg daily is unlicensed and not in keeping with BNF guidance. High probability that high number of patients on bicalutamide have been prescribed inappropriate dose of Tamoxifen. Mark to discuss issue with Dr Gormley/ Dr O'Kane .

Department	Name and HNC	Screening Update	Screening Outcome	Confirmed outcome (SCRR/Not SCRR)	Attachments
urology	Personal Information redacted by the USI	records reviewed by Prof Sethia - comment : Incorrect bicalutamide dose - probably no harm From review form: 2014 Gleason 9 Ca prostate Started on bicalutamide 50 2019 admitted with urosepsis. Bicalutamide increased to 150			Document
urology		records reviewed by Prof Sethia - comment : Significantly delayed follow up scans			
urology		records reviewed by Prof Sethia - comment : Delayed diagnosis and harm?			
UROLOGY		records reviewed by Prof Sethia - comment : Delay in referral for DXR			
urology		records reviewed by Prof Sethia - comment : Review medication			
urology		records reviewed by Prof Sethia - comment : Needs plan. May still have stent			
urology		records reviewed by Prof Sethia - comment : Needs decision re prostate biopsies			
		records reviewed by Prof Sethia - comment : Too long wait for stone Rx and stent			
urology		records reviewed by Prof Sethia - comment : ?Overdue stent change			
urology		records reviewed by Prof Sethia - comment : ?Plan for raised PSA			
urology		records reviewed by Prof Sethia - comment : Needs further ultrasound			
urology		records reviewed by Prof Sethia - comment : No record of ureteroscopy being done			
urology		records reviewed by Prof Sethia - comment : ? Ultrasound as eGFR falling			
urology		records reviewed by Prof Sethia - comment : ? Needs stone imaging			
urology		records reviewed by Prof Sethia - comment : Needs imaging			
urology		records reviewed by Prof Sethia - comment : ?needs repeat scan			

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

urology	Personal Information redacted by the USI	ecords reviewed by Prof Sethia - comment : ?Plan for raised PSA			
urology		ecords reviewed by Prof Sethia - comment : Not clear if he needs further scan			
urology		ecords reviewed by Prof Sethia - comment : Unclear records			
urology		ecords reviewed by Prof Sethia - comment : check stent status			
urology		ecords reviewed by Prof Sethia - comment : Needs PSA check			
urology		ecords reviewed by Prof Sethia - comment : records unclear ? Awaiting conduit			
urology		ecords reviewed by Prof Sethia - comment : To check f/u plan			
urology		ecords reviewed by Prof Sethia - comment : Not clear if she had bleeding - no nvestigation/letter			
urology		ecords reviewed by Prof Sethia - comment : check f/u protocol kidney			
urology		ecords reviewed by Prof Sethia - comment : ? Should have UDS and check renal function			
urology		ecords reviewed by Prof Sethia - comment : Check there is a follow-up plan			
urology		ecords reviewed by Prof Sethia - comment : check on w/l- needs treating			
urology		ecords reviewed by Prof Sethia - comment : Plan unclear - ? Should have urgent hernia repair			
urology		ecords reviewed by Prof Sethia - comment : Check he really needs a TURP			
urology		ecords reviewed by Prof Sethia - comment : No follow up plan - ?review symptoms			
urology		ecords reviewed by Prof Sethia - comment : To check stone tretament and follow-up			
urology		ecords reviewed by Prof Sethia - comment : Check follow up of large AML			
urology		ecords reviewed by Prof Sethia - comment : To check he has follow-up appointment			
urology		ecords reviewed by Prof Sethia - comment : Needs decision re prostate biopsies			
urology		ecords reviewed by Prof Sethia - comment : Haematuria no investigated but ? No need			
urology		ecords reviewed by Prof Sethia - comment : Needs PSA check			

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

urology	Personal information redacted by the USI	ecords reviewed by Prof Sethia - comment : Check follow up plan in place / renogram appt	
urology		ecords reviewed by Prof Sethia - comment : Has stent been removed?	
urology		ecords reviewed by Prof Sethia - comment : Check follow up plan	
urology		ecords reviewed by Prof Sethia - comment : Check on PSA surveillance	
urology		ecords reviewed by Prof Sethia - comment : Check he has follow up plan	
urology		ecords reviewed by Prof Sethia - comment : Delays in treatment. No clear follow-up plan	
urology		ecords reviewed by Prof Sethia - comment : Check follow up plan	
urology		ecords reviewed by Prof Sethia - comment : ?does not need TURP	
urology		ecords reviewed by Prof Sethia - comment : Check on surveillance - probably is	
		ecords reviewed by Prof Sethia - comment : Check on surveillance - probably is	
urology		ecords reviewed by Prof Sethia - comment : Possible delay in surgery	
urology		ecords reviewed by Prof Sethia - comment : No clinic or PSA since 2019	
urology		ecords reviewed by Prof Sethia - comment : No follow-up imaging after cryo	
urology		ecords reviewed by Prof Sethia - comment : No follow-up imaging after cryo	
urology		ecords reviewed by Prof Sethia - comment : Has stent been removed?	

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

UROLOGY PATIENT REVIEW FORM

This form is to be completed for each patient previously under the care of Mr O'Brien reviewed by the Southern Trust Urology team since Mr O'Brien's departure on 17th July 2020. This form is to be retained in the patient notes and copied to Martina Corrigan, Head of Service.

Patient Details

Name	Personal Information redacted by the USI	
H&C Number		
Date of Birth		

Patient Details

Presenting Condition(s)	
Patient Summary	2014 Gleason 9 Ca prostate Started on bicalutamide 50 2019 admitted with urosepsis. Bicalutamide increased to 150 Died Personal Information redacted by the USI

Regarding the patients current care

	Question	Y / N / Unable to Determine	Details
1	**Is the present diagnosis / diagnoses reasonable?** ('Reasonable' to consider if *diagnosis / diagnoses is consistent with investigations and examinations carried out to date, is there a requirement for further investigations / examinations to confirm diagnosis / diagnoses?)*		**Yes**

2	**Are the current medications prescribed appropriate?** *('Appropriate' to consider if prescribing is consistent with current best evidence based practice, are any deviations from guidance recorded and rationale fully noted?)*		**N/A**
3	**Is a secure clinical management plan currently in place?** *('Secure Clinical Management Plan' to consider if the current patient treatment pathway is optimal and in line with current best evidence based practice and guidance)*		
4	**If there is not a secure clinical management plan in place please document immediate actions required to be taken**		

Based on the information available at the time of previous reviews, please answer the following to the best of your knowledge. If a determination cannot be made please give reasons why.

No.	Question	Y / N / Unable to Determine	Details
4	**Were appropriate and complete investigations carried out for all relevant conditions?** *('Appropriate' to consider if investigations consistent with current best evidence based practice at the time of review, are deviations from guidance recorded and rationale fully noted?)*		**Yes**

5	**Were the medications prescribed appropriate?** *('Appropriate' to consider if prescribing was consistent with current best evidence based practice at the time of previous review, are deviations from guidance recorded and rationale fully noted?)*		**No – wrong dose of bicalutamide**
6	**Were the diagnosis / diagnoses reasonable?** *('Reasonable' to consider if diagnosis / diagnoses is consistent with investigations and examinations carried at the time of review, was there a*		**Yes**
	requirement for further investigations / examinations to confirm diagnosis / diagnoses?)		
7	**Was the clinical management approach taken reasonable?** *('Reasonable' to consider if clinical management plan if the patient treatment pathway at the time was optimal and in line with best evidence based practice and guidance available at that time.)*		**Yes**
8	**Were there unreasonable delays within the Consultants control with any aspect of care (reviews, prescribing, diagnostics, dictation etc)** *('Unreasonable Delays' to consider if diagnosis required more urgent treatment / intervention that was received based on best evidence based practice and guidance available at that time. The Southern Health and Social Care Trust will consider any delays in treatment highlighted to assess if these were within the Consultants control or due to systematic issues e.g. length of waiting lists)*		**No**

9	**On balance, did the patient suffer any harm or detriment as a result of any of the above questions (4-9) ?**		**Probably not**

Clinical Professional Reviewing Care

Name	Krishna Sethia
Title	Professor
Date of Appointment	

SIGN OFF REPORTS

Time period: **01/09/2022 to 30/09/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	July	August	September
Southern	65866	66698	66656
Western	41295	42939	41907
Belfast	19562	24097	22591
South-Eastern	21052	19434	20312
Northern	9692	11718	13396
Total	**157467**	**164886**	**164862**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	12678	70656	17.9%
Histopathology	1029	8194	12.6%
Cytology	260	9089	2.9%
Blood Sciences	129883	1448627	9.0%
Microbiology	20966	187586	11.2%
Blood Bank	46	8744	0.5%
Total	**164862**	**1732896**	**9.5%**

Total Sign Off for Southern Trust previous three months

Month	June	July	August
Total	66118	65866	66698

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3829	52558	9863	269	113	24	0	**66656**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2355	34681	6720	185	61	24	0	**44026**
Daisy Hill Hospital	1282	12829	2370	83	51	0	0	**16615**
Lurgan Hospital	98	3380	336	0	0	0	0	**3814**
South Tyrone Hospital	2	711	170	0	0	0	0	**883**
0	87	525	157	1	1	0	0	**771**
Musgrave Park Hospital	2	188	21	0	0	0	0	**211**
Community	3	143	42	0	0	0	0	**188**
St Luke's Hospital	0	94	0	0	0	0	0	**94**
Mullinure Health & Wellbein	0	7	47	0	0	0	0	**54**
	3829	**52558**	**9863**	**269**	**113**	**24**	**0**	66656

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2355**	**34681**	**6720**	**185**	**61**	**24**	**0**	44026
Doctor	707	14697	2122	61	12	3	0	**17602**
Consultant	1568	12500	2240	124	49	21	0	**16502**
Midwife	1	3493	1987	0	0	0	0	**5481**
Nurse	77	3088	356	0	0	0	0	**3521**
Physician Associate	1	383	11	0	0	0	0	**395**
Pharmacist	0	284	0	0	0	0	0	**284**
AHP	1	223	4	0	0	0	0	**228**
Student	0	13	0	0	0	0	0	**13**
Daisy Hill Hospital	**1282**	**12829**	**2370**	**83**	**51**	**0**	**0**	16615
Doctor	358	7870	1031	1	16	0	0	**9276**
Consultant	880	2033	613	80	31	0	0	**3637**
Physician Associate	22	2058	417	0	0	0	0	**2497**
Midwife	21	583	240	2	4	0	0	**850**
Nurse	1	231	68	0	0	0	0	**300**
AHP	0	42	1	0	0	0	0	**43**
Pharmacist	0	12	0	0	0	0	0	**12**
Grand Total	**3637**	**47510**	**9090**	**268**	**112**	**24**	**0**	60641

SIGN OFF REPORTS

Time period: **01/09/2022 to 30/09/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Southern	369	158	1440	369	15	0	19	**2001**
		Southern	326	118	930	326	3	15	2	**1394**
		Southern	179	60	1135	179	0	0	0	**1374**
		Southern	575	13	709	575	0	0	0	**1297**
		Southern	174	29	965	174	1	0	0	**1169**
		Southern	358	76	656	358	0	0	0	**1090**
		Southern	47	21	956	47	0	0	0	**1024**
		Southern	287	12	593	287	0	0	0	**892**
		Southern	118	56	692	118	0	0	0	**866**
		Southern	58	65	700	58	0	0	0	**823**
		Southern	154	13	614	154	0	0	0	**781**
		Southern	106	114	470	106	13	0	0	**703**
		Southern	42	46	598	42	0	0	0	**686**
		Southern	237	17	409	237	8	0	0	**671**
		Southern	155	0	506	155	0	0	0	**661**
		Southern	61	3	582	61	0	0	0	**646**
		Southern	84	115	425	84	13	0	0	**637**
		Southern	75	2	541	75	0	0	0	**618**
		Southern	111	97	355	111	5	5	0	**573**
		Southern	186	0	377	186	0	0	0	**563**
		Southern	26	101	434	26	0	0	0	**561**
		Southern	14	17	516	14	0	0	0	**547**
		Southern	39	24	479	39	2	0	0	**544**
		Southern	117	41	374	117	0	0	0	**532**
		Southern	14	11	490	14	0	0	0	**515**
			Grand Total	**1209**	**15946**	**3912**	**60**	**20**	**21**	**21168**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/08/2022 to 31/08/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	June	July	August
Southern	66118	65866	66698
Western	45851	41295	42939
Belfast	20869	19562	24097
South-Eastern	18920	21052	19434
Northern	8915	9692	11718
Total	**160673**	**157467**	**164886**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	12678	70656	17.9%
Histopathology	1029	8194	12.6%
Cytology	260	9089	2.9%
Blood Sciences	129907	1448627	9.0%
Microbiology	20966	187586	11.2%
Blood Bank	46	8744	0.5%
Total	**164886**	**1732896**	**9.5%**

Total Sign Off for Southern Trust previous three months

Month	May	June	July
Total	68785	66118	65866

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3829	52605	9861	266	113	24	0	**66698**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2355	34728	6718	182	61	24	0	**44068**
Daisy Hill Hospital	1282	12829	2370	83	51	0	0	**16615**
Lurgan Hospital	98	3380	336	0	0	0	0	**3814**
South Tyrone Hospital	2	711	170	0	0	0	0	**883**
0	87	525	157	1	1	0	0	**771**
Musgrave Park Hospital	2	188	21	0	0	0	0	**211**
Community	3	143	42	0	0	0	0	**188**
St Luke's Hospital	0	94	0	0	0	0	0	**94**
Mullinure Health & Wellbein	0	7	47	0	0	0	0	**54**
	3829	**52605**	**9861**	**266**	**113**	**24**	**0**	66698

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2355**	**34728**	**6718**	**182**	**61**	**24**	**0**	44068
Doctor	707	14744	2120	61	12	3	0	**17647**
Consultant	1568	12500	2240	121	49	21	0	**16499**
Midwife	1	3493	1987	0	0	0	0	**5481**
Nurse	77	3088	356	0	0	0	0	**3521**
Physician Associate	1	383	11	0	0	0	0	**395**
Pharmacist	0	284	0	0	0	0	0	**284**
AHP	1	223	4	0	0	0	0	**228**
Student	0	13	0	0	0	0	0	**13**
Daisy Hill Hospital	**1282**	**12829**	**2370**	**83**	**51**	**0**	**0**	16615
Doctor	358	7870	1031	1	16	0	0	**9276**
Consultant	880	2033	613	80	31	0	0	**3637**
Physician Associate	22	2058	417	0	0	0	0	**2497**
Midwife	21	583	240	2	4	0	0	**850**
Nurse	1	231	68	0	0	0	0	**300**
AHP	0	42	1	0	0	0	0	**43**
Pharmacist	0	12	0	0	0	0	0	**12**
Grand Total	**3637**	**47557**	**9088**	**265**	**112**	**24**	**0**	60683

SIGN OFF REPORTS

Time period: **01/08/2022 to 31/08/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	158	1440	369	15	0	19	**2001**
		Consultant	Craigavon Area Hospital	118	930	326	3	15	2	**1394**
		Consultant	Craigavon Area Hospital	60	1135	179	0	0	0	**1374**
		Doctor	Craigavon Area Hospital	13	709	575	0	0	0	**1297**
		Consultant	Craigavon Area Hospital	29	965	174	1	0	0	**1169**
		Doctor	Daisy Hill Hospital	76	656	358	0	0	0	**1090**
		Doctor	Lurgan Hospital	21	956	47	0	0	0	**1024**
		Physician Associate	Daisy Hill Hospital	12	593	287	0	0	0	**892**
		Consultant	Craigavon Area Hospital	56	692	118	0	0	0	**866**
		Doctor	Craigavon Area Hospital	65	700	58	0	0	0	**823**
		Doctor	Lurgan Hospital	13	614	154	0	0	0	**781**
		Consultant	Daisy Hill Hospital	114	470	106	13	0	0	**703**
		Doctor	Daisy Hill Hospital	46	598	42	0	0	0	**686**
		Doctor	Craigavon Area Hospital	17	409	237	8	0	0	**671**
		Midwife	Craigavon Area Hospital	0	506	155	0	0	0	**661**
		Doctor	Lurgan Hospital	3	582	61	0	0	0	**646**
		Consultant	Craigavon Area Hospital	115	425	84	13	0	0	**637**
		Doctor	South Tyrone Hospital	2	541	75	0	0	0	**618**
		Consultant	Daisy Hill Hospital	97	355	111	5	5	0	**573**
		Midwife	Craigavon Area Hospital	0	377	186	0	0	0	**563**
		Consultant	Craigavon Area Hospital	101	434	26	0	0	0	**561**
		Doctor	Craigavon Area Hospital	17	516	14	0	0	0	**547**
		Doctor	Craigavon Area Hospital	24	479	39	2	0	0	**544**
		Doctor	Daisy Hill Hospital	41	374	117	0	0	0	**532**
		Doctor	Daisy Hill Hospital	11	490	14	0	0	0	**515**
			Grand Total	**1209**	**15946**	**3912**	**60**	**20**	**21**	**21168**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/07/2022 to 31/07/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	May	June	July
Southern	68785	66118	65866
Western	49199	45851	41295
South-Eastern	19964	18920	21052
Belfast	20950	20869	19562
Northern	10151	8915	9692
Total	**169049**	**160673**	**157467**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10520	63946	16.5%
Histopathology	1133	7792	14.5%
Cytology	224	9145	2.4%
Blood Sciences	122695	1390135	8.8%
Microbiology	22842	207815	11.0%
Blood Bank	53	8004	0.7%
Total	**157467**	**1686837**	**9.3%**

Total Sign Off for Southern Trust previous three months

Month	April	May	June
Total	63787	68785	66118

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3185	52587	9649	340	69	36	0	**65866**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2090	36126	6332	213	41	36	0	**44838**
Daisy Hill Hospital	960	11338	2329	127	28	0	0	**14782**
Lurgan Hospital	99	3389	468	0	0	0	0	**3956**
0	28	442	117	0	0	0	0	**587**
South Tyrone Hospital	5	732	216	0	0	0	0	**953**
Musgrave Park Hospital	2	188	12	0	0	0	0	**202**
Community	1	280	68	0	0	0	0	**349**
Mullinure Health & Wellbein	0	6	107	0	0	0	0	**113**
St Luke's Hospital	0	84	0	0	0	0	0	**84**
Longstone	0	1	0	0	0	0	0	**1**
Ards Community Hospital	0	1	0	0	0	0	0	**1**
	3185	**52587**	**9649**	**340**	**69**	**36**	**0**	65866

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2090**	**36126**	**6332**	**213**	**41**	**36**	**0**	**44838**
Doctor	769	19251	2498	52	6	0	0	**22576**
Consultant	1300	11153	1841	147	35	35	0	**14511**
Midwife	0	2922	1760	0	0	0	0	**4682**
Nurse	19	2250	216	14	0	1	0	**2500**
Pharmacist	0	129	0	0	0	0	0	**129**
AHP	1	188	11	0	0	0	0	**200**
Physician Associate	1	233	6	0	0	0	0	**240**
Daisy Hill Hospital	**960**	**11338**	**2329**	**127**	**28**	**0**	**0**	**14782**
Doctor	278	6678	928	8	0	0	0	**7892**
Consultant	668	2223	853	115	28	0	0	**3887**
Physician Associate	10	1406	216	0	0	0	0	**1632**
Midwife	3	872	284	0	0	0	0	**1159**
Nurse	1	123	42	4	0	0	0	**170**
AHP	0	0	6	0	0	0	0	**6**
Pharmacist	0	36	0	0	0	0	0	**36**
Grand Total	**3050**	**47464**	**8661**	**340**	**69**	**36**	**0**	59620

SIGN OFF REPORTS

Time period: **01/07/2022 to 31/07/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	81	1354	291	0	1	2	**1729**
		Consultant	Craigavon Area Hospital	135	917	236	12	3	30	**1333**
		Consultant	Craigavon Area Hospital	9	1010	165	6	0	0	**1190**
		Doctor	Craigavon Area Hospital	31	668	305	0	0	0	**1004**
		Consultant	Daisy Hill Hospital	76	624	286	0	0	0	**986**
		Doctor	Lurgan Hospital	18	699	186	0	0	0	**903**
		Doctor	Daisy Hill Hospital	16	828	35	0	0	0	**879**
		Consultant	Craigavon Area Hospital	33	764	71	8	0	0	**876**
		Doctor	Craigavon Area Hospital	17	595	190	0	0	0	**802**
		Doctor	Craigavon Area Hospital	28	654	61	1	0	0	**744**
		Doctor	Craigavon Area Hospital	0	713	0	0	0	0	**713**
		Consultant	Craigavon Area Hospital	83	413	160	19	1	0	**676**
		Doctor	Daisy Hill Hospital	20	565	89	0	0	0	**674**
		Doctor	Craigavon Area Hospital	30	539	105	0	0	0	**674**
		Doctor	South Tyrone Hospital	4	562	93	0	0	0	**659**
		Doctor	Daisy Hill Hospital	37	406	215	0	0	0	**658**
		Midwife	Daisy Hill Hospital	3	535	86	0	0	0	**624**
		Doctor	Craigavon Area Hospital	38	436	136	1	0	0	**611**
		Doctor	Lurgan Hospital	12	553	44	0	0	0	**609**
		Doctor	Craigavon Area Hospital	5	422	176	6	0	0	**609**
		Consultant	Craigavon Area Hospital	68	475	35	0	0	0	**578**
		Midwife	Craigavon Area Hospital	0	418	137	0	0	0	**555**
		Doctor	Craigavon Area Hospital	0	437	98	0	0	0	**535**
		Doctor	Lurgan Hospital	5	476	46	0	0	0	**527**
		Doctor	Daisy Hill Hospital	5	514	5	0	0	0	**524**
			Grand Total	**754**	**15577**	**3251**	**53**	**5**	**32**	**19672**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/06/2022 to 30/06/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	April	May	June
Southern	63787	68785	66118
Western	43151	49199	45851
Belfast	17539	20950	20869
South-Eastern	17242	19964	18920
Northern	9146	10151	8915
Total	**150865**	**169049**	**160673**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	12311	68542	18.0%
Histopathology	1287	7430	17.3%
Cytology	226	9189	2.5%
Blood Sciences	124147	1443952	8.6%
Microbiology	22676	208788	10.9%
Blood Bank	26	8481	0.3%
Total	**160673**	**1746382**	**9.2%**

Total Sign Off for Southern Trust previous three months

Month	March	April	May
Total	68241	63787	68785

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3888	52185	9482	465	75	23	0	**66118**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2407	34682	6034	296	45	22	0	**43486**
Daisy Hill Hospital	1318	12255	2449	169	30	1	0	**16222**
Lurgan Hospital	103	3374	496	0	0	0	0	**3973**
0	49	885	207	0	0	0	0	**1141**
South Tyrone Hospital	3	707	184	0	0	0	0	**894**
Musgrave Park Hospital	8	151	12	0	0	0	0	**171**
Community	0	67	43	0	0	0	0	**110**
Mullinure Health & Wellbein	0	14	55	0	0	0	0	**69**
St Luke's Hospital	0	23	0	0	0	0	0	**23**
Longstone	0	20	1	0	0	0	0	**21**
Ards Community Hospital	0	5	1	0	0	0	0	**6**
Drumglass Lodge Community	0	2	0	0	0	0	0	**2**
	3888	**52183**	**9482**	**465**	**75**	**23**	**0**	66118

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2407**	**34682**	**6034**	**296**	**45**	**22**	**0**	**43486**
Doctor	874	18377	2204	85	3	2	0	**21545**
Consultant	1489	10168	1952	201	42	20	0	**13872**
Midwife	0	3165	1658	0	0	0	0	**4823**
Nurse	42	2368	209	9	0	0	0	**2628**
Pharmacist	0	172	0	0	0	0	0	**172**
AHP	0	176	5	0	0	0	0	**181**
Physician Associate	2	256	6	1	0	0	0	**265**
Daisy Hill Hospital	**1318**	**12255**	**2449**	**169**	**30**	**1**	**0**	**16222**
Doctor	332	7822	1241	20	0	0	0	**9415**
Consultant	962	2128	614	149	30	1	0	**3884**
Physician Associate	21	1590	342	0	0	0	0	**1953**
Midwife	3	500	225	0	0	0	0	**728**
Nurse	0	186	18	0	0	0	0	**204**
AHP	0	1	9	0	0	0	0	**10**
Pharmacist	0	28	0	0	0	0	0	**28**
Grand Total	**3725**	**46937**	**8483**	**465**	**75**	**23**	**0**	59708

SIGN OFF REPORTS

Time period: **01/06/2022 to 30/06/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]	Personal Information redacted by the USI	onsultant	Craigavon Area Hospital	75	1049	382	0	0	0	**1506**
		onsultant	Craigavon Area Hospital	180	893	298	14	2	18	**1405**
		octor	Daisy Hill Hospital	42	665	341	0	0	0	**1048**
		octor	Daisy Hill Hospital	62	494	319	0	0	0	**875**
		idwife	Craigavon Area Hospital	0	725	133	0	0	0	**858**
		octor	Lurgan Hospital	16	739	84	0	0	0	**839**
		octor	Craigavon Area Hospital	35	767	29	0	0	0	**831**
		octor	Craigavon Area Hospital	46	692	77	0	0	0	**815**
		onsultant	Craigavon Area Hospital	28	645	65	6	0	0	**744**
		onsultant	Craigavon Area Hospital	98	439	180	5	2	0	**724**
		octor	Daisy Hill Hospital	3	668	8	0	0	0	**679**
		octor	Craigavon Area Hospital	61	484	130	0	0	0	**675**
		octor	Lurgan Hospital	20	456	195	0	0	0	**671**
		onsultant	0	46	517	93	0	0	0	**656**
		octor	Craigavon Area Hospital	22	457	166	0	0	1	**646**
		onsultant	Daisy Hill Hospital	122	353	135	20	11	0	**641**
		onsultant	Craigavon Area Hospital	111	456	53	0	0	0	**620**
		hysician Associate	Daisy Hill Hospital	9	467	141	0	0	0	**617**
		octor	Craigavon Area Hospital	13	434	160	0	0	0	**607**
		octor	Craigavon Area Hospital	2	482	119	0	0	0	**603**
		octor	Craigavon Area Hospital	32	399	156	0	0	0	**587**
		onsultant	Craigavon Area Hospital	9	545	26	1	0	0	**581**
		octor	South Tyrone Hospital	1	487	90	0	0	0	**578**
		onsultant	Craigavon Area Hospital	22	440	111	0	0	0	**573**
		octor	Craigavon Area Hospital	36	443	64	0	0	0	**543**
			Grand Total	**1091**	**14196**	**3555**	**46**	**15**	**19**	**18922**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/05/2022 to 31/05/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	March	April	May
Southern	68241	63787	68785
Western	47304	43151	49199
Belfast	21779	17539	20950
South-Eastern	17522	17242	19964
Northern	10446	9146	10151
Total	**165292**	**150865**	**169049**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	12480	71331	17.5%
Histopathology	1055	8199	12.9%
Cytology	225	10467	2.1%
Blood Sciences	129915	1480301	8.8%
Microbiology	25335	220804	11.5%
Blood Bank	39	8779	0.4%
Total	**169049**	**1799881**	**9.4%**

Total Sign Off for Southern Trust previous three months

Month	February	March	April
Total	59198	68241	63787

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3856	54784	9689	374	54	28	0	**68785**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2439	37628	6118	245	33	26	0	**46489**
Daisy Hill Hospital	1208	12384	2445	129	21	2	0	**16189**
Lurgan Hospital	134	3107	568	0	0	0	0	**3809**
South Tyrone Hospital	2	821	161	0	0	0	0	**984**
0	62	628	198	0	0	0	0	**888**
Musgrave Park Hospital	7	115	25	0	0	0	0	**147**
Mullinure Health & Wellbein	0	20	112	0	0	0	0	**132**
Community	4	68	59	0	0	0	0	**131**
Longstone	0	12	0	0	0	0	0	**12**
Ards Community Hospital	0	1	3	0	0	0	0	**4**
	3856	**54784**	**9689**	**374**	**54**	**28**	**0**	**68785**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2439**	**37628**	**6118**	**245**	**33**	**26**	**0**	**46489**
Doctor	872	19983	2239	45	5	0	0	**23144**
Consultant	1534	11435	1997	194	28	26	0	**15214**
Midwife	0	2632	1601	0	0	0	0	**4233**
Nurse	31	2645	278	6	0	0	0	**2960**
Pharmacist	0	205	0	0	0	0	0	**205**
AHP	0	283	1	0	0	0	0	**284**
Physician Associate	2	445	2	0	0	0	0	**449**
Daisy Hill Hospital	**1208**	**12384**	**2445**	**129**	**21**	**2**	**0**	**16189**
Doctor	293	7094	1051	6	0	0	0	**8444**
Consultant	871	2392	694	122	21	2	0	**4102**
Physician Associate	26	1913	327	0	0	0	0	**2266**
Midwife	14	625	311	0	0	0	0	**950**
Nurse	4	237	60	1	0	0	0	**302**
AHP	0	76	2	0	0	0	0	**78**
Pharmacist	0	47	0	0	0	0	0	**47**
Grand Total	**3647**	**50012**	**8563**	**374**	**54**	**28**	**0**	**62678**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/05/2022 to 31/05/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Doctor	Daisy Hill Hospital	52	746	536	1	0	0	**1335**
		Consultant	Craigavon Area Hospital	178	792	308	16	3	26	**1323**
		Consultant	Craigavon Area Hospital	80	921	319	0	0	0	**1320**
		Consultant	Craigavon Area Hospital	35	1045	142	2	0	0	**1224**
		Consultant	Craigavon Area Hospital	31	831	53	3	0	0	**918**
		Doctor	Craigavon Area Hospital	23	859	35	0	0	0	**917**
		Doctor	Lurgan Hospital	22	633	175	0	0	0	**830**
		Physician Associate	Daisy Hill Hospital	4	658	164	0	0	0	**826**
		Doctor	Craigavon Area Hospital	45	608	171	0	0	0	**824**
		Consultant	Craigavon Area Hospital	37	540	243	0	0	0	**820**
		Doctor	Lurgan Hospital	21	523	173	0	0	0	**717**
		Doctor	Craigavon Area Hospital	38	652	25	0	0	0	**715**
		Doctor	Craigavon Area Hospital	17	450	223	4	1	0	**695**
		Consultant	Daisy Hill Hospital	108	430	132	4	10	0	**684**
		Consultant	Craigavon Area Hospital	58	545	21	0	0	0	**624**
		Consultant	Daisy Hill Hospital	95	381	118	15	0	0	**609**
		Doctor	Craigavon Area Hospital	7	444	139	0	0	0	**590**
		Doctor	South Tyrone Hospital	1	508	78	0	0	0	**587**
		Midwife	Craigavon Area Hospital	0	481	92	0	0	0	**573**
		Midwife	Craigavon Area Hospital	0	289	271	0	0	0	**560**
		Consultant	Daisy Hill Hospital	50	391	92	1	0	2	**536**
		Doctor	Daisy Hill Hospital	25	442	67	0	0	0	**534**
		Consultant	Craigavon Area Hospital	9	492	30	0	0	0	**531**
		Doctor	Craigavon Area Hospital	1	487	37	0	0	0	**525**
		Doctor	Craigavon Area Hospital	4	482	37	0	0	0	**523**
			Grand Total	**941**	**14630**	**3681**	**46**	**14**	**28**	**19340**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/04/2022 to 30/04/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	59198	68241	63787
Western	40733	47304	43151
Belfast	19007	21779	17539
South-Eastern	14517	17522	17242
Northern	11203	10446	9146
Total	**144658**	**165292**	**150865**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10679	66491	16.1%
Histopathology	998	8414	11.9%
Cytology	181	9387	1.9%
Blood Sciences	113818	1379536	8.3%
Microbiology	25146	217395	11.6%
Blood Bank	43	8144	0.5%
Total	**150865**	**1689367**	**8.9%**

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	65099	59198	68241

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3359	49873	10112	352	60	31	0	**63787**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2042	33966	6550	256	31	31	0	**42876**
Daisy Hill Hospital	1148	10824	2435	96	29	0	0	**14532**
Lurgan Hospital	118	3588	637	0	0	0	0	**4343**
South Tyrone Hospital	6	797	209	0	0	0	0	**1012**
0	40	518	134	0	0	0	0	**692**
Musgrave Park Hospital	5	134	28	0	0	0	0	**167**
Community	0	25	60	0	0	0	0	**85**
Mullinure Health & Wellbein	0	2	55	0	0	0	0	**57**
Longstone	0	13	4	0	0	0	0	**17**
Community Health Office	0	3	0	0	0	0	0	**3**
St Luke's Hospital	0	3	0	0	0	0	0	**3**
	3359	**49873**	**10112**	**352**	**60**	**31**	**0**	63787

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2042**	**33966**	**6550**	**256**	**31**	**31**	**0**	**42876**
Doctor	695	17611	2285	58	5	6	0	**20660**
Consultant	1305	11117	2380	188	26	22	0	**15038**
Midwife	1	2436	1618	0	0	0	0	**4055**
Nurse	38	2238	258	10	0	3	0	**2547**
Pharmacist	0	152	0	0	0	0	0	**152**
AHP	1	118	4	0	0	0	0	**123**
Physician Associate	2	294	5	0	0	0	0	**301**
Daisy Hill Hospital	**1148**	**10824**	**2435**	**96**	**29**	**0**	**0**	**14532**
Doctor	329	6422	1031	0	1	0	0	**7783**
Consultant	794	1875	650	95	28	0	0	**3442**
Physician Associate	21	1672	401	0	0	0	0	**2094**
Midwife	0	612	317	0	0	0	0	**929**
Nurse	4	152	30	1	0	0	0	**187**
AHP	0	66	6	0	0	0	0	**72**
Pharmacist	0	25	0	0	0	0	0	**25**
Grand Total	**3190**	**44790**	**8985**	**352**	**60**	**31**	**0**	57408

SIGN OFF REPORTS

Time period: **01/04/2022 to 30/04/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	60	872	354	0	1	2	**1289**
		Consultant	Craigavon Area Hospital	155	812	237	11	1	18	**1234**
		Doctor	Lurgan Hospital	26	808	241	0	0	0	**1075**
		Consultant	Craigavon Area Hospital	60	595	362	0	0	0	**1017**
		Doctor	Daisy Hill Hospital	53	506	436	0	0	0	**995**
		Consultant	Craigavon Area Hospital	19	770	137	2	0	0	**928**
		Doctor	Craigavon Area Hospital	45	653	217	0	0	6	**921**
		Consultant	Craigavon Area Hospital	111	589	167	24	1	0	**892**
		Consultant	Craigavon Area Hospital	30	704	81	8	1	2	**826**
		Doctor	Lurgan Hospital	21	652	147	0	0	0	**820**
		Doctor	Craigavon Area Hospital	14	496	215	3	0	0	**728**
		Doctor	Craigavon Area Hospital	71	564	89	0	0	0	**724**
		Doctor	Lurgan Hospital	1	628	89	0	0	0	**718**
		Doctor	Daisy Hill Hospital	33	461	208	0	0	0	**702**
		Doctor	Craigavon Area Hospital	13	473	206	0	0	0	**692**
		Physician Associate	Daisy Hill Hospital	2	440	229	0	0	0	**671**
		Consultant	Daisy Hill Hospital	105	399	145	20	0	0	**669**
		Doctor	South Tyrone Hospital	3	523	141	0	0	0	**667**
		Consultant	Craigavon Area Hospital	85	525	19	0	0	0	**629**
		Physician Associate	Daisy Hill Hospital	10	388	159	0	0	0	**557**
		Consultant	Craigavon Area Hospital	40	385	126	0	0	0	**551**
		Consultant	Daisy Hill Hospital	109	321	106	8	5	0	**549**
		Doctor	Craigavon Area Hospital	2	512	0	0	0	0	**514**
		Doctor	Craigavon Area Hospital	8	349	133	0	1	0	**491**
		Midwife	Craigavon Area Hospital	0	233	258	0	0	0	**491**
			Grand Total	**1076**	**13658**	**4502**	**76**	**10**	**28**	**19350**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/03/2022 to 31/03/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	65099	59198	68241
Western	45456	40733	47304
Belfast	18535	19007	21779
South-Eastern	19018	14517	17522
Northern	13363	11203	10446
Total	**161471**	**144658**	**165292**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11443	67774	16.9%
Histopathology	985	9046	10.9%
Cytology	204	10265	2.0%
Blood Sciences	124203	1456767	8.5%
Microbiology	28428	241468	11.8%
Blood Bank	29	8382	0.3%
Total	**165292**	**1793702**	**9.2%**

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	64240	65099	59198

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3612	53563	10632	359	58	17	0	**68241**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2174	36621	6856	274	33	17	0	**45975**
Daisy Hill Hospital	1282	11467	2706	84	25	0	0	**15564**
Lurgan Hospital	116	3651	708	0	0	0	0	**4475**
South Tyrone Hospital	4	868	91	0	0	0	0	**963**
0	36	701	119	0	0	0	0	**856**
Community	0	167	47	0	0	0	0	**214**
Musgrave Park Hospital	0	66	50	0	0	0	0	**116**
Mullinure Health & Wellbein	0	9	55	0	0	0	0	**64**
Longstone	0	8	0	1	0	0	0	**9**
St Luke's Hospital	0	4	0	0	0	0	0	**4**
Drumglass Lodge Communit	0	1	0	0	0	0	0	**1**
	3612	**53563**	**10632**	**359**	**58**	**17**	**0**	**68241**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2174**	**36621**	**6856**	**274**	**33**	**17**	**0**	**45975**
Doctor	747	18741	2354	64	4	0	0	**21910**
Consultant	1393	11685	2419	202	29	17	0	**15745**
Midwife	0	2698	1783	0	0	0	0	**4481**
Nurse	34	2822	289	8	0	0	0	**3153**
Pharmacist	0	174	0	0	0	0	0	**174**
AHP	0	278	0	0	0	0	0	**278**
Physician Associate	0	223	11	0	0	0	0	**234**
Daisy Hill Hospital	**1282**	**11467**	**2706**	**84**	**25**	**0**	**0**	**15564**
Doctor	245	6915	1459	0	5	0	0	**8624**
Consultant	1021	1934	502	84	20	0	0	**3561**
Physician Associate	13	1368	355	0	0	0	0	**1736**
Midwife	1	1008	354	0	0	0	0	**1363**
Nurse	2	87	30	0	0	0	0	**119**
AHP	0	93	6	0	0	0	0	**99**
Pharmacist	0	62	0	0	0	0	0	**62**
Grand Total	**3456**	**48088**	**9562**	**358**	**58**	**17**	**0**	**61539**

SIGN OFF REPORTS

Time period: **01/03/2022 to 31/03/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		onsultant	Craigavon Area Hospital	108	1366	592	1	0	1	**2068**
		octor	Lurgan Hospital	37	1119	224	0	0	0	**1380**
		octor	Daisy Hill Hospital	44	521	709	0	0	0	**1274**
		onsultant	Craigavon Area Hospital	117	808	204	8	0	16	**1153**
		octor	Craigavon Area Hospital	13	615	359	2	0	0	**989**
		octor	Craigavon Area Hospital	50	637	178	1	0	0	**866**
		octor	Craigavon Area Hospital	22	615	188	0	0	0	**825**
		onsultant	Craigavon Area Hospital	79	699	37	0	0	0	**815**
		idwife	Daisy Hill Hospital	1	688	113	0	0	0	**802**
		onsultant	Craigavon Area Hospital	17	720	36	8	0	0	**781**
		onsultant	Craigavon Area Hospital	76	557	90	13	1	0	**737**
		onsultant	Craigavon Area Hospital	57	597	67	5	0	0	**726**
		octor	Daisy Hill Hospital	14	559	136	0	0	0	**709**
		onsultant	Craigavon Area Hospital	73	375	209	0	0	0	**657**
		octor	Craigavon Area Hospital	5	641	6	0	0	0	**652**
		octor	Lurgan Hospital	7	403	234	0	0	0	**644**
		onsultant	Daisy Hill Hospital	636	0	1	0	0	0	**637**
		hysician Associate	Daisy Hill Hospital	12	319	300	0	0	0	**631**
		octor	South Tyrone Hospital	4	560	65	0	0	0	**629**
		octor	Daisy Hill Hospital	25	433	149	0	0	0	**607**
		octor	Craigavon Area Hospital	3	521	81	0	0	0	**605**
		idwife	Craigavon Area Hospital	0	354	222	0	0	0	**576**
		onsultant	Craigavon Area Hospital	14	316	243	0	0	0	**573**
		onsultant	Craigavon Area Hospital	74	393	76	0	2	0	**545**
		octor	Craigavon Area Hospital	12	441	89	0	0	0	**542**
			Grand Total	**1500**	**14257**	**4608**	**38**	**3**	**17**	**20423**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/02/2022 to 28/02/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	64240	65099	59198
Western	42477	45456	40733
Belfast	19893	18535	19007
South-Eastern	18225	19018	14517
Northern	9306	13363	11203
Total	**154141**	**161471**	**144658**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10259	57970	17.7%
Histopathology	935	7187	13.0%
Cytology	213	8660	2.5%
Blood Sciences	108548	1293619	8.4%
Microbiology	24671	210161	11.7%
Blood Bank	32	7448	0.4%
Total	**144658**	**1585045**	**9.1%**

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	68037	64240	65099

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3434	46744	8540	375	79	26	0	**59198**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1982	30419	5398	241	45	20	0	**38105**
Daisy Hill Hospital	1319	11703	2347	133	34	6	0	**15542**
Lurgan Hospital	94	2823	368	1	0	0	0	**3286**
South Tyrone Hospital	2	844	156	0	0	0	0	**1002**
0	36	722	155	0	0	0	0	**913**
Community	1	136	49	0	0	0	0	**186**
Musgrave Park Hospital	0	97	18	0	0	0	0	**115**
Mullinure Health & Wellbein	0	0	49	0	0	0	0	**49**
	3434	**46744**	**8540**	**375**	**79**	**26**	**0**	59198

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1982**	**30419**	**5398**	**241**	**45**	**20**	**0**	**38105**
Doctor	570	15999	1533	25	4	0	0	**18131**
Consultant	1380	9526	2010	211	41	20	0	**13188**
Midwife	0	1964	1562	0	0	0	0	**3526**
Nurse	30	2465	286	5	0	0	0	**2786**
Pharmacist	0	157	0	0	0	0	0	**157**
AHP	0	123	1	0	0	0	0	**124**
Physician Associate	2	185	6	0	0	0	0	**193**
Daisy Hill Hospital	**1319**	**11703**	**2347**	**133**	**34**	**6**	**0**	**15542**
Doctor	229	6639	1082	1	0	1	0	**7952**
Consultant	1061	2475	596	132	34	5	0	**4303**
Physician Associate	27	1229	245	0	0	0	0	**1501**
Midwife	1	906	305	0	0	0	0	**1212**
Nurse	1	229	114	0	0	0	0	**344**
Pharmacist	0	28	0	0	0	0	0	**28**
Clinical Admin	0	197	5	0	0	0	0	**202**
Grand Total	**3301**	**42122**	**7745**	**374**	**79**	**26**	**0**	53647

SIGN OFF REPORTS

Time period: **01/02/2022 to 28/02/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	168	1220	431	12	3	19	**1853**
		Doctor	Daisy Hill Hospital	49	708	480	1	0	0	**1238**
		Consultant	Craigavon Area Hospital	54	904	93	10	0	0	**1061**
		Consultant	Craigavon Area Hospital	45	516	310	0	0	0	**871**
		Consultant	Craigavon Area Hospital	112	577	117	15	2	0	**823**
		Consultant	Craigavon Area Hospital	15	679	110	8	0	0	**812**
		Consultant	Craigavon Area Hospital	85	478	218	1	0	1	**783**
		Doctor	South Tyrone Hospital	1	605	136	0	0	0	**742**
		Doctor	Daisy Hill Hospital	5	713	9	0	0	0	**727**
		Midwife	Daisy Hill Hospital	1	604	91	0	0	0	**696**
		Doctor	Craigavon Area Hospital	11	536	144	0	0	0	**691**
		Consultant	Daisy Hill Hospital	20	639	22	0	0	0	**681**
		Doctor	Daisy Hill Hospital	31	433	184	0	0	0	**648**
		Doctor	Craigavon Area Hospital	48	401	190	0	0	0	**639**
		Consultant	Daisy Hill Hospital	602	0	4	0	0	0	**606**
		Doctor	Lurgan Hospital	26	432	128	0	0	0	**586**
		Physician Associate	Daisy Hill Hospital	17	370	161	0	0	0	**548**
		Doctor	Craigavon Area Hospital	2	354	168	3	0	0	**527**
		Consultant	Craigavon Area Hospital	11	483	23	2	0	0	**519**
		Doctor	Craigavon Area Hospital	11	429	72	0	0	0	**512**
		Consultant	Craigavon Area Hospital	103	279	80	8	3	0	**473**
		Consultant	Daisy Hill Hospital	69	273	102	29	0	0	**473**
		Doctor	Craigavon Area Hospital	0	441	20	0	0	0	**461**
		Consultant	Daisy Hill Hospital	37	243	139	11	16	0	**446**
		Doctor	Daisy Hill Hospital	26	304	91	0	0	0	**421**
			Grand Total	**1549**	**12621**	**3523**	**100**	**24**	**20**	**17837**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/01/2022 to 31/01/2022**

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	68037	64240	65099
Western	42491	42477	45456
South-Eastern	16771	18225	19018
Belfast	20039	19893	18535
Northern	9550	9306	13363
Total	**156888**	**154141**	**161471**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	12037	63479	19.0%
Histopathology	868	7775	11.2%
Cytology	198	9909	2.0%
Blood Sciences	117861	1325510	8.9%
Microbiology	30475	233535	13.0%
Blood Bank	32	7663	0.4%
Total	**161471**	**1647871**	**9.8%**

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	64164	68037	64240

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3926	50795	10039	264	55	20	0	**65099**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2142	32767	6663	173	29	20	0	**41794**
Daisy Hill Hospital	1661	13550	2579	91	26	0	0	**17907**
Lurgan Hospital	82	3227	516	0	0	0	0	**3825**
0	37	614	119	0	0	0	0	**770**
South Tyrone Hospital	4	479	65	0	0	0	0	**548**
Community	0	104	24	0	0	0	0	**128**
Musgrave Park Hospital	0	46	31	0	0	0	0	**77**
Mullinure Health & Wellbein	0	6	39	0	0	0	0	**45**
Drumglass Lodge Communit	0	2	0	0	0	0	0	**2**
St Luke's Hospital	0	0	2	0	0	0	0	**2**
Community Health Office	0	0	1	0	0	0	0	**1**
	3926	**50795**	**10039**	**264**	**55**	**20**	**0**	65099

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2142**	**32767**	**6663**	**173**	**29**	**20**	**0**	41794
Doctor	811	16348	2272	28	4	0	0	**19463**
Consultant	1257	10621	2294	141	25	20	0	**14358**
Midwife	0	2674	1842	0	0	0	0	**4516**
Nurse	72	2448	252	4	0	0	0	**2776**
Pharmacist	0	185	0	0	0	0	0	**185**
AHP	0	196	2	0	0	0	0	**198**
Physician Associate	2	295	1	0	0	0	0	**298**
Daisy Hill Hospital	**1661**	**13550**	**2579**	**91**	**26**	**0**	**0**	17907
Doctor	258	8118	1040	1	4	0	0	**9421**
Consultant	1389	2646	790	90	22	0	0	**4937**
Physician Associate	11	1559	361	0	0	0	0	**1931**
Midwife	0	902	336	0	0	0	0	**1238**
Nurse	2	218	46	0	0	0	0	**266**
Pharmacist	0	37	0	0	0	0	0	**37**
Clinical Admin	1	70	6	0	0	0	0	**77**
Grand Total	**3803**	**46317**	**9242**	**264**	**55**	**20**	**0**	59701

SIGN OFF REPORTS

Time period: **01/01/2022 to 31/01/2022**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		onsultant	Craigavon Area Hospital	118	1704	543	0	0	0	**2365**
		octor	Daisy Hill Hospital	57	667	405	1	0	0	**1130**
		onsultant	Craigavon Area Hospital	12	800	140	5	0	0	**957**
		octor	Craigavon Area Hospital	13	697	197	0	0	0	**907**
		onsultant	Craigavon Area Hospital	86	574	192	0	0	0	**852**
		octor	Craigavon Area Hospital	59	448	291	0	0	0	**798**
		onsultant	Daisy Hill Hospital	793	0	0	0	0	0	**793**
		octor	Lurgan Hospital	27	468	297	0	0	0	**792**
		idwife	Craigavon Area Hospital	0	357	422	0	0	0	**779**
		hysician Associate	Daisy Hill Hospital	4	586	171	0	0	0	**761**
		octor	Craigavon Area Hospital	29	597	125	0	1	0	**752**
		octor	Craigavon Area Hospital	21	498	211	3	0	0	**733**
		idwife	Craigavon Area Hospital	0	437	270	0	0	0	**707**
		onsultant	Daisy Hill Hospital	19	658	18	0	0	0	**695**
		onsultant	Craigavon Area Hospital	82	499	107	5	1	0	**694**
		octor	Daisy Hill Hospital	33	550	105	0	0	0	**688**
		onsultant	Craigavon Area Hospital	25	562	88	0	0	0	**675**
		onsultant	Craigavon Area Hospital	87	433	124	1	3	0	**648**
		onsultant	Craigavon Area Hospital	31	557	27	7	0	0	**622**
		octor	Craigavon Area Hospital	12	597	12	0	0	0	**621**
		octor	Craigavon Area Hospital	70	389	132	0	0	0	**591**
		octor	Craigavon Area Hospital	50	465	48	0	0	0	**563**
		onsultant	Daisy Hill Hospital	104	365	70	14	0	0	**553**
		onsultant	Craigavon Area Hospital	72	439	25	0	0	0	**536**
		idwife	Craigavon Area Hospital	0	364	169	0	0	0	**533**
			Grand Total	**1804**	**13711**	**4189**	**36**	**5**	**0**	**19745**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/12/2021 to 31/12/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	October	November	December
Southern	64164	68037	64240
Western	36852	42491	42477
Belfast	17427	20039	19893
South-Eastern	14833	16771	18225
Northern	10025	9550	9306
Total	**143301**	**156888**	**154141**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11156	60755	18.4%
Histopathology	966	8354	11.6%
Cytology	194	10827	1.8%
Blood Sciences	115423	1226154	9.4%
Microbiology	26361	234325	11.2%
Blood Bank	41	8009	0.5%
Total	**154141**	**1548424**	**10.0%**

Total Sign Off for Southern Trust previous three months

Month	September	October	November
Total	62783	64164	68037

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3642	50627	9494	385	62	30	0	**64240**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2066	33650	6087	283	43	29	0	**42158**
Daisy Hill Hospital	1473	12540	2663	102	18	0	0	**16796**
Lurgan Hospital	50	3138	468	0	0	1	0	**3657**
0	50	669	177	0	1	0	0	**897**
South Tyrone Hospital	0	429	38	0	0	0	0	**467**
Musgrave Park Hospital	1	114	15	0	0	0	0	**130**
Community	2	87	10	0	0	0	0	**99**
Mullinure Health & Wellbein	0	0	35	0	0	0	0	**35**
St Luke's Hospital	0	0	1	0	0	0	0	**1**
	3642	**50627**	**9494**	**385**	**62**	**30**	**0**	64240

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2066**	**33650**	**6087**	**283**	**43**	**29**	**0**	42158
Doctor	679	16724	1597	46	8	2	0	**19056**
Consultant	1335	10877	2551	227	35	25	0	**15050**
Midwife	0	2660	1715	0	0	1	0	**4376**
Nurse	52	2746	214	10	0	1	0	**3023**
Pharmacist	0	204	0	0	0	0	0	**204**
AHP	0	192	0	0	0	0	0	**192**
Physician Associate	0	154	5	0	0	0	0	**159**
Student	0	93	5	0	0	0	0	**98**
Daisy Hill Hospital	**1473**	**12540**	**2663**	**102**	**18**	**0**	**0**	16796
Doctor	237	8174	1321	1	1	0	0	**9734**
Consultant	1221	2296	702	101	17	0	0	**4337**
Physician Associate	12	1287	270	0	0	0	0	**1569**
Midwife	2	601	350	0	0	0	0	**953**
Nurse	1	124	10	0	0	0	0	**135**
Pharmacist	0	34	0	0	0	0	0	**34**
Clinical Admin	0	24	10	0	0	0	0	**34**
Grand Total	**3539**	**46190**	**8750**	**385**	**61**	**29**	**0**	58954

SIGN OFF REPORTS

Time period: **01/12/2021 to 31/12/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	107	1541	561	0	0	0	**2209**
		Consultant	Craigavon Area Hospital	18	887	186	3	0	0	**1094**
		Doctor	Daisy Hill Hospital	21	539	496	0	0	0	**1056**
		Consultant	Craigavon Area Hospital	92	696	136	4	1	0	**929**
		Doctor	Lurgan Hospital	13	694	215	0	0	1	**923**
		Doctor	Craigavon Area Hospital	49	732	86	0	0	0	**867**
		Consultant	Craigavon Area Hospital	55	499	246	1	0	0	**801**
		Consultant	Craigavon Area Hospital	49	616	54	13	0	0	**732**
		Consultant	Daisy Hill Hospital	116	478	120	5	2	0	**721**
		Consultant	Craigavon Area Hospital	73	462	179	2	1	0	**717**
		Consultant	Daisy Hill Hospital	667	0	6	0	0	0	**673**
		Physician Associate	Daisy Hill Hospital	0	565	101	0	0	0	**666**
		Doctor	Lurgan Hospital	14	594	41	0	0	0	**649**
		Doctor	Craigavon Area Hospital	32	465	142	0	2	0	**641**
		Consultant	Daisy Hill Hospital	93	398	108	16	0	0	**615**
		Consultant	Craigavon Area Hospital	99	470	39	0	0	0	**608**
		Consultant	Craigavon Area Hospital	65	316	155	15	1	25	**577**
		Consultant	Craigavon Area Hospital	17	441	112	0	0	0	**570**
		Consultant	Craigavon Area Hospital	18	507	34	4	0	0	**563**
		Doctor	Daisy Hill Hospital	19	399	143	0	0	0	**561**
		Doctor	Craigavon Area Hospital	9	485	66	0	0	0	**560**
		Doctor	Craigavon Area Hospital	32	372	129	0	0	0	**533**
		Consultant	0	50	366	114	0	1	0	**531**
		Doctor	Lurgan Hospital	1	449	75	0	0	0	**525**
		Doctor	Craigavon Area Hospital	51	424	33	0	0	0	**508**
			Grand Total	**1760**	**13395**	**3577**	**63**	**8**	**26**	**18829**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/11/2021 to 30/11/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	September	October	November
Southern	62783	64164	68037
Western	34887	36852	42491
Belfast	20146	17427	20039
South-Eastern	14330	14833	16771
Northern	10689	10025	9550
Total	**142835**	**143301**	**156888**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11979	66627	18.0%
Histopathology	1218	9091	13.4%
Cytology	189	12335	1.5%
Blood Sciences	117418	1359314	8.6%
Microbiology	26021	226198	11.5%
Blood Bank	63	8440	0.7%
Total	**156888**	**1682005**	**9.3%**

Total Sign Off for Southern Trust previous three months

Month	August	September	October
Total	59826	62783	64164

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3652	53781	10085	406	65	48	0	**68037**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2293	35007	6509	274	38	48	0	**44169**
Daisy Hill Hospital	1211	14015	2610	131	24	0	0	**17991**
Lurgan Hospital	122	3221	611	1	0	0	0	**3955**
South Tyrone Hospital	3	825	109	0	0	0	0	**937**
0	22	451	118	0	3	0	0	**594**
Community	0	124	36	0	0	0	0	**160**
Musgrave Park Hospital	1	133	45	0	0	0	0	**179**
Mullinure Health & Wellbein	0	0	44	0	0	0	0	**44**
Drumglass Lodge Communit	0	5	0	0	0	0	0	**5**
St Luke's	0	0	3	0	0	0	0	**3**
	3652	**53781**	**10085**	**406**	**65**	**48**	**0**	68037

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2293**	**35007**	**6509**	**274**	**38**	**48**	**0**	**44169**
Doctor	644	16604	1753	51	3	0	0	**19055**
Consultant	1599	12237	2703	209	35	48	0	**16831**
Midwife	0	2974	1785	0	0	0	0	**4759**
Nurse	50	2461	267	14	0	0	0	**2792**
AHP	0	194	1	0	0	0	0	**195**
Pharmacist	0	246	0	0	0	0	0	**246**
Physician Associate	0	291	0	0	0	0	0	**291**
Daisy Hill Hospital	**1211**	**14015**	**2610**	**131**	**24**	**0**	**0**	**17991**
Doctor	250	9056	1299	2	1	0	0	**10608**
Consultant	947	3163	763	128	23	0	0	**5024**
Physician Associate	9	1136	231	1	0	0	0	**1377**
Midwife	2	344	218	0	0	0	0	**564**
Nurse	0	240	78	0	0	0	0	**318**
Pharmacist	0	69	0	0	0	0	0	**69**
Clinical Admin	3	7	21	0	0	0	0	**31**
Grand Total	**3504**	**49022**	**9119**	**405**	**62**	**48**	**0**	**62160**

SIGN OFF REPORTS

Time period: **01/11/2021 to 30/11/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	105	2044	582	0	0	0	**2731**
		Doctor	Daisy Hill Hospital	75	991	421	0	0	0	**1487**
		Doctor	Lurgan Hospital	56	974	233	0	0	0	**1263**
		Consultant	Craigavon Area Hospital	136	707	215	37	3	48	**1146**
		Consultant	Craigavon Area Hospital	14	917	149	6	0	0	**1086**
		Consultant	Craigavon Area Hospital	72	514	476	0	0	0	**1062**
		Doctor	Lurgan Hospital	20	726	239	0	0	0	**985**
		Consultant	Craigavon Area Hospital	122	448	225	11	1	0	**807**
		Consultant	Craigavon Area Hospital	127	608	37	0	0	0	**772**
		Doctor	South Tyrone Hospital	3	643	105	0	0	0	**751**
		Consultant	Daisy Hill Hospital	89	540	106	7	6	0	**748**
		Consultant	Daisy Hill Hospital	41	591	98	2	0	0	**732**
		Doctor	Craigavon Area Hospital	5	581	130	0	0	0	**716**
		Consultant	Craigavon Area Hospital	66	555	78	0	0	0	**699**
		Doctor	Craigavon Area Hospital	41	561	84	0	0	0	**686**
		Doctor	Daisy Hill Hospital	42	528	115	0	0	0	**685**
		Midwife	Craigavon Area Hospital	0	499	121	0	0	0	**620**
		Consultant	Craigavon Area Hospital	57	419	130	0	0	0	**606**
		Consultant	Daisy Hill Hospital	119	305	108	20	0	0	**552**
		Consultant	Craigavon Area Hospital	0	401	147	0	1	0	**549**
		Consultant	Craigavon Area Hospital	17	509	14	5	0	0	**545**
		Consultant	Craigavon Area Hospital	94	330	90	28	2	0	**544**
		Doctor	Craigavon Area Hospital	11	334	191	0	0	0	**536**
		Doctor	Craigavon Area Hospital	24	312	184	0	0	0	**520**
		Doctor	Craigavon Area Hospital	22	465	24	0	0	0	**511**
			Grand Total	**1358**	**15502**	**4302**	**116**	**13**	**48**	**21339**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/10/2021 to 31/10/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	August	September	October
Southern	59826	62783	64164
Western	34571	34887	36852
Belfast	17377	20146	17427
South-Eastern	15608	14330	14833
Northern	11560	10689	10025
Total	**138942**	**142835**	**143301**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10928	69782	15.7%
Histopathology	961	7283	13.2%
Cytology	212	10699	2.0%
Blood Sciences	107460	1395898	7.7%
Microbiology	23707	236060	10.0%
Blood Bank	33	8319	0.4%
Total	**143301**	**1728041**	**8.3%**

Total Sign Off for Southern Trust previous three months

Month	July	August	September
Total	65600	59826	62783

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3427	51377	8945	316	73	26	0	**64164**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2231	34219	5525	188	44	25	0	**42232**
Daisy Hill Hospital	1011	12114	2412	128	27	1	0	**15693**
Lurgan Hospital	128	3420	672	0	0	0	0	**4220**
South Tyrone Hospital	8	714	127	0	0	0	0	**849**
0	46	632	95	0	2	0	0	**775**
Community	1	205	54	0	0	0	0	**260**
Musgrave Park Hospital	2	66	24	0	0	0	0	**92**
Mullinure Health & Wellbein	0	0	36	0	0	0	0	**36**
Drumglass Lodge Communit	0	6	0	0	0	0	0	**6**
St Luke's	0	1	0	0	0	0	0	**1**
	3427	**51377**	**8945**	**316**	**73**	**26**	**0**	64164

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2231**	**34219**	**5525**	**188**	**44**	**25**	**0**	**42232**
Doctor	696	18755	1814	58	5	0	0	**21328**
Consultant	1472	10088	1644	122	39	24	0	**13389**
Midwife	0	2540	1810	0	0	0	0	**4350**
Nurse	63	2333	248	8	0	1	0	**2653**
AHP	0	279	0	0	0	0	0	**279**
Pharmacist	0	190	1	0	0	0	0	**191**
Physician Associate	0	34	8	0	0	0	0	**42**
Daisy Hill Hospital	**1011**	**12114**	**2412**	**128**	**27**	**1**	**0**	**15693**
Doctor	256	7900	1080	0	1	1	0	**9238**
Consultant	736	2047	696	128	26	0	0	**3633**
Physician Associate	17	1254	210	0	0	0	0	**1481**
Midwife	0	776	392	0	0	0	0	**1168**
Nurse	0	76	29	0	0	0	0	**105**
Pharmacist	0	36	0	0	0	0	0	**36**
Clinical Admin	2	25	5	0	0	0	0	**32**
Grand Total	**3242**	**46333**	**7937**	**316**	**71**	**26**	**0**	**57925**

SIGN OFF REPORTS

Time period: **01/10/2021 to 31/10/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Doctor	Lurgan Hospital	56	1058	302	0	0	0	**1416**
		Consultant	Craigavon Area Hospital	89	1042	219	0	0	0	**1350**
		Doctor	Lurgan Hospital	12	873	261	0	0	0	**1146**
		Doctor	Daisy Hill Hospital	57	762	312	0	0	1	**1132**
		Doctor	Craigavon Area Hospital	58	816	173	1	0	0	**1048**
		Consultant	Craigavon Area Hospital	14	884	53	3	0	0	**954**
		Doctor	Craigavon Area Hospital	10	752	140	0	0	0	**902**
		Consultant	Craigavon Area Hospital	62	558	260	0	0	0	**880**
		Consultant	Craigavon Area Hospital	90	669	116	0	0	0	**875**
		Doctor	Craigavon Area Hospital	63	656	140	0	1	0	**860**
		Doctor	Daisy Hill Hospital	68	555	179	0	0	0	**802**
		Consultant	Craigavon Area Hospital	118	483	136	11	2	24	**774**
		Doctor	Craigavon Area Hospital	1	688	58	0	0	0	**747**
		Midwife	Daisy Hill Hospital	0	558	127	0	0	0	**685**
		Midwife	Craigavon Area Hospital	0	338	337	0	0	0	**675**
		Consultant	Craigavon Area Hospital	171	412	72	0	0	0	**655**
		Consultant	Craigavon Area Hospital	7	588	21	6	0	0	**622**
		Doctor	South Tyrone Hospital	7	532	82	0	0	0	**621**
		Doctor	Craigavon Area Hospital	25	531	39	0	0	0	**595**
		Consultant	Daisy Hill Hospital	84	400	80	21	3	0	**588**
		Doctor	Craigavon Area Hospital	1	584	2	0	0	0	**587**
		Consultant	Craigavon Area Hospital	31	453	95	1	0	0	**580**
		Consultant	Craigavon Area Hospital	59	436	69	4	1	0	**569**
		Doctor	Craigavon Area Hospital	22	528	15	0	0	0	**565**
		Doctor	Craigavon Area Hospital	0	558	3	0	0	0	**561**
			Grand Total	**1105**	**15714**	**3291**	**47**	**7**	**25**	**20189**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/09/2021 to 30/09/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	July	August	September
Southern	65600	59826	62783
Western	36937	34571	34887
Belfast	14845	17377	20146
South-Eastern	13981	15608	14330
Northern	8541	11560	10689
Total	**139904**	**138942**	**142835**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11387	71560	15.9%
Histopathology	927	8531	10.9%
Cytology	197	10250	1.9%
Blood Sciences	106696	1395075	7.6%
Microbiology	23593	233086	10.1%
Blood Bank	35	8592	0.4%
Total	**142835**	**1727094**	**8.3%**

Total Sign Off for Southern Trust previous three months

Month	June	July	August
Total	67165	65600	59826

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3784	50204	8389	315	64	27	0	**62783**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2261	33662	5302	186	27	26	0	**41464**
Daisy Hill Hospital	1374	12587	2238	129	37	1	0	**16366**
Lurgan Hospital	113	2560	535	0	0	0	0	**3208**
South Tyrone Hospital	1	680	125	0	0	0	0	**806**
0	33	523	76	0	0	0	0	**632**
Community	1	107	67	0	0	0	0	**175**
Musgrave Park Hospital	1	70	19	0	0	0	0	**90**
Mullinure Health & Wellbein	0	9	26	0	0	0	0	**35**
Drumglass Lodge Communit	0	6	0	0	0	0	0	**6**
Community Health Office	0	0	1	0	0	0	0	**1**
	3784	**50204**	**8389**	**315**	**64**	**27**	**0**	62783

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2261**	**33662**	**5302**	**186**	**27**	**26**	**0**	**41464**
Doctor	651	17789	1914	40	3	2	0	**20399**
Consultant	1534	10182	1212	138	24	24	0	**13114**
Midwife	0	2923	1826	0	0	0	0	**4749**
Nurse	76	2358	350	8	0	0	0	**2792**
Pharmacist	0	235	0	0	0	0	0	**235**
AHP	0	175	0	0	0	0	0	**175**
Daisy Hill Hospital	**1374**	**12587**	**2238**	**129**	**37**	**1**	**0**	16366
Doctor	306	8009	922	2	7	1	0	**9247**
Consultant	1049	2369	783	127	30	0	0	**4358**
Physician Associate	18	1345	126	0	0	0	0	**1489**
Midwife	0	601	372	0	0	0	0	**973**
Nurse	1	173	27	0	0	0	0	**201**
Pharmacist	0	86	0	0	0	0	0	**86**
Clinical Admin	0	4	8	0	0	0	0	**12**
Grand Total	**3635**	**46249**	**7540**	**315**	**64**	**27**	**0**	57830

SIGN OFF REPORTS

Time period: **01/09/2021 to 30/09/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Doctor	Craigavon Area Hospital	18	1492	266	0	0	2	**1778**
		Consultant	Craigavon Area Hospital	94	1281	181	2	0	3	**1561**
		Doctor	Daisy Hill Hospital	68	1012	261	0	1	0	**1342**
		Doctor	Daisy Hill Hospital	99	801	199	0	2	0	**1101**
		Consultant	Craigavon Area Hospital	189	718	165	3	0	0	**1075**
		Doctor	Craigavon Area Hospital	55	829	170	0	0	0	**1054**
		Doctor	Lurgan Hospital	30	584	331	0	0	0	**945**
		Doctor	Lurgan Hospital	29	728	117	0	0	0	**874**
		Consultant	Daisy Hill Hospital	103	578	118	12	16	0	**827**
		Consultant	Craigavon Area Hospital	13	738	15	1	0	0	**767**
		Consultant	Craigavon Area Hospital	19	632	71	3	0	0	**725**
		Doctor	Craigavon Area Hospital	37	602	79	0	0	0	**718**
		Consultant	Craigavon Area Hospital	109	537	20	0	0	0	**666**
		Consultant	Craigavon Area Hospital	34	599	24	7	0	0	**664**
		Doctor	South Tyrone Hospital	1	535	113	0	0	0	**649**
		Consultant	Craigavon Area Hospital	141	373	86	15	2	21	**638**
		Physician Associate	Daisy Hill Hospital	13	540	50	0	0	0	**603**
		Doctor	Craigavon Area Hospital	0	570	14	0	0	0	**584**
		Consultant	Daisy Hill Hospital	96	372	93	23	0	0	**584**
		Doctor	Craigavon Area Hospital	39	425	111	0	0	0	**575**
		Doctor	Craigavon Area Hospital	33	484	54	0	0	0	**571**
		Consultant	Craigavon Area Hospital	20	515	22	0	0	0	**557**
		Consultant	Daisy Hill Hospital	130	340	58	29	0	0	**557**
		Doctor	Craigavon Area Hospital	7	527	18	0	0	0	**552**
		Midwife	Craigavon Area Hospital	0	328	224	0	0	0	**552**
			Grand Total	**1377**	**16140**	**2860**	**95**	**21**	**26**	**20519**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/08/2021 to 31/08/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	June	July	August
Southern	67165	65600	59826
Western	33182	36937	34571
Belfast	14099	14845	17377
South-Eastern	16408	13981	15608
Northern	8052	8541	11560
Total	**139361**	**139904**	**138942**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9702	63047	15.4%
Histopathology	820	7740	10.6%
Cytology	213	8544	2.5%
Blood Sciences	105132	1294508	8.1%
Microbiology	23048	192593	12.0%
Blood Bank	27	8181	0.3%
Total	**138942**	**1574613**	**8.8%**

Total Sign Off for Southern Trust previous three months

Month	May	June	July
Total	63942	67165	65600

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3200	48832	7385	302	89	18	0	**59826**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1849	31425	4563	158	39	18	0	**38052**
Daisy Hill Hospital	1182	12811	2095	144	50	0	0	**16282**
Lurgan Hospital	111	3334	447	0	0	0	0	**3892**
0	56	490	106	0	0	0	0	**652**
South Tyrone Hospital	0	456	85	0	0	0	0	**541**
Community	0	153	36	0	0	0	0	**189**
Musgrave Park Hospital	2	138	8	0	0	0	0	**148**
Mullinure Health & Wellbein	0	5	45	0	0	0	0	**50**
Drumglass Lodge Communit	0	13	0	0	0	0	0	**13**
St Luke's	0	7	0	0	0	0	0	**7**
	3200	**48832**	**7385**	**302**	**89**	**18**	**0**	59826

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1849**	**31425**	**4563**	**158**	**39**	**18**	**0**	**38052**
Doctor	578	16830	1545	44	3	1	0	**19001**
Consultant	1206	9117	977	113	36	17	0	**11466**
Midwife	0	2752	1802	0	0	0	0	**4554**
Nurse	65	2491	239	1	0	0	0	**2796**
AHP	0	65	0	0	0	0	0	**65**
Pharmacist	0	170	0	0	0	0	0	**170**
Daisy Hill Hospital	**1182**	**12811**	**2095**	**144**	**50**	**0**	**0**	**16282**
Doctor	307	8571	758	2	3	0	0	**9641**
Consultant	859	2333	842	142	47	0	0	**4223**
Physician Associate	15	1239	160	0	0	0	0	**1414**
Midwife	1	483	282	0	0	0	0	**766**
Nurse	0	172	53	0	0	0	0	**225**
Pharmacist	0	13	0	0	0	0	0	**13**
Grand Total	**3031**	**44236**	**6658**	**302**	**89**	**18**	**0**	54334

SIGN OFF REPORTS

Time period: **01/08/2021 to 31/08/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Doctor	Lurgan Hospital	38	1197	210	0	0	0	**1445**
		Doctor	Craigavon Area Hospital	11	1016	108	0	0	1	**1136**
		Consultant	Craigavon Area Hospital	17	1012	82	4	0	0	**1115**
		Consultant	Craigavon Area Hospital	57	888	104	0	0	0	**1049**
		Doctor	Craigavon Area Hospital	41	856	137	3	0	0	**1037**
		Doctor	Daisy Hill Hospital	60	807	166	0	0	0	**1033**
		Doctor	Craigavon Area Hospital	36	818	93	1	1	0	**949**
		Consultant	Craigavon Area Hospital	123	623	124	9	2	17	**898**
		Doctor	Craigavon Area Hospital	2	825	5	0	0	0	**832**
		Doctor	Lurgan Hospital	18	659	137	0	0	0	**814**
		Consultant	Craigavon Area Hospital	12	683	26	1	0	0	**722**
		Consultant	Daisy Hill Hospital	118	409	144	24	1	0	**696**
		Doctor	Craigavon Area Hospital	20	446	217	0	0	0	**683**
		Consultant	Daisy Hill Hospital	69	444	94	3	8	0	**618**
		Midwife	Craigavon Area Hospital	0	325	289	0	0	0	**614**
		Midwife	Craigavon Area Hospital	0	365	222	0	0	0	**587**
		Doctor	Craigavon Area Hospital	24	454	100	5	0	0	**583**
		Doctor	Daisy Hill Hospital	79	396	82	0	0	0	**557**
		Physician Associate	Daisy Hill Hospital	4	440	105	0	0	0	**549**
		Doctor	Craigavon Area Hospital	6	532	7	0	0	0	**545**
		Consultant	Craigavon Area Hospital	85	378	69	2	0	0	**534**
		Doctor	Daisy Hill Hospital	18	444	66	0	1	0	**529**
		Doctor	Craigavon Area Hospital	0	498	18	0	0	0	**516**
		Nurse	Craigavon Area Hospital	41	408	47	0	0	0	**496**
		Midwife	Craigavon Area Hospital	0	338	157	0	0	0	**495**
			Grand Total	**879**	**15261**	**2809**	**52**	**13**	**18**	**19032**

Personal Information redacted by the USI

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/07/2021 to 31/07/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	May	June	July
Southern	63942	67165	65600
Western	33192	33182	36937
Belfast	11961	14099	14845
South-Eastern	13741	16408	13981
Northern	7841	8052	8541
Total	**135482**	**139361**	**139904**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9890	66255	14.9%
Histopathology	1006	7872	12.8%
Cytology	247	10242	2.4%
Blood Sciences	106243	1316754	8.1%
Microbiology	22488	187135	12.0%
Blood Bank	30	8460	0.4%
Total	**139904**	**1596718**	**8.8%**

Total Sign Off for Southern Trust previous three months

Month	April	May	June
Total	62074	63942	67165

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3594	53436	8028	412	113	17	0	**65600**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2051	33427	4835	201	42	17	0	**40573**
Daisy Hill Hospital	1410	14738	2383	211	71	0	0	**18813**
Lurgan Hospital	78	3788	491	0	0	0	0	**4357**
South Tyrone Hospital	0	601	149	0	0	0	0	**750**
0	53	372	79	0	0	0	0	**504**
Community	2	453	48	0	0	0	0	**503**
Mullinure Health & Wellbein	0	17	41	0	0	0	0	**58**
Drumglass Lodge Communit	0	40	0	0	0	0	0	**40**
Community Health Office	0	0	1	0	0	0	0	**1**
St Luke's	0	0	1	0	0	0	0	**1**
	3594	**53436**	**8028**	**412**	**113**	**17**	**0**	**65600**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2051**	**33427**	**4835**	**201**	**42**	**17**	**0**	**40573**
Doctor	608	17447	1325	46	3	2	0	**19431**
Consultant	1407	10626	1372	150	39	14	0	**13608**
Midwife	0	2597	1924	0	0	0	0	**4521**
Nurse	36	2465	211	5	0	1	0	**2718**
AHP	0	175	3	0	0	0	0	**178**
Pharmacist	0	117	0	0	0	0	0	**117**
Daisy Hill Hospital	**1410**	**14738**	**2383**	**211**	**71**	**0**	**0**	**18813**
Doctor	355	10032	925	5	2	0	0	**11319**
Consultant	1018	2933	928	206	69	0	0	**5154**
Physician Associate	32	1029	126	0	0	0	0	**1187**
Midwife	4	532	372	0	0	0	0	**908**
Nurse	1	156	32	0	0	0	0	**189**
Pharmacist	0	47	0	0	0	0	0	**47**
Clinical Admin	0	9	0	0	0	0	0	**9**
Grand Total	**3461**	**48165**	**7218**	**412**	**113**	**17**	**0**	**59386**

SIGN OFF REPORTS

Time period: **01/07/2021 to 31/07/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	163	1845	249	2	0	2	**2261**
		Consultant	Craigavon Area Hospital	256	1261	279	31	2	12	**1841**
		Doctor	Lurgan Hospital	37	1261	201	0	0	0	**1499**
		Consultant	Daisy Hill Hospital	73	841	107	23	0	0	**1044**
		Consultant	Craigavon Area Hospital	27	899	98	2	0	0	**1026**
		Doctor	Craigavon Area Hospital	35	846	134	1	0	0	**1016**
		Doctor	Lurgan Hospital	17	758	180	0	0	0	**955**
		Doctor	Craigavon Area Hospital	36	815	91	2	0	1	**945**
		Doctor	Craigavon Area Hospital	23	600	76	5	0	0	**704**
		Doctor	Daisy Hill Hospital	15	539	141	0	0	0	**695**
		Doctor	Craigavon Area Hospital	9	593	78	0	1	0	**681**
		Doctor	Craigavon Area Hospital	38	587	37	0	0	0	**662**
		Consultant	Craigavon Area Hospital	13	555	59	0	0	0	**627**
		Consultant	Craigavon Area Hospital	42	488	91	1	0	0	**622**
		Consultant	Craigavon Area Hospital	1	602	13	5	0	0	**621**
		Midwife	Craigavon Area Hospital	0	438	178	0	0	0	**616**
		Doctor	Daisy Hill Hospital	21	486	107	1	0	0	**615**
		Consultant	Craigavon Area Hospital	82	449	54	12	6	0	**603**
		Doctor	Craigavon Area Hospital	15	564	10	0	0	0	**589**
		Consultant	Daisy Hill Hospital	88	345	96	32	1	0	**562**
		Doctor	South Tyrone Hospital	0	467	76	0	0	0	**543**
		Consultant	Daisy Hill Hospital	89	290	139	10	12	0	**540**
		Doctor	Craigavon Area Hospital	1	521	10	0	0	0	**532**
		Doctor	Craigavon Area Hospital	20	443	65	0	0	1	**529**
		Doctor	Craigavon Area Hospital	26	468	23	0	0	0	**517**
			Grand Total	**1127**	**16961**	**2592**	**127**	**22**	**16**	**20845**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/06/2021 to 30/06/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	April	May	June
Southern	62074	63942	67165
Western	34423	33192	33182
South-Eastern	13741	16408	15741
Belfast	11961	14099	15221
Northern	7005	7841	8052
Total	**129204**	**135482**	**139361**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11989	69977	17.1%
Histopathology	1116	7127	15.7%
Cytology	326	11334	2.9%
Blood Sciences	105858	1436358	7.4%
Microbiology	20045	183945	10.9%
Blood Bank	27	9375	0.3%
Total	**139361**	**1718116**	**8.1%**

Total Sign Off for Southern Trust previous three months

Month	March	April	May
Total	60787	62074	63942

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	4216	54468	7936	415	115	15	0	**67165**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2608	34883	4839	235	59	15	0	**42639**
Daisy Hill Hospital	1489	15520	2473	180	56	0	0	**19718**
Lurgan Hospital	58	2443	392	0	0	0	0	**2893**
South Tyrone Hospital	1	447	50	0	0	0	0	**498**
Community	2	504	44	0	0	0	0	**550**
0	58	562	91	0	0	0	0	**711**
St Luke's	0	4	4	0	0	0	0	**8**
Drumglass Lodge Communit	0	90	0	0	0	0	0	**90**
Mullinure Health & Wellbein	0	15	43	0	0	0	0	**58**
	4216	**54468**	**7936**	**415**	**115**	**15**	**0**	**67165**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2608**	**34883**	**4839**	**235**	**59**	**15**	**0**	**42639**
Doctor	840	18232	1433	63	10	0	0	**20578**
Consultant	1741	11638	1353	161	49	15	0	**14957**
Midwife	0	2522	1816	0	0	0	0	**4338**
Nurse	27	2201	227	11	0	0	0	**2466**
AHP	0	132	10	0	0	0	0	**142**
Pharmacist	0	158	0	0	0	0	0	**158**
Daisy Hill Hospital	**1489**	**15520**	**2473**	**180**	**56**	**0**	**0**	**19718**
Doctor	453	11213	1172	3	4	0	0	**12845**
Consultant	1007	2246	832	177	52	0	0	**4314**
Physician Associate	28	1326	145	0	0	0	0	**1499**
Midwife	0	492	314	0	0	0	0	**806**
Nurse	1	176	10	0	0	0	0	**187**
Pharmacist	0	49	0	0	0	0	0	**49**
Clinical Admin	0	18	0	0	0	0	0	**18**
Grand Total	**4097**	**50403**	**7312**	**415**	**115**	**15**	**0**	**62357**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/06/2021 to 30/06/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	136	1972	194	0	1	0	**2303**
		Doctor	Daisy Hill Hospital	59	870	218	0	0	0	**1147**
		Consultant	Craigavon Area Hospital	24	1010	107	5	0	0	**1146**
		Doctor	Craigavon Area Hospital	40	937	99	0	0	0	**1076**
		Consultant	Craigavon Area Hospital	182	653	182	23	3	14	**1057**
		Doctor	Lurgan Hospital	18	863	172	0	0	0	**1053**
		Doctor	Craigavon Area Hospital	9	908	76	0	0	0	**993**
		Consultant	Craigavon Area Hospital	29	654	104	5	0	0	**792**
		Consultant	Craigavon Area Hospital	3	727	37	5	0	0	**772**
		Doctor	Craigavon Area Hospital	0	763	0	0	0	0	**763**
		Doctor	Daisy Hill Hospital	66	639	25	0	0	0	**730**
		Doctor	Craigavon Area Hospital	29	491	190	0	0	0	**710**
		Doctor	Craigavon Area Hospital	4	689	5	0	0	0	**698**
		Doctor	Craigavon Area Hospital	28	620	35	0	0	0	**683**
		Consultant	Daisy Hill Hospital	109	463	99	5	7	0	**683**
		Consultant	Craigavon Area Hospital	135	473	29	0	0	0	**637**
		Consultant	Craigavon Area Hospital	20	590	17	4	0	0	**631**
		Physician Associate	Daisy Hill Hospital	7	500	108	0	0	0	**615**
		Consultant	Craigavon Area Hospital	108	366	99	10	1	0	**584**
		Doctor	Craigavon Area Hospital	12	402	164	1	0	0	**579**
		Consultant	Craigavon Area Hospital	14	504	57	0	0	0	**575**
		Doctor	Craigavon Area Hospital	36	518	14	0	0	0	**568**
		Doctor	Daisy Hill Hospital	31	253	275	0	1	0	**560**
		Consultant	Daisy Hill Hospital	107	294	116	5	5	0	**527**
		Doctor	Daisy Hill Hospital	41	410	74	0	0	0	**525**
			Grand Total	**1247**	**16569**	**2496**	**63**	**18**	**14**	**20407**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/05/2021 to 31/05/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	March	April	May
Southern	60787	62074	63942
Western	31626	34423	33192
South-Eastern	15571	13741	16408
Belfast	14525	11961	14099
Northern	7338	7005	7841
Total	**129847**	**129204**	**135482**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10491	68672	15.3%
Histopathology	805	6764	11.9%
Cytology	234	10399	2.3%
Blood Sciences	102587	1371358	7.5%
Microbiology	21331	188798	11.3%
Blood Bank	34	8893	0.4%
Total	**135482**	**1654884**	**8.2%**

Total Sign Off for Southern Trust previous three months

Month	February	March	April
Total	52979	60787	62074

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3769	51566	8205	273	107	22	0	**63942**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2186	31662	5140	160	52	21	0	**39221**
Daisy Hill Hospital	1464	15812	2348	113	55	1	0	**19793**
Lurgan Hospital	93	2892	498	0	0	0	0	**3483**
South Tyrone Hospital	1	361	47	0	0	0	0	**409**
Community	1	385	71	0	0	0	0	**457**
0	24	312	60	0	0	0	0	**396**
St Luke's	0	72	0	0	0	0	0	**72**
Drumglass Lodge Communit	0	54	0	0	0	0	0	**54**
Mullinure Health & Wellbein	0	16	41	0	0	0	0	**57**
	3769	**51566**	**8205**	**273**	**107**	**22**	**0**	**63942**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2186**	**31662**	**5140**	**160**	**52**	**21**	**0**	**39221**
Doctor	737	18052	1895	70	12	2	0	**20768**
Consultant	1383	8912	1100	83	40	19	0	**11537**
Midwife	0	2269	1877	0	0	0	0	**4146**
Nurse	66	2142	236	7	0	0	0	**2451**
AHP	0	160	31	0	0	0	0	**191**
Pharmacist	0	127	1	0	0	0	0	**128**
Daisy Hill Hospital	**1464**	**15812**	**2348**	**113**	**55**	**1**	**0**	**19793**
Doctor	501	11689	1048	2	4	0	0	**13244**
Consultant	932	1775	753	111	51	0	0	**3622**
Physician Associate	25	1197	137	0	0	0	0	**1359**
Midwife	4	732	367	0	0	1	0	**1104**
Nurse	1	187	35	0	0	0	0	**223**
Pharmacist	0	39	0	0	0	0	0	**39**
0	1	193	8	0	0	0	0	**202**
Grand Total	**3650**	**47474**	**7488**	**273**	**107**	**22**	**0**	**59014**

SIGN OFF REPORTS

Time period: **01/05/2021 to 31/05/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	107	1187	167	3	0	0	**1464**
		Doctor	Lurgan Hospital	16	1097	205	0	0	0	**1318**
		Doctor	Daisy Hill Hospital	82	890	278	0	0	0	**1250**
		Doctor	Craigavon Area Hospital	56	947	133	0	0	0	**1136**
		Consultant	Craigavon Area Hospital	131	521	167	16	6	18	**859**
		Doctor	Daisy Hill Hospital	15	774	2	0	0	0	**791**
		Doctor	Lurgan Hospital	45	497	222	0	0	0	**764**
		Doctor	Craigavon Area Hospital	23	619	116	0	0	0	**758**
		Doctor	Craigavon Area Hospital	20	489	223	0	0	0	**732**
		Consultant	Craigavon Area Hospital	13	653	42	3	0	0	**711**
		Consultant	Daisy Hill Hospital	132	406	129	12	0	0	**679**
		Doctor	Craigavon Area Hospital	34	437	196	0	1	0	**668**
		Doctor	Craigavon Area Hospital	13	592	52	1	0	0	**658**
		Doctor	Daisy Hill Hospital	49	480	106	0	1	0	**636**
		Midwife	Daisy Hill Hospital	3	529	95	0	0	1	**628**
		Doctor	Craigavon Area Hospital	9	616	0	0	0	0	**625**
		Consultant	Daisy Hill Hospital	74	413	100	8	6	0	**601**
		Nurse	Craigavon Area Hospital	26	448	103	0	0	0	**577**
		Midwife	Craigavon Area Hospital	0	416	148	0	0	0	**564**
		Consultant	Craigavon Area Hospital	81	457	26	0	0	0	**564**
		Consultant	Craigavon Area Hospital	4	540	13	0	0	0	**557**
		Doctor	Craigavon Area Hospital	20	441	79	0	0	0	**540**
		Doctor	Craigavon Area Hospital	0	535	0	0	0	0	**535**
		Doctor	Daisy Hill Hospital	73	442	19	0	0	0	**534**
		Doctor	Daisy Hill Hospital	4	510	9	0	0	0	**523**
			Grand Total	**1030**	**14936**	**2630**	**43**	**14**	**19**	**18672**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/04/2021 to 30/04/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	52979	60787	62074
Western	30040	31626	34423
South-Eastern	13447	15571	13741
Belfast	12012	14525	11961
Northern	5908	7338	7005
Total	**114386**	**129847**	**129204**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10819	63877	16.9%
Histopathology	902	6435	14.0%
Cytology	211	10747	2.0%
Blood Sciences	97078	1299541	7.5%
Microbiology	20160	185917	10.8%
Blood Bank	34	8200	0.4%
Total	**129204**	**1574717**	**8.2%**

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	54317	52979	60787

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	4336	49241	8009	390	72	26	0	**62074**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2128	30460	4790	232	25	25	0	**37660**
Daisy Hill Hospital	2103	14692	2519	158	47	1	0	**19520**
Lurgan Hospital	84	3096	552	0	0	0	0	**3732**
South Tyrone Hospital	3	387	59	0	0	0	0	**449**
Community	0	277	38	0	0	0	0	**315**
0	18	176	36	0	0	0	0	**230**
St Luke's	0	98	0	0	0	0	0	**98**
Drumglass Lodge Communit	0	51	0	0	0	0	0	**51**
Mullinure Health & Wellbein	0	4	15	0	0	0	0	**19**
	4336	**49241**	**8009**	**390**	**72**	**26**	**0**	**62074**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2128**	**30460**	**4790**	**232**	**25**	**25**	**0**	**37660**
Doctor	671	15616	1484	76	7	0	0	**17854**
Consultant	1430	9665	951	148	18	24	0	**12236**
Midwife	0	2670	2131	0	0	0	0	**4801**
Nurse	27	2093	217	8	0	1	0	**2346**
AHP	0	209	7	0	0	0	0	**216**
Pharmacist	0	207	0	0	0	0	0	**207**
Daisy Hill Hospital	**2103**	**14692**	**2519**	**158**	**47**	**1**	**0**	**19520**
Doctor	388	10945	1068	2	4	0	0	**12407**
Consultant	1673	1849	1002	156	43	1	0	**4724**
Physician Associate	30	1063	87	0	0	0	0	**1180**
Midwife	12	580	352	0	0	0	0	**944**
Nurse	0	141	10	0	0	0	0	**151**
Pharmacist	0	60	0	0	0	0	0	**60**
0	0	54	0	0	0	0	0	**54**
Grand Total	**4231**	**45152**	**7309**	**390**	**72**	**26**	**0**	**57180**

SIGN OFF REPORTS

Time period: **01/04/2021 to 30/04/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	60	1251	161	0	0	0	**1472**
		Consultant	Craigavon Area Hospital	167	1042	177	24	1	24	**1435**
		Doctor	Daisy Hill Hospital	65	927	233	0	0	0	**1225**
		Consultant	Craigavon Area Hospital	17	1037	71	5	1	0	**1131**
		Consultant	Craigavon Area Hospital	114	841	93	0	0	0	**1048**
		Consultant	Daisy Hill Hospital	1016	0	12	0	0	0	**1028**
		Doctor	Lurgan Hospital	35	758	190	0	0	0	**983**
		Doctor	Lurgan Hospital	18	740	208	0	0	0	**966**
		Doctor	Craigavon Area Hospital	16	678	176	1	1	0	**872**
		Doctor	Craigavon Area Hospital	37	675	109	0	0	0	**821**
		Consultant	Daisy Hill Hospital	132	406	194	5	7	0	**744**
		Doctor	Daisy Hill Hospital	67	597	23	0	0	0	**687**
		Consultant	Craigavon Area Hospital	81	503	86	0	1	0	**671**
		Midwife	Craigavon Area Hospital	0	430	240	0	0	0	**670**
		Consultant	Craigavon Area Hospital	110	437	37	2	0	0	**586**
		Consultant	Craigavon Area Hospital	21	494	39	3	0	0	**557**
		Doctor	Daisy Hill Hospital	3	549	0	0	0	0	**552**
		Doctor	Craigavon Area Hospital	5	539	0	0	0	0	**544**
		Physician Associate	Daisy Hill Hospital	23	476	39	0	0	0	**538**
		Consultant	Daisy Hill Hospital	97	304	109	25	0	0	**535**
		Consultant	Craigavon Area Hospital	11	460	56	0	0	0	**527**
		Consultant	Daisy Hill Hospital	87	291	126	11	7	0	**522**
		Doctor	Daisy Hill Hospital	13	495	12	0	0	0	**520**
		Midwife	Daisy Hill Hospital	12	388	95	0	0	0	**495**
		Doctor	Craigavon Area Hospital	0	494	0	0	0	0	**494**
			Grand Total	**2207**	**14812**	**2486**	**76**	**18**	**24**	**19623**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SIGN OFF REPORTS

Time period: **01/03/2021 to 31/03/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	54317	52979	60787
Western	28163	30040	31626
South-Eastern	12409	13447	15571
Belfast	10529	12012	14525
Northern	5721	5908	7338
Total	**111139**	**114386**	**129847**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9438	62049	15.2%
Histopathology	781	6508	12.0%
Cytology	191	10481	1.8%
Blood Sciences	100187	1338090	7.5%
Microbiology	19217	183444	10.5%
Blood Bank	33	8652	0.4%
Total	**129847**	**1609224**	**8.1%**

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	52060	54317	52979

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3485	49316	7617	285	56	28	0	**60787**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2224	29306	4737	179	18	28	0	**36492**
Daisy Hill Hospital	1115	15315	2269	104	38	0	0	**18841**
Lurgan Hospital	89	3211	443	0	0	0	0	**3743**
South Tyrone Hospital	3	522	53	0	0	0	0	**578**
Community	3	360	32	0	0	0	0	**395**
0	51	280	47	2	0	0	0	**380**
Drumglass Lodge Communit	0	198	0	0	0	0	0	**198**
St Luke's	0	124	0	0	0	0	0	**124**
Mullinure Health & Wellbein	0	0	35	0	0	0	0	**35**
Community Health Office	0	0	1	0	0	0	0	**1**
	3485	**49316**	**7616**	**285**	**56**	**28**	**0**	**60787**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2224**	**29306**	**4737**	**179**	**18**	**28**	**0**	**36492**
Doctor	580	14058	1116	54	2	1	0	**15811**
Consultant	1610	10008	1386	111	16	27	0	**13158**
Midwife	2	2783	1937	0	0	0	0	**4722**
Nurse	32	2008	280	14	0	0	0	**2334**
AHP	0	285	18	0	0	0	0	**303**
Pharmacist	0	164	0	0	0	0	0	**164**
Daisy Hill Hospital	**1115**	**15315**	**2269**	**104**	**38**	**0**	**0**	**18841**
Doctor	385	10516	924	4	15	0	0	**11844**
Consultant	717	2571	877	100	23	0	0	**4288**
Physician Associate	9	1152	68	0	0	0	0	**1229**
Midwife	0	701	376	0	0	0	0	**1077**
Nurse	0	242	18	0	0	0	0	**260**
Pharmacist	0	45	1	0	0	0	0	**46**
0	4	88	5	0	0	0	0	**97**
Grand Total	**3339**	**44621**	**7006**	**283**	**56**	**28**	**0**	**55333**

SIGN OFF REPORTS

Time period: **01/03/2021 to 31/03/2021**

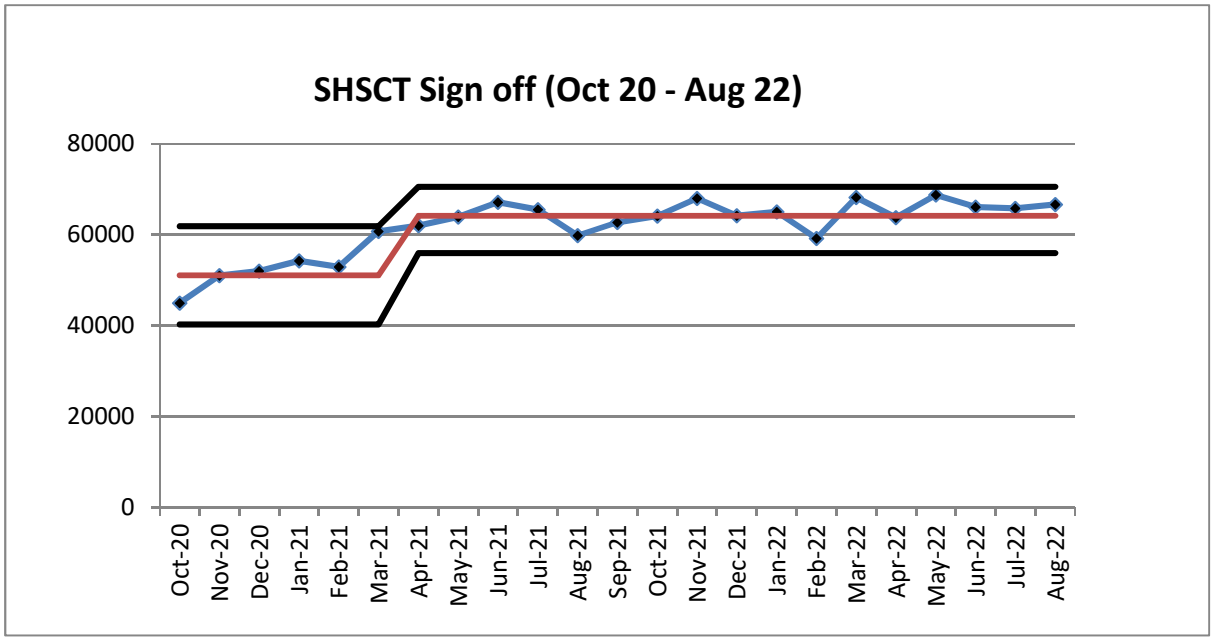
Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Doctor	Lurgan Hospital	14	1040	198	0	0	0	**1252**
		Consultant	Craigavon Area Hospital	82	1024	123	0	0	0	**1229**
		Consultant	Craigavon Area Hospital	26	1010	64	6	0	0	**1106**
		Doctor	Daisy Hill Hospital	48	797	165	0	0	0	**1010**
		Consultant	Craigavon Area Hospital	151	665	156	4	0	24	**1000**
		Doctor	Daisy Hill Hospital	77	728	144	0	0	0	**949**
		Consultant	Craigavon Area Hospital	104	680	159	0	0	3	**946**
		Consultant	Craigavon Area Hospital	137	659	50	0	1	0	**847**
		Doctor	Craigavon Area Hospital	36	704	80	0	0	0	**820**
		Doctor	Lurgan Hospital	32	607	170	0	0	0	**809**
		Doctor	Craigavon Area Hospital	49	682	44	0	0	0	**775**
		Doctor	Daisy Hill Hospital	14	647	1	0	0	0	**662**
		Consultant	Craigavon Area Hospital	10	591	39	0	0	0	**640**
		Consultant	Daisy Hill Hospital	127	364	123	23	0	0	**637**
		Consultant	Daisy Hill Hospital	121	401	105	2	5	0	**634**
		Consultant	Daisy Hill Hospital	30	523	77	1	0	0	**631**
		Consultant	Craigavon Area Hospital	19	597	7	5	0	0	**628**
		Midwife	Craigavon Area Hospital	0	436	178	0	0	0	**614**
		Consultant	Craigavon Area Hospital	95	286	204	0	0	0	**585**
		Midwife	Daisy Hill Hospital	0	487	95	0	0	0	**582**
		Doctor	Craigavon Area Hospital	24	370	140	0	1	0	**535**
		Consultant	Craigavon Area Hospital	125	284	119	1	3	0	**532**
		Doctor	Craigavon Area Hospital	0	505	0	0	0	0	**505**
		Doctor	Craigavon Area Hospital	4	480	10	0	0	0	**494**
		Midwife	Craigavon Area Hospital	0	275	214	0	0	0	**489**
			Grand Total	**1325**	**14842**	**2665**	**42**	**10**	**27**	**18911**

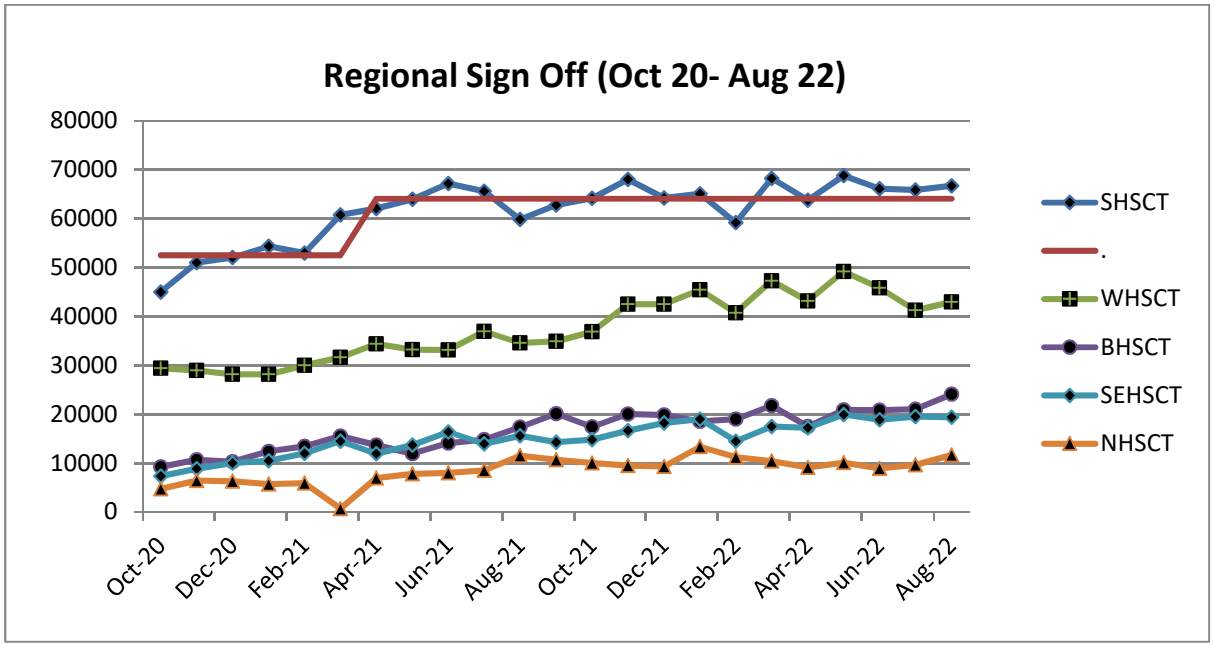
Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Sign Off Review

1) SHSCT Sign Off Overview



2) Regional Sign Off Overview Benchmark



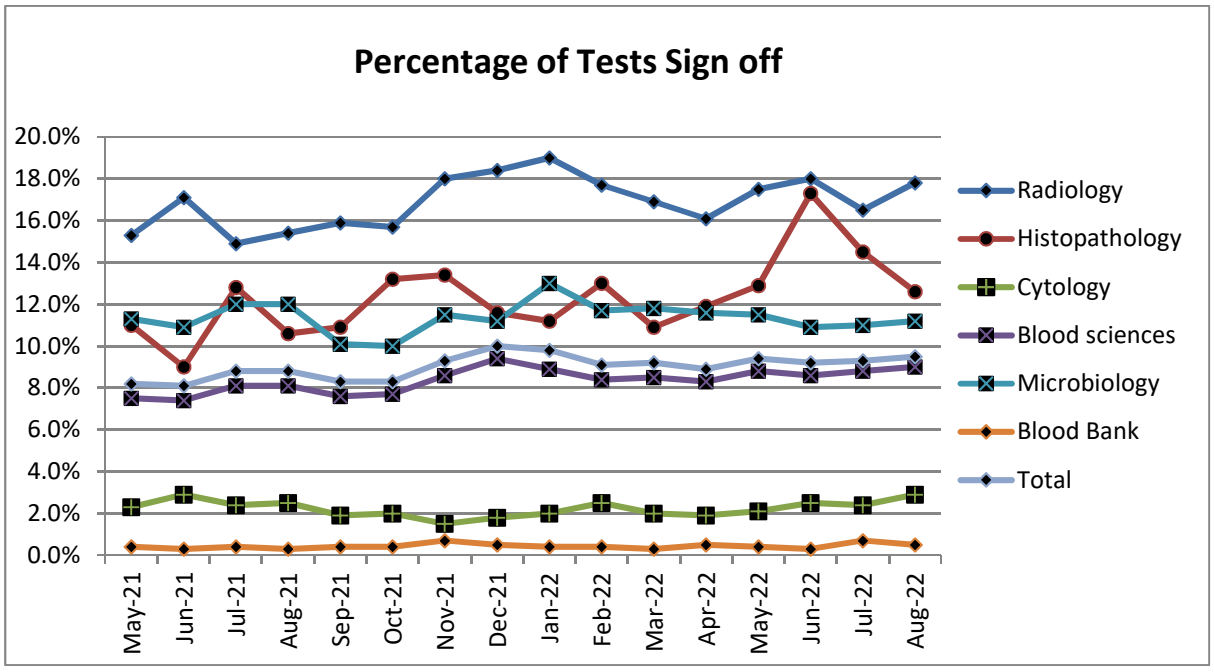
Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

3) Feb 2022 Percentage of Tests Signed Off

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	12678	70656	17.9%
Histopathology	1029	8194	12.6%
Cytology	260	9089	2.9%
Blood Sciences	129907	1448627	9.0%
Microbiology	20966	187586	11.2%
Blood Bank	46	8744	0.5%
Total	**164886**	**1732896**	**9.5%**

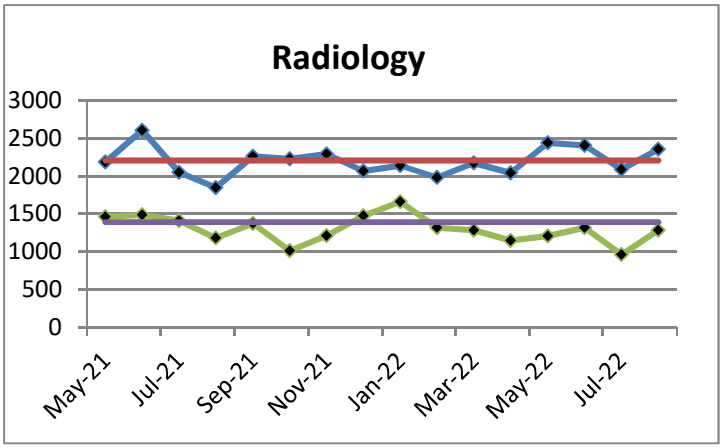
4) Overview of Percentage of Tests Signed Off

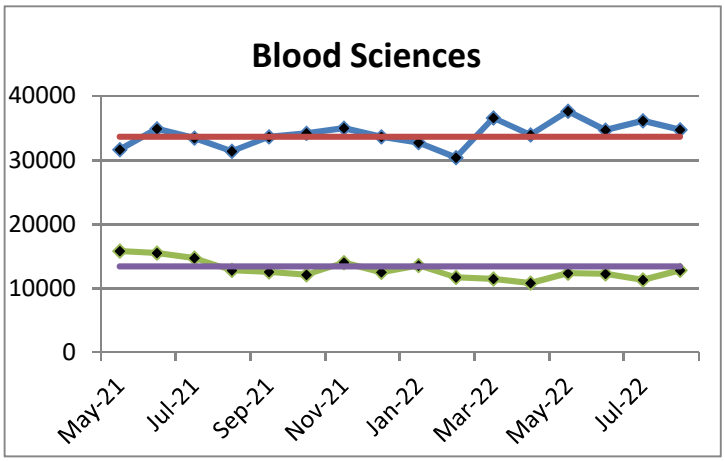


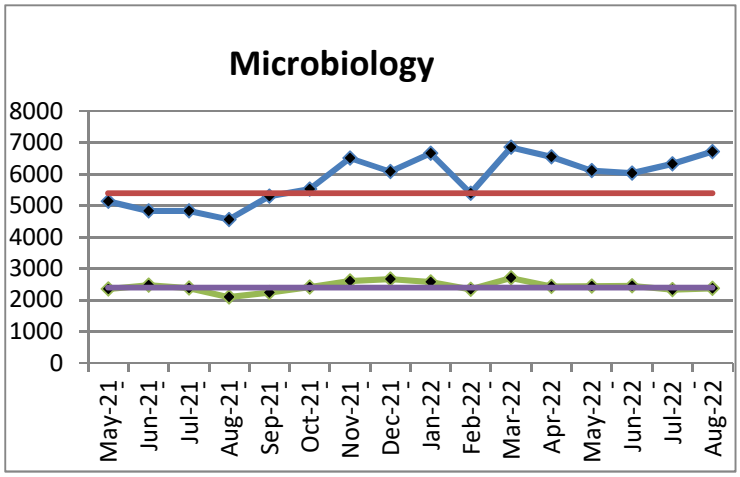
Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

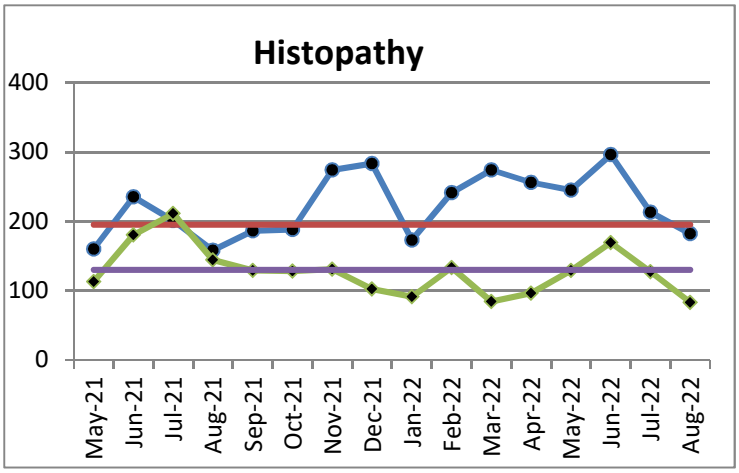
Sign Off Review

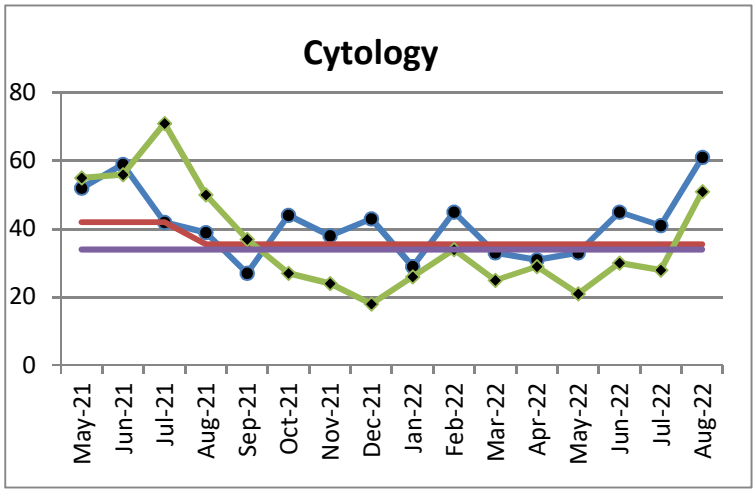
5) Overview of Sign Off per Test











Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Part A

Appendix 1

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Band 8B **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? _____

Clinical Governance Co-ordinator

KEY ISSUES & OUTCOMES	COMMENTS
Personal Information redacted by the USI	

Received from CH

Objectives for Next Year:

Personal Information redacted by the USI

Reviewee Staff Name (Print) ___C WAMSLEY_____ Signature _Personal Information redacted by the USI_ Date __29/11/2021_

Reviewer Manager/Supervisor (Print) _Personal Information redacted by the USI_ Signature _Personal Information redacted by the USI_ Date __29/11/21

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: [redacted]

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Oct 19	
	Departmental Induction/Orientation	Oct 19	
	Equality, Good Relations and Human Rights – Making A Difference	-	Update with 3 months
	Fire Safety	-	Update with 3 months
	Infection Prevention Control	-	Update with 3 months
	Information Governance Awareness	20/11/2020	
	Cyber Security Awareness	17/6/2021	
	Moving and Handling	-	Update with 12 months
	Safeguarding People, Children & Vulnerable Adults	June 19	
Role Specific Essential Training	Basic ICT	-	
	Control of Substances Hazardous to Health (COSHH)	-	Update with 3 months
	Food Safety	-	Update with 12 months
	MAPA (level 3 or 4)	n/a	
	Professional Registration	Sept 21	
	Right Patient, Right Blood (Theory/Competency)	June 19	
	Waste Management	17/6/2021	
Best practice/ Development (Relevant to current job role)	SAI Training	-	Requested to attend next available sessions through Corporate team.

Reviewee Staff Name (Print) _____C WAMSLEY_____ Signature [redacted] Date __29/11/2021

Reviewer Manager/Supervisor (Print) [redacted] Signature [redacted] Date 29/11/21

PLEASE SEND COMPLETED PART B TO:
VWAC, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL: [redacted]

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework (KSF)

Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development
Directorate responsible for document:	HR & Organisational Development
Issue Date:	16 May 2019
Review Date:	09 October 2021
Reviewed On:	18 May 2021
Next Review Date:	17 May 2023

Working together Excellence Openness & Honesty Compassion

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Policy Checklist

Policy name:	Performance and Personal Development Review Policy
Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development)
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Heather Clyde, Vocational Workforce and Assessment Centre
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	09 October 2018
Date approved by SMT:	N/A
Policy circulated to:	All Heads of Service/Department and Line Managers
Policy uploaded to:	Placed on Intranet and SharePoint

Version Control

Version:	Version 4.0
Supersedes:	Legacy Policies for Craigavon and Banbridge, Craigavon Area Hospital, Newry & Mourne, and Armagh & Dungannon Trusts

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Version 1.0	Contact Details, Introduction to Policy 1:7, Appendix 2 Revalidation incorporated.	01/12/2008	Assistant Director Human Resources / ELD – Mrs Heather Ellis
Version 2.0	Contact Details, Appendix 2 Revalidation Form Removed	22/03/2016	Director Human Resources Mrs Vivienne Toal
Version 3.0	Hyperlinks added at 3.8 and 3.12 and 8.0. Differentiation between Supervision and Appraisal added at 5.1. KSF PDP Form updated (Appendix 1). Contacted details updated (Appendix 3). 9.4 change in wording due to UK leaving EU – becomes - UK General Data Protection Regulations (UK GDPR) 2018.	15/02/2021	Anne Forsythe, Head of Workforce & Organisational Development

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Contents

Appendices

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

1.0 Introduction

1.1 The Southern Health and Social Care Trust (hereafter referred to as "the Trust") is committed to ensuring that robust corporate governance arrangements are in place in the operation of its business.

1.2 The Trust is committed to performance review and personal development and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each of member of staff to develop their potential.

1.3 The Trust will ensure that each member of staff knows what is expected of them including standards of conduct and performance required of them, this will be done through personal feedback from their line manager and set in the context of objective setting and review.

1.4 In support of this, the performance review and personal development documentation has been based on the NHS Knowledge and Skills Framework (KSF). KSF defines and describes the knowledge and skills that Health and Social Care staff need to apply in order to deliver quality services. It provides a single consistent, comprehensive and explicit framework on which to base performance review and personal development for staff. KSF is used to develop outlines for individual jobs. These outlines provide links to gateways for pay progression.

1.5 As part of this process, Continued Professional Development (CPD) will be discussed. Each individual profession will have their own requirements for this and reference should be made to these guidelines as appropriate.

1.6 The Trust is committed to supporting staff in their CPD and expects all qualified staff to undertake the necessary amount/levels of CPD as required by their profession. CPD is a personal commitment to keeping your personal professional knowledge up to date and improving your capabilities throughout your working life. It is about knowing where you are today, where you want to be in the future and making sure you have formulated a direction in association with your line manager in order to help you get there.

1.7 Also with reference to management standards Health & Social Care in Northern Ireland have adopted The Healthcare Leadership Model which has been developed by the NHS Leadership Academy. It is an evidenced based research model that reflects the values of the NHS. It comprises of nine dimensions and the model provides NHS staff with a means of analysing their leadership roles and responsibilities.

1.8 Other agreed competency frameworks may also be used for reference.

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2.0 Purpose and Aims

2.1 The Southern Trust, through this policy ensures that staff have a strong and effective performance review and personal development which has a very positive effect on the individual's performance, their development and that of the organisation and can therefore contribute greatly to the improvement and development of the services the Trust provides for its patients and clients.

2.2 Recognise achievements and provide help in overcoming obstacles to successful performance.

2.3 Through this policy the Trust will ensure the roll out of performance review and personal development using the KSF Framework across the organisation.

2.4 The Trust will ensure that all staff are clear about their responsibilities for staff development.

2.5 Provide the basis for future training and workforce development strategies and plans.

2.6 Encourage the development of a flexible learning culture across the organisation.

3.0 Objectives of this Policy

3.1 The process of performance review and personal development process begins with a focus on the review of an individual's work in relation to individual service and organisational objectives. This provides an opportunity to receive feedback from the line manager on work performance, ways in which performance can be sustained or improved, and have these laid out in the form of agreed objectives.

3.2 Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve.

3.3 The framework provided in the documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process - Appendix 1.

3.4 A set of agreed objectives will be formulated from this discussion between the member of staff and the line manager. The action points supporting these objectives should be written using the SMARTER criteria (Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Repeated).

3.5 The individual's objectives should reflect those of the Organisation, Directorate and Team. Where improvement is not required objectives may focus upon both maintenance and innovation.

3.6 The personal development review element of performance review focuses upon reviewing an individual's skills, knowledge and experience, and how they are applied in relation to the requirements of their post using the KSF outline. Training and development needs are identified; ways in which these needs can be

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addressed are discussed and set out in the form of a Personal Development Plan (PDP).

3.7 Development review is a cyclical process that comprises of four stages:-

- A joint review between the individual and their line manager (or another person acting in that capacity) of the individual's work against the demands of their post, as set out in the KSF outline for that post.
- The formulation of an agreed PDP that identifies the individual's learning and development needs and interests.
- Learning and development by the individual, supported by their manager.
- Evaluation of the learning & development that has occurred and how the individual has applied it in their work.

3.8 Outlines developed for posts within the Trust are available from the Knowledge and Skills Framework link on share-point, (click here). It is only these outlines that should be used in the performance review. These outlines will be reviewed and further developed and are therefore liable to alteration. It is the responsibility of both parties to obtain the relevant and up to date outline as part of the preparation for a performance review. However, in the event of an outline not being available the KSF team within the Vocational Workforce Assessment Centre (VWAC) should be contacted for guidance (see Appendix 2).

3.9 The performance review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. Demonstrable knowledge and skills evident in a person's work will be considered in relation to all the dimensions included in the outline.

3.10 A Personal Development Plan (PDP) is formulated from this performance review. This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post.

3.11 The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

3.12 PDP's need to be completed annually. Line Managers should record completion of a PDP directly on HRPTS (click here for guidance). Alternatively, completed PDP's can be forwarded to the Vocational Workforce Assessment Centre to be recorded centrally. .

3.13 Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to

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Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

4.0 Policy Statement

The Trust has an obligation to fully implement the Agenda for Change initiative. The Trust will ensure that there are effective systems in place to support the appraisal process and include ensuring that all supervisors have the appropriate knowledge and skills to completely undertake this role.

5.0 Scope of Policy

This policy applies to all permanent staff and those on a fixed term contract and long term agency staff (6 months) other than Medical, Dental staff, and Directors for which there are separate arrangements.

5.1 It is important to differentiate between supervision and appraisal. Whilst Supervision activities should inform, and are informed by, the KSF PDR process, neither activity should be substituted for the other, as each activity has a different purpose.

6.0 Responsibilities

In the Southern Trust there are key individuals with responsibility for ensuring KSF PDR process is implemented.

6.1 Chief Executive

The Chief Executive has overall responsibility and accountability for the quality of service provision. Appraisal plays an important role in ensuring the delivery of high quality, safe and effective care.

6.2 Directors

All Directors have responsibility for ensuring that arrangements are in place to implement and ensure compliance with this policy and that resources are available to support the process including that supervisors have the appropriate skills and knowledge to undertake appraisal. Directors also have responsibility to complete KSF reviews and PDP's for all those staff they manage.

6.3 Assistant Directors

Assistant Directors have responsibility for coordinating and facilitating implementation of the KSF process. They are responsible for agreeing the models to be employed within their area of responsibility and must ensure that appropriate resources are in place to meet the requirements of this policy. They are responsible for monitoring the level and quality of activity and supporting operational and professional Heads of Services and managers in the implementation of this policy. They also have responsibility to carryout KSF reviews and PDP's for all staff they manage.

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6.4 Head of Service / Line Managers

The Head of Service/Line Manager has a responsibility to carryout KSF reviews for all those staff they manage. The Head of Service/Line Manager must also avail of KSF reviews and act as a supervisor for identified staff. S/he is also responsible for ensuring that arrangements are in place for the implementation and local monitoring of KSF activities.

6.5 Supervisors

Supervisors have a responsibility to maintain and develop their own skills and competencies relevant to KSF review in line with this policy. They have a responsibility to participate in and prepare for agreed KSF meetings. It is their responsibility to keep a record of the appraisal meeting and implement agreed action.

6.6 Supervisees

Supervisees have a responsibility to engage fully in the KSF process. They have a responsibility to participate in and where relevant, prepare for the agreed meeting. Where required supervisees should keep a record of appraisal and implement agreed actions.

7.0 Evaluation & Review

Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

8.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

Policy on Professional and Operational Management Interface within the Integrated Care Teams – click here

9.0 Equality & Human Rights Considerations

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

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

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

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Rights contained in the Act.

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

9.4 Staff must comply with relevant legislation, professional standards and guidance and other DHSSPS publications as follows:-

UK General Data Protection Regulations (UK GDPR) 2018.

10.0 Sources of Advice & Further Information

Further information about the Performance and Personal Development Review Policy can be obtained from the: Vocational Workforce Assessment Centre, St Luke's Hospital, Hill Building, Armagh, BT61 7NQ.

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: _____ **Staff Number:** _____

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☐ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☐ **NO** ☐ **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** **Line Manager's Feedback on staff members performance over past year:**
Objectives for Next Year:	

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Equality, Good Relations and Human Rights – Making A Difference		
	Fire Safety		
	Infection Prevention Control		
	Information Governance Awareness		
	Cyber Security Awareness		
	Moving and Handling		
	Safeguarding People, Children & Vulnerable Adults		
Role Specific Essential Training	Basic ICT		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	MAPA (level 3 or 4)		
	Professional Registration		
	Right Patient, Right Blood (Theory/Competency)		
	Waste Management		
Best practice/ Development (Relevant to current job role)	(eg Coaching)		

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

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Appendix 2

Flowchart for completing KSF

Personal Development Review and Plan

	Line Manager	Staff Member
BEFORE MEETING	Read post outline and job description for staff member	Read post outline and job description Reflect on how you have achieved the levels
DURING MEETING	Discuss general performance and progress Evaluate skills against post-outline and job description Agree areas for further development where necessary Discuss career development Complete PART A of form including staff member's comments and line manager's feedback from discussion	
AFTER MEETING	Keep a copy of completed form Set an annual review date (or sooner if actions identified in Part A require on-going meetings)	Keep a copy of completed form Undertake any actions identified in Part A Undertake agreed learning and development activities

FORWARD PART B TO VWAC TEAM

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Contacts for KSF (Knowledge & Skills Framework)

Lynn Irwin **Senior HR Manager (Vocational Workforce Development)**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail [redacted]
Margretta Chambers **Union Representative KSF Advisor**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail – [redacted]
Ann McCann **KSF Support**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail – [redacted]
Gemma Cunningham **KSF Support**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail – [redacted]
Tara Davison **KSF Support**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail – [redacted]
Carol McGreevy **KSF Support**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail – [redacted]
Heather Clyde **KSF Support**	Tel: Personal Information redacted by the USI Mob: [redacted] E Mail - [redacted]
Forward PDPs to	Tel: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI

PRACTICE HOURS LOG TEMPLATE

NMC Nursing & Midwifery Council

Guide to completing practice hours log

To record your hours of practice as a registered nurse, midwife and nursing associate, please fill in a page for each of your periods of practice. Please enter your most recent practice first and then any other practice until you reach 450 hours. You can only count practice hours during the three year period since your last registration renewal or initial registration. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks. For example if you work full time, please just make one entry of hours. If you have worked in a range of settings please set these out individually. You may need to print additional pages to add more periods of practice. If you are both a nurse and a midwife or a nursing associate and nurse you will need to provide information to cover 450 hours of practice for each of these registrations.

Work setting

- Ambulance service
- Care home sector
- Community setting (including district nursing and community psychiatric nursing)
- Consultancy
- Cosmetic or aesthetic sector
- Governing body or other leadership
- GP practice or other primary care
- Hospital or other secondary care
- Inspectorate or regulator
- Insurance or legal
- Maternity unit or birth centre
- Military
- Occupational health
- Police
- Policy organisation
- Prison
- Private domestic setting
- Public health organisation
- School
- Specialist or other tertiary care including hospice
- Telephone or e-health advice
- Trade union or professional body
- University or other research facility
- Voluntary or charity sector
- Other

Scope of practice

- Commissioning
- Consultancy
- Education
- Management
- Policy
- Direct patient care
- Quality assurance or inspection

Registration

- Nurse
- Midwife
- Nurse/SCPHN
- Midwife/SCPHN
- Nurse and Midwife (including Nurse/SCHPN and Midwife/SCPHN)

Dates:	Name and address of organisation:	Your work setting (choose from list above):	Your scope of practice (choose from list above):	Number of hours:	Your registration (choose from list above):	Brief description of your work:
01/09/2018 - 15/11/2019	BHSCT Mater Hospital	Hospital	Direct patient care	>450 hours	Nurse	Ward Manager of Acute Medical ward within Mater Hospital
16/10/2019 – 05/07/2021	SHSCT CAH	Hospital	Management	>450 hours	Nurse	Lead Nurse for several Acute Medical units and specialist nurses.
05/07/2021 – current	SHSCT CAH	Hospital	Quality Assurance or inspection	> 450 hours	Nurse	Acute Clinical Governance Coordinator for the SHSCT.

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CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

LOG TEMPLATE

NMC Nursing & Midwifery Council

Guide to completing CPD record log

Examples of learning method

- Online learning
- Course attendance
- Independent learning

What was the topic?

Please give a brief outline of the key points of the learning activity, how it is linked to your scope of practice, what you learnt, and how you have applied what you learnt to your practice.

Link to Code

Please identify the part or parts of the Code relevant to the CPD.

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Please provide the following information for each learning activity, until you reach 35 hours of CPD (of which 20 hours must be participatory). For examples of the types of CPD activities you could undertake, and types of evidence you could retain, refer to our guidance sheet at www.revalidation.nmc.org.uk/download-resources/guidance-and-information.

Dates:	Method Please describe the methods you used for the activity:	Topic(s):	Link to Code:	Number of hours:	Number of participatory hours:
25/9/18 – 27/9/18	Course Attendance	Operational Excellence	PE, PS	22.5 hrs	22.5 hrs
10/10/18	Independent Learning	Operational Excellence learning set	PE, PS	2 hrs	2 hrs
20/11/18 – 22/11/18	Course Attendance	Leadership and Change	PP, PE, PS, PPT	22.5 hrs	22.5 hrs
7/12/18	Independent Learning	Leadership and Change learning set	PP, PE, PS, PPT	2 hrs	2 hrs

26/3/19-28/3/19	Course Attendance	Quality and Process Management	PP, PE, PS	22.5 hrs	22.5 hrs
16/4/19	Independent Learning	Quality and Process Management learning set	PP, PE, PS	2 hrs	2 hrs
7/5/19 – 9/5/19	Course Attendance	Strategy	PP, PE, PS	22.5 hrs	22.5 hrs
3/6/19	Independent Learning	Strategy Learning set	PP, PE, PS	2 hrs	2 hrs
31/3/20 – 2/4/20	Course Attendance	Financial Decision making	PE	22.5 hrs	22.5 hrs
27/4/20	Independent Learning	Financial Decision making Learning set	PE	2 hrs	2 hrs
24/9/19-26/9/19	Course Attendance	Innovation Management	PP, PE, PS	22.5 hrs	22.5 hrs
15/10/19	Independent Learning	Innovation Management learning set	PP, PE, PS	2 hrs	2 hrs
28/01/20-30/01/20	Course Attendance	People Development and Management	PP, PE, PS, PPT	22.5 hrs	22.5 hrs
25/02/20	Independent Learning	People Development and Management Learning set	PP, PE, PS, PPT	2 hrs	2 hrs
				Total: 171.5 hours	**Total: 171.5 hrs**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

FEEDBACK LOG TEMPLATE

NMC Nursing & Midwifery Council

Guide to completing a feedback log

Examples of sources of feedback

- Patients or service users
- Colleagues – nurses, midwives, nursing associates, other healthcare professionals
- Students
- Annual appraisal
- Team performance reports
- Serious event reviews

Examples of types of feedback

- Verbal
- Letter or card
- Survey
- Report

Please provide the following information for each of your five pieces of feedback. You should not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information in How to revalidate with the NMC provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

You might want to think about how your feedback relates to the Code, and how it could be used in your reflective accounts.

Date	**Source of feedback** **Where did this feedback come from?**	**Type of feedback** **How was the feedback received?**	**Content of feedback** **What was the feedback about and how has it influenced your practice?**
15/03/2021	Communication from line manager and Service user relative	Email	It surrounded a complaint response to a service user's son when his mother's dentures had been lost while in the hospital as an inpatient during the Covid pandemic. This reinforced the importance of being open, transparent during all communications especially when deescalating incidents such as adverse incidents and complaints

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18/06/2021	Communication from staff member who I manage.	Email.	It surrounded the management of a personal trauma which required time off work. The staff member wanted details to remain confidential and lacked confidence her current temporary line manager would maintain her confidence. I took the lead while the staff member was absent from work, on her return I mediated and facilitated a meeting between both the manager and herself to resolve difficulties and establish a successful working relationship moving forward.
12/6/2020	Communication from Head of Health Records	Email	Email provided a thank you for continued support to the admin team during the initial stages of the Covid 19 pandemic. With a very fluid situation I was the single lead nurse within Medicine CAH for medical wards. The pandemic increases the workload with a shortage of frontline staff placed consequently this increased pressure on the ward support staff. My continued support and liaison between the two services assisted in maintaining communication between the two teams and assisted to improve communication between the hospital and service users family members

12/6/2021	Email from a staff member	Email	Email was sent to thank myself for the continued support over a very difficult few months. Within her clinical area she was a clinical sister alongside 2 fellow band 6s and a band 7. From January to May there was only herself as a senior nurse for her side of the ward due to sickness and risk assessed isolations, she had less than 6 months experience within her band 6 role at that time. During this time I ensured to always meet in person once a week and assisted in her role development and management of the clinical area. For complete events I facilitated and support her to take the lead to increase her competence and confidence.
29/05/2020	Email from the complaints department surrounding management of complaints.	Email	Email thanked me for my management of a concern raised through the complaints department surrounding a complaint. During the call I address her areas of compliant but they it was evident they had guilt surrounding their loved ones death, I took the time to discuss their care, their involvement and roles in caring for their loved one over the past few years. This reinforced the value of accepting complaint resolution takes time but also the importance of meeting the needs of all service users and their families, even more so now when greater restrictions are in place and patients last moments are too often spent away from their loved ones, friends and family.

Wamsley, Chris

Dear Chris,

Some very positive feedback from [redacted] regarding your communication with him.

Regards Anne

Anne McVey
Assistant Director of Acute Services Medicine
COVID 19 Lead Acute
Tel: [Personal Information redacted by the USI]
Mobile: [redacted]
Email: [redacted]

From: [redacted] mailto:patrick.mccool@virgin.net
Sent: 22 February 2021 08:34
Subject: Urgent Assistance Required

Re - [redacted]. Ward 3 North Medical

Dear [redacted]

I understand from [redacted] and Chris Wamsley that you are aware of my mother's situation regarding her lost dentures and her subsequent inability to either speak or eat properly.

Added to that, the indignity and embarrassment of not having her dentures makes her situation even worse.

I understand from the ward staff that despite their best efforts she can eat very little and has lost a lot of weight in the two weeks since her dentures were lost.

I had a very kind call from Chris Wamsley on Friday afternoon when he informed me amongst other things that because there was a Covid outbreak on the ward that a member of the hospital Dental team would be unable to visit my mother to take an impression to have new dentures made.

The ward staff who are wonderful with my mother, now tell me that all the recent swabs have returned negative and that the ward is now clear.

This is a perfect opportunity to have a member of the Hospital Dental team visit my mother and take a dental impression

I would be extremely grateful if you would be of assistance in organising this as a matter of urgency.

I wanted to do Chris Wamsley the courtesy of copying him into this email but unfortunately do not have his email address.

Maybe you could let me have his email address or forward this email to him with my thanks for his telephone call on Friday

Many thanks in anticipation of your assistance.

Yours Sincerely
[redacted]

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Wamsley, Chris

Subject: FW: ++

From: [redacted]
Sent: 18 June 2021 13:31
To: Wamsley, Chris
Subject: ++

Hey Chris,

Just letting you know I'm off now for the next 6 weeks, so I wanted to say thank you for your kindness and help through the past few months. Your confidentiality has been greatly appreciated and forwarding me the policy etc. I have spoken to [redacted] and explained things and my wish for complete confidentiality. You probably won't be in post when I come back so just wanted to say thanks and wish you all the best in your new job.

[redacted]

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Wamsley, Chris

Subject: FW: Thanks

From: [redacted]
Sent: 12 June 2020 12:43
To: [redacted]
Subject: Thanks

Just wanted to say thank you to you all. During the whole COVID bit you have been really supportive to Sinead, Ceara and myself – things haven't been ideal, but you have worked with us and I have really appreciated your support.

Thanks everyone –

[redacted]
Head of Health Records
Admin Floor, CAH

This item has been archived by HP Consolidated Archive. View Restore

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Wamsley, Chris

Subject: FW: New job

From: [redacted]
Sent: 05 July 2021 16:26
To: Wamsley, Chris
Subject: New job

Hi Chris,

I hear you have got a new job! Just wanted to say congratulations and thank you for all your help over the last few years, especially your support over the last few months.

Kind regards,

[redacted]

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Wamsley, Chris

Subject: FW: Phone Call

From: ClientLiaison, AcutePatient
Sent: 29 May 2020 16:59
To: Wamsley, Chris
Subject: RE: Phone Call

Chris thank you for this and I am so glad you spoke with her so honestly and eloquently.

I would need 10 more of you J

We will need to followed this up with a formalised letter to date if that suits I am happy to meet if it would be easier for you

Yours Sincerely
[redacted]

Acute Governance Manager | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

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NMC Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC.*

Reflective account: **Management of Bereavement Inquiry**

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

Initial concerns raised through Covid bereavement team.
Initial concerns were addressed however at each interface further concerns identified.
Eventually family advised to raise concerns through complaints process due to the complexity of concerns. Initially refused.
Delay obtaining contact with family which lead to a 6 week gap.
Family contacted myself and requested complaints procedure due to excessive delay in arranging meeting during Covid Pandemic and relationship build destroyed.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

At each interface I took notes however as these were addressed I placed notes in confidential waste, leaving no record of conversations.
As such once the complaint arrived I had no written record of conversations had with family.
Due to length of time calls took (approx. 2 hours per interface) I had to select opportunities appropriately to liaise with family members; this limited my available slots to contact family which exacerbated delay. Due to delicate nature of content I did not want to leave an email or voicemail.

How did you change or improve your practice as a result?

- Record and retain all conversation by telephone associated with bereavement and complaints.
- Leave a message (voicemail or email) for evidence of contact and evidence proof of call.
- Negative impact because although this family were exceptionally difficult to correspond with and address concerns they were going through a grieving process following death of service user. The poor contact and delay further impacted their grief processes.

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

Prioritising People

Promoting Professionalism and Trust.

NMC Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

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Reflective account: **Use of personal experience in engaging with service users and families**

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

During the pandemic there was a large volume of bereavement and complaints associated with service user deaths within hospital, lack of visiting and feeling of guilt from complainants.
I utilised my own experience of a family death during pandemic to empathise, support, deescalate and meet the duty of care needs to the families.
Predominately positive experience with positive feedback from bereavement team and service user's families regarding support provided.
One family although appreciative at time of call used this as a basis during a complaint, specified details out of context.
Reflection to provide balance opinion on appropriateness of using personal example for support and guidance of others.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

- Predominantly the experience assisted others through their grief process.
- Would engage with relatives longer on calls surrounding bereavement team and complaints surrounding deaths over covid pandemic period due to the adverse impact of reduced visiting – well received with positive feedback returned from both complaints and bereavement team.
- Outside of palliative conversations I would use personal examples to explain medical jargon in real life terms, to promote open, honest, person centered relationships.
- Experience working across chronic specialist care, frailty, general medicine and this was first negative response form personalising and relating to service users and families at personal levels, within appropriate contexts.

How did you change or improve your practice as a result?

- I have found the use of engagement both at professional and personal levels with service users and carers help establish real, open, honest, therapeutic relationships.
- Although disheartened by the negative impact this communication may have had I feel the complaint surrounding the use of this experience was on the back of my poor communication with the family. The use of this example which at time of call was one short example relating to the service users relatives grieving processes surrounding guilt.
- I must appreciate and be accountable for my role within the negative experience of this family's bereavement process, since this event I will leave a voicemail to respond if unable to obtain family on the phone.
- Throughout my nursing career this open relevant sharing of experience I believe adds to my ability to relate, engage and build relationships effectively, to discontinue using my experiences to relate to service users and families when appropriate would reduce the quality of my care provision; the negative actions for one individual should not prevent effective care provision which potential supports in future events.

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

PE, PS, PPT, PP

NMC Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

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Reflective account: **Management of inaccurate complaint response**

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

Complaint response arrived from ward sister for review, LN approval and to forward onto HOS and AD.
Complaint process completed and sent to family member.
HCA involved in complaint raised concerns surrounding inaccuracies in content within response.
Met with HCA and union representative to discuss complaint.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

- Complaint response was completed, unable to obtain ward manager events as she was on maternity leave.
- Complaint discussed an interaction with HCA, advises that she did ~~want~~ what was discussed in complaint but was not patronising or disrespectful.
- Component of complaint stated that HCA would not reposition service user at friends request as it was not due.
- HCA stated she was not in pain and not due as per chart.
- Unable to confirm all components of HCA recollection of events due to time passed, over 1 year.
- Apology given that staff engagement not completed effectively at their perception.
- Advised that component of the complaint remains valid. Apology was fair as if patient was uncomfortable minimally an assessment and repositioning should have been facilitated. Discussing care from a door way also provided a poor reflection of engagement in the needs of the patient and the visitors.
- Apology provided that the complaint response was sent out without her first seeing content.
- Unfair to both complainant and HCA if response was inaccurate and agreed actions not completed effectively.

How did you change or improve your practice as a result?

- Ensure complaint responses which directly involve staff members are reviewed by the individual prior to approving for HOS/AD approval.
- Ensure clinical areas ~~are~~ have evidence of completed agreed actions discussed within complaint responses.

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

PP, PPT.

NMC Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

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Reflective account: **Performance Management during Pandemic**

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

Trying to implement a performance management plan during the pandemic

A band 7 was underperforming however due to an inability to attend clinical environments, step down of different attributes of their role and severe staff shortages I was unable to instigate an action plan which was timely.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

- There needs to be improved induction processes for all bands of nursing staff.
- I had regular open dialogue with the ward manager providing positive and negative feedback however with limitations on visiting clinical environments and starting and stopping of services implementation of an effective process has been limited.
- As the ability to implement the process has been difficult this has devalued the importance and responsiveness of the action plan.

How did you change or improve your practice as a result?

- Design of a booklet to work through collectively over zoom and phone formats.
- Progress has occurred however it is a much slower transition that want would be tolerated within normal medical times.

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

PP, PE, PS

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Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

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Reflective account: **Use of business improvement knowledge in Healthcare**

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

Use of business improvement theory within my managerial and quality improvement approaches.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

- Numerous approaches and skills for use of data and analytics.
- Promoted a need to review data presented within current practice in an attempt to present in an easily understood and transferable format so it will be embraced from boardroom to bedside.
- Have used small scale for areas within MUSC to develop targeted action plans and instigate tailored action plans which yield greater results.

How did you change or improve your practice as a result?

- Commencing my new role in governance I want to bring data usage to the frontline, promoting a greater focus on proactive governance strategies.
- Review of current key datix themes to pull trends and provide sound evidence for collectively working with Nursing governance teams and Acute quality leads.
- Improve quality of datix reporting so appropriate action can be identified and implement to develop a safer, higher quality healthcare provision

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

PP, PPT, PS PE

NMC Nursing & Midwifery Council

REFLECTIVE DISCUSSION FORM

You must use this form to record your reflective discussion with another NMC-registered nurse, midwife or nursing associate about your five written reflective accounts. During your discussion you should not discuss patients, service users, colleagues in a way that could identify them unless they expressly agree, and in the discussion summary section below make sure you do not include any information that might identify an individual. Please refer to the section on non-identifiable information in How to revalidate with the NMC for further information. For more information about reflective discussion, please refer to our guidance sheet on reflective practice for revalidation.

To be completed by the nurse, midwife or nursing associate:

Name:	Chris Wamsley
NMC Pin:	Personal Information redacted by the USI

To be completed by the nurse, midwife or nursing associate with whom you had the discussion:

Name:	Melanie McClements
NMC Pin:	Personal Information redacted by the USI
Email address:	Personal Information redacted by the USI
Professional address including postcode:	Admin Floor Craigavon Area Hospital 68 Lurgan Rd, Portadown, Craigavon BT63 5QQ
Contact number:	Personal Information redacted by the USI
Date of discussion:	31/8/2021
Short summary of discussion:	Personal Information redacted by the USI

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I have discussed five written reflective accounts with the named nurse, midwife or nursing associate as part of a reflective discussion. I agree to be contacted by the NMC to provide further information if necessary for verification purposes.	Signature: Personal Information redacted by the USI Date: 31/8/22.

CONFIRMATION FORM

Nursing & Midwifery Council

You must use this form to record your confirmation.

To be completed by the nurse, midwife or nursing associate:

Name:	Chris Wamsley
NMC Pin:	Personal Information redacted by the USI
Date of last renewal of registration or joined the register:	Joined Register September 2009

I have received confirmation from (select applicable):

X	A line manager who is also an NMC-registered nurse, midwife or nursing associate
	A line manager who is not an NMC-registered nurse, midwife or nursing associate
	Another NMC-registered nurse, midwife or nursing associate
	A regulated healthcare professional
	An overseas regulated healthcare professional
	Other professional in accordance with the NMC's online confirmation tool

To be completed by the confirmer:

Name:	Melanie McClements
Job title:	Director of Acute Services
Email address:	Personal Information redacted by the USI
Professional address including postcode:	Admin Floor Craigavon Area Hospital 68 Lurgan Rd, Portadown, Craigavon BT63 5QQ
Contact number:	Personal Information redacted by the USI
Date of confirmation discussion:	31/08/2021

If you are an NMC-registered nurse, midwife or nursing associate please provide:

NMC Pin:

If you are a regulated healthcare professional please provide:

Profession:
Registration number for regulatory body:

If you are an overseas regulated healthcare professional please provide:

Country:
Profession:
Registration number for regulatory body:

If you are another professional please provide:

Profession:
Registration number for regulatory body (if relevant):

Confirmation checklist of revalidation requirements

Practice hours

☐ You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has practised the minimum number of hours required for their registration

Continuing professional development

☐ You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has undertaken 35 hours of CPD relevant to their practice as a nurse, midwife or nursing associate

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☐ You have seen evidence that at least 20 of the 35 hours include participatory learning relevant to their practice as a nurse, midwife or nursing associate.

☐ You have seen accurate records of the CPD undertaken.

Practice-related feedback

☐ You are satisfied that the nurse, midwife or nursing associate has obtained five pieces of practice-related feedback.

Written reflective accounts

☐ You have seen five written reflective accounts on the nurse, midwife or nursing associate's CPD and/or practice-related feedback and/or an event or experience in their practice and how this relates to the Code, recorded on the NMC form.

Reflective discussion

☐ You have seen a completed and signed form showing that the nurse, midwife or nursing associate has discussed their reflective accounts with another NMC-registered individual(or you are an NMC-registered individual who has discussed these with the nurse, midwife or nursing associate yourself).

I confirm that I have read Information for confirmers, and that the above named NMC-registered nurse, midwife or nursing associate has demonstrated to me that they have met all of the NMC revalidation requirements listed above during the three years since their registration was last renewed or they joined the register as set out in Information for confirmers. I agree to be contacted by the NMC to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse, midwife or nursing associate's registration application at risk.
Signature:
Date:

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REVALIDATION

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

CONTENTS

This updated document was updated in May 2019

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

WHAT DOES THIS DOCUMENT DO?

This document is for nurses, midwives and nursing associates who are registered with the NMC. It sets out how to renew your registration with the NMC through revalidation every three years.

The requirements for revalidation are either prescribed in the Nursing and Midwifery Order 2001 (the Order)[1] and the Education, Registration and Registration Appeals Rules (the Rules)[2], or are standards set by the NMC for revalidation and readmission.[3]

About the NMC

We're the independent regulator for nurses and midwives in the UK and nursing associates in England.

Better and safer care for people is at the heart of what we do, supporting the healthcare professionals on our register to deliver the highest standards of care.

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How to use this document

This document gives an overview of the revalidation requirements which you will have to meet every three years in order to renew your registration. It also sets out how you should collect the required information and approach the process, including suggested templates which you can use as well as mandatory forms which you must complete as part of your revalidation application.

This document includes a checklist of the revalidation requirements and the supporting evidence for each requirement.

Each requirement is presented on pages 18-37 followed by information about:

- the purpose of the requirement
- how to meet the requirement
- the recommended or mandatory approach to collecting and recording the required information, and
- how to demonstrate to us that you have met the requirement in your online application.

You should read this document in conjunction with the Code[4] and other guidance on our website. We have published a range of resources that you might find helpful in preparing for revalidation, including completed templates and case studies. We have also provided information for confirmers, which you should ensure that your confirmer has read, as well as information for employers, which we recommend you encourage your employer (if applicable) to read.

Please note that you must still pay your annual registration fee every year to retain your registration with the NMC.

How the NMC will use your information

As part of the revalidation process you are required to submit information about yourself to the NMC. We will only process your personal data, as permitted by the Data Protection Act 2018 ('DPA').

Details of our data protection policy are included in our privacy notice at:
www.nmc.org.uk/privacy

We will use your personal data for the purposes of administering and assessing your revalidation application and any subsequent verification of that application. We may also use information obtained through the revalidation process for research, and for the purpose of maintaining and improving our internal systems and processes.

Your responsibility

You are responsible for your revalidation application. You need to sufficiently plan to ensure, to the best of your ability, that you will meet the requirements within your three year renewal period. If you require support from us to help you revalidate, please see our support to help you revalidate guidance sheet.

We expect you to complete your revalidation application on NMC online. This should not be delegated to someone else unless we have granted you an adjustment. You must provide accurate information in your online application.

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You must adhere to the conditions we set out in this guidance and in the guidance we provide for confirmers and employers (if appropriate). Examples of these conditions include (but are not limited to) avoiding conflicts of interest and having your reflective discussion with a person on the NMC register.

If there are grounds for believing that you have not met these conditions, and/or that you have made a false declaration as part of your revalidation application, we will investigate and your registration could be at risk. Information supplied by you may be used to investigate any alleged breach of the Code and for the purpose of any subsequent fitness to practise proceedings.

Equality, diversity and inclusion

We value the diversity of the people on our register, and the wider community we serve. We are dedicated to ensuring revalidation is supportive and fair.

The Equality Act 2010 ('the Act') is legislation that applies in England, Wales and Scotland.[5] This Act protects people from discrimination, harassment or victimisation by specifying a number of 'protected characteristics':

- age
- gender reassignment
- being married or being in a civil partnership
- being pregnant or in the maternity period
- disability[6]
- race, including colour, nationality, ethnic or national origin
- religion, belief, or lack of religion or belief
- sex
- sexual orientation.

We expect all employers of nurses, midwives and nursing associates to meet their legal duty in the Equality Act 2010. We expect them to support you based on your individual needs and remove any unnecessary barriers to help you meet the revalidation requirements.

We cannot change the revalidation requirements as they are competence standards that demonstrate that you can practise safely and effectively. However, we can support you to renew your registration by providing adjustments that help you revalidate. For example, we can provide you with a short extension to your application date so you have more time to meet the revalidation requirements or give you a paper application form.

You can find further information on the support we offer on our website.

How to contact the NMC

For more information please see the revalidation section of the NMC website at: **www.nmc.org.uk**. If you are unable to find the information you need and you still require further help you can email us at: **revalidation.escalation@nmc-uk.org**.

If you wish to make a complaint or provide feedback about the standard of our service, please visit the 'Contact us' pages of our website at **www.nmc.org.uk/contact-us/complaints-about-us**.

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WHAT IS REVALIDATION?

Revalidation

- is the process that allows you to maintain your registration with the NMC
- demonstrates your continued ability to practise safely and effectively, and
- is a continuous process that you will engage with throughout your career.

Revalidation is your responsibility. You are the owner of your own revalidation application. We recommend that you work towards meeting the revalidation requirements throughout the three year revalidation period so you are prepared when your application is due.

Revalidation is not

- an assessment of your fitness to practise
- a new way to raise fitness to practise concerns (any concerns about a nurse, midwife or nursing associate's practice should be raised through the existing fitness to practise process), nor
- an assessment against the requirements of your current/former employment.

Purpose of revalidation

- to raise awareness of the Code and professional standards expected of you
- to provide you with the opportunity to reflect on the role of the Code in your practice as a nurse, midwife or nursing associate and demonstrate that you are 'living' these standards
- to encourage you to stay up to date in your professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals
- to encourage a culture of sharing, reflection and improvement
- to encourage you to engage in professional networks and discussions about your practice, and
- to strengthen public confidence in the nursing and midwifery professions.

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Revalidation and the Code

One of the main strengths of revalidation is that it reinforces the Code by asking you to use it as the reference point for all the requirements, including your written reflective accounts and reflective discussion.

This should highlight the Code's central role in the nursing and midwifery professions and encourage you to consider how it applies in your everyday practice.

The Code (paragraph 22) requires you to fulfil all registration requirements. To achieve this you must:

- meet any reasonable requests so we can oversee the registration process (22.1)
- keep to our prescribed hours of practice and carry out continuing professional development (CPD) activities (22.2), and
- keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (22.3).

Revalidation and the standards of proficiency

One purpose of revalidation is to help you to maintain safe and effective practice. Revalidation does this by encouraging you to update your knowledge and develop new skills. The NMC publishes and regularly updates standards of proficiency for everyone on our register. These set out what we expect students to know, understand and be able to do to apply to join our register and to practise safely and effectively. It is important for you to become familiar with the most recent standards, identify which ones relate to your scope of practice and identify your training needs. This will help you to advance your practice and also means that you will be equipped to supervise and assess students if this is part of your role.

It is important that you speak to your employers about the types of continuous professional development that will help you achieve this.

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Overall, revalidation should lead to improved practice and therefore public protection benefits.

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CHECKLIST OF REQUIREMENTS AND SUPPORTING EVIDENCE

These are all of the requirements that you must meet in order to complete your revalidation and renew your registration every three years with the NMC.

Requirements	Supporting evidence
450 practice hours for each registration. **Dual registration (e.g. nurse and midwife) requires 900 practice hours[7]**	Maintain a record of practice hours you have completed, including: • dates of practice • the number of hours you undertook • name, address and postcode of the organisation • scope of practice (see tip box on page 22) • work setting (see tip box on page 22) • a description of the work you undertook, and • evidence of those practice hours should be recorded. See our practice hours requirements guidance sheet and suggested template at guidance and information.
35 hours of continuing professional development (of which 20 must be participatory)	Maintain accurate and verifiable records of your CPD activities, including: • the CPD method (examples of 'CPD method' are self-learning, online learning, course) • a brief description of the topic and how it relates to your scope of practice • dates the CPD activity was undertaken • the number of hours and participatory hours • identification of the part of the Code most relevant to the CPD, and • you should record evidence of the CPD activity. See our guidance sheet and suggested template at guidance and information
Five pieces of practice-related feedback	Notes on the content of the feedback and how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts. Make sure your notes do not include any personal data (see the section on non-identifiable information on pages 15-17).

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Requirements	Supporting evidence
Five written reflective accounts	Five written reflective accounts that explain what you learnt from your CPD activity and/or feedback and/or an event or experience in your practice, how you changed or improved your work as a result, and how this is relevant to the Code. You must use the NMC form on page 47 and make sure your accounts do not include any personal data (see the section on non-identifiable information).
Reflective discussion	A reflective discussion form which includes the name and NMC Pin of the NMC-registered nurse, midwife or nursing associate that you had the discussion with as well as the date you had the discussion. You must use the NMC form on page 48 and make sure the discussion summary section does not contain any personal data (see the section on non-identifiable information).
Health and character	You must make a declaration as to your health and character as part of your online revalidation application. You can find more information in our guidance on health and character.
Professional indemnity arrangement	Evidence to demonstrate that you have an appropriate indemnity arrangement in place. You must tell us whether your indemnity arrangement is through your employer, membership of a professional body or through a private insurance arrangement. If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will need to record the name of the professional body or provider.
Confirmation	A confirmation form signed by your confirmer. You must use the NMC form on pages 49-51.

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THE REVALIDATION PROCESS

During the three years since your last renewal/you joined the register

You need to meet a range of revalidation requirements to show that you are keeping your skills and knowledge up to date and maintaining safe and effective practice

▶ See pages 18–37: for details of the requirements

In the 12 months before your renewal date

Once you have met the requirements, you will need to discuss your revalidation with a confirmer. As part of this confirmation discussion, you will demonstrate that you have complied with all of the revalidation requirements, except having a professional indemnity arrangement and meeting the requirements of health and character.

▶ See pages 35–37: 'Confirmation'

At least 60 days before your revalidation application date

Every three years you will be asked to apply for revalidation using NMC Online. We will notify you at least 60 days before your application is due, either by email if you have set up an NMC Online account, or by letter sent to your registered address.

▶ See pages 38–40: The application process'

In the 60 days before your revalidation application date

Once you receive your notification you will need to go online and complete the application form. As part of that application, you need to declare to the NMC that you have complied with the revalidation requirements.

▶ See pages 38–40: The application process'

Following submission of your revalidation application

Each year we will select a sample of revalidation applications and ask those professionals to provide us with further information so we can verify the declarations they made as part of their revalidation application. If you are selected your registration will be held effective until the verification process is complete and you can continue to practise as normal during this time. Your registration will only renew if the verification is completed successfully.

▶ See pages 41–42: 'Verification of your application'

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HOW TO APPROACH REVALIDATION

Understand key terms

1. The registration process: Every three years from when you join (or re-join) the register you will need to renew your registration by revalidating. Every year you will also need to retain your registration by paying an annual registration fee. If you don't complete these processes on time your registration will expire.
2. Fee expiry date: The deadline for paying your annual registration fee in order to retain your registration.
3. Revalidation application date: The deadline for submitting your revalidation application. It is the first day of the month in which your registration expires, so if your renewal date is 30 April, your revalidation application date will be 1 April.
4. Renewal date: The date on which your registration will be renewed if you have successfully completed your revalidation application. It is the last day of the month in which your registration expires.

Keep a portfolio

5. We strongly recommend that you keep evidence that you have met the revalidation requirements in a portfolio. This does not necessarily need to be an e-portfolio; please see our guidance sheet on e-portfolios at **revalidation.nmc.org.uk/download-resources/guidance-and-information** for further information. We have provided forms you must use and templates you may like to use to record your evidence for each requirement; these are available at the end of this document and on our website at **revalidation.nmc.org.uk/download-resources/forms-and-templates,** where you will also find examples of completed forms and templates for you to refer to.
6. We expect any evidence to be kept in English, and nurses, midwives and nursing associates must submit their revalidation application, and any subsequent requested verification information in English.
7. The portfolio will be helpful for the discussion you have with your confirmer (see pages 35-37). You will also need to have this information available in case we request to see it to verify the declarations you made as part of your application (see pages 41-42).
8. You may already keep a professional portfolio. If so, you do not need to maintain a separate portfolio but you might like to add to it.

The NMC recognises the culture and linguistic needs of the Welsh speaking public (for further information please see **www.nmc.org.uk/about-us/our-equality-and-diversity-commitments/welsh-language-scheme**). We have published Welsh language versions of our guidance for nurses and midwives, confirmers and employers, as well as our templates and forms, on our website at **revalidation.nmc.org.uk/download-resources/guidance-and-information**.

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9. You can use the checklist on page 9 to make sure that all of the information is in your portfolio before you have your confirmation discussion with your confirmer or submit your revalidation application.
10. We recommend that you keep your portfolio until after you complete your next revalidation. For example, if you revalidated in 2016, we suggest that you should keep your portfolio until after you have revalidated again in 2019.
11. Your portfolio must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your portfolio does not contain any information that might identify an individual.
12. During your revalidation application we will not request that you upload your evidence or submit your portfolio to the NMC. However, each year we will select a sample of revalidation applications and request further information from you to verify your revalidation application via NMC online. In some cases, we may request further evidence, so it is important that you keep all of your revalidation evidence safe.

Conflicts of interest and perceptions of bias

13. A conflict of interest is a situation that has the potential to undermine the impartiality and objectivity of decision making within the revalidation process. Conflicts of interest can arise when an individual's judgement is influenced subjectively through association with colleagues out of loyalty to the relationship they have, rather than through an objective process.
14. Conflicts of interest can occur because of personal or commercial relationships.
15. You need to be mindful about any personal or commercial relationship between you, your confirmer and your reflective discussion partner. You may not choose a family member or person with whom you have a close personal relationship, such as a close friend to undertake either of these roles
16. You, your confirmer and reflective discussion partner will need to take responsibility for deciding whether there is any conflict of interest or perception of bias to ensure that the confirmation process and reflective discussion retains credibility and remains objective. If you think that there is a risk there might be a conflict of interest you should use a different person as your confirmer and reflective discussion partner.

Appraisals

17. Many nurses, midwives and nursing associates have an employer. It is important for their employers to be aware of the Code and the standards expected of people on our register in their professional practice. See our Employers guide to revalidation at **revalidation.nmc.org.uk/download-resources/guidance-and-information.**
18. Appraisals are a way for employers to assess the performance of their employees against the requirements of their role and identify areas for improvement and development.
19. The revalidation process is designed so that it can be undertaken as part of a regular appraisal. If you are an employee who does not have a regular appraisal you could consider asking your employer to arrange an appraisal for you in advance of your revalidation application date.

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20. The confirmation discussion has a different purpose from an appraisal, as it is about demonstrating to an appropriate confirmer that you have met the revalidation requirements, not the requirements of your employment (please see the section on Confirmation on pages 35-37 for more details). However, it can be incorporated into an appraisal, and we recommend that, where possible, your confirmation discussion forms part of an annual appraisal, if you have one.
21. If your line manager is also registered with the NMC, you might like to have both your reflective discussion and your confirmation discussion as part of an annual appraisal, if you have one. You might find it helpful to have a discussion with your confirmer every year as part of an annual appraisal, so that you can keep them updated on your revalidation.
22. If you are not an employee, or if you are an employee who has been unable to arrange an appraisal in advance of your revalidation application date, you will still be able to renew your registration by meeting the revalidation requirements. You are not required to arrange for another person or organisation to conduct an appraisal for the purposes of revalidation, but you will still need to arrange a reflective discussion and confirmation discussion.

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NON-IDENTIFIABLE INFORMATION

23. You are likely to process personal data as part of your day to day role. If you are employed, you are likely to be covered by your employer's registration under data protection legislation. If you are practising as an independent or self-employed nurse, midwife or nursing associate you are already likely to be registered under data protection legislation in your capacity.
24. This section sets out your obligations in relation to confidentiality and data protection in relation to meeting the revalidation requirements. It does not cover your existing obligations in relation to data protection legislation.

Personal data means data which identifies an individual.
Section 1(1) of the Data Protection Act 1998.

Your obligations in relation to confidentiality under the Code

25. The Code sets out the professional standards that you must uphold in order to be registered to practise in the UK. Standard 5 of the Code states:

Respect people's right to privacy and confidentiality

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

To achieve this, you must:

- respect a person's right to privacy in all aspects of their care (5.1)
- make sure that people are informed about how and why information is used and shared by those who will be providing care (5.2)
- respect that a person's right to privacy and confidentiality continues after they have died (5.3)
- share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality, and (5.4)
- share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand. (5.5)

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Making sure that your evidence does not include any personal information

26. In meeting the revalidation requirements and keeping your evidence, you must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information recorded must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information.

27. For example, any notes or reflections must not include:

    - the name of any individual
    - the date of any incident or event referred to
    - the particular ward or place where the event occurred, or
    - descriptions of unique circumstances where an individual could be identified from the circumstances.

28. Any information extracted from employer data (such as complaints logs) must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal account, or download and take copies of employer records. You must seek consent to access or use your employer's information.

Example scenarios

29. You will already be aware of the importance of keeping personal information confidential, and not processing personal information outside of your employment or work settings. However, we have provided some simple examples below to demonstrate how an instance of feedback could be recorded in a way that no individual can be identified.

Scenario 1

In January 2015 Mrs Jones was in ward 8 with a broken hip. She made a complaint about lack of hydration. You want to use this feedback in one of your reflections as an example of where you put in place a new process to make sure all patients were offered water on a regular basis.

In your reflective account you could say: 'A patient with a serious injury made a complaint about lack of hydration.'

No dates, names or wards have been included in the record, and the type of injury has also been omitted, so Mrs Jones cannot be identified from this information. You can then explain what you did, what improvement you made and how this is related to the Code.

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Scenario 2

In reviewing the complaints log held by the maternity unit where you work, you noticed a complaint made by Mrs Smith in relation to a lack of continuity of care and handover between midwives at the end of a shift on 12 January 2015. You were one of the midwives involved, along with your colleague Sarah. You discussed this with your colleagues and have made improvements in the way you handover at the end of shifts. You want to use this feedback in one of your reflections.

Before writing your reflective account, you need to check with your employer that you can use information from the complaints log. In your reflective account you could say: 'A complaint was received about the lack of continuity of care and handover between myself and a colleague at the end of a shift'.

No information identifying any individual, including both Mrs Smith and your colleague, has been included in this record. You can then explain what you did, what improvement you made and how this is related to the Code.

Storing your reflective accounts form, reflective discussion form and confirmation form

30. You are not required to submit your reflective accounts form, reflective discussion form and confirmation form to the NMC at any point in the revalidation application. There is no requirement to store them electronically or upload them into NMC Online as part of your application, or provide them if you are selected so we can verify your evidence.
31. Your 'reflective discussion form' and 'confirmation form' contain personal data about another person. This means that there are data protection implications for nurses, midwives and nursing associates completing these forms, when they are processing electronic records. There is not an exemption under Data Protection legislation which applies to personal data processed by our registrants, as part of the reflection and discussion elements of revalidation. However, the Information Commissioner's Office (ICO) have recognised that it would be highly disproportionate to expect our registrants to have to register with them as data controllers when processing electronic records, or to pay a fee. The ICO has confirmed that it does not plan to take any action against any of our registrants for failing to register with them.
32. You may choose to store your completed reflective discussion and confirmation forms in either paper or electronic format. You should still respect the fact that these forms contain personal data about your reflective discussion partner and confirmer. Please see our guidance sheet on e-portfolios for further information at guidance and information.

The Information Commissioner's Office has published a guide to data protection legislation at **ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/**

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PRACTICE HOURS

The requirements

33. You must have practised as a registered nurse, midwife or nursing associate for a minimum number of hours over the three year period since your registration was last renewed or you joined the register.[8]

Registration	Minimum total practice hours required
Nurse	450 practice hours required
Midwife	450 practice hours required
Nursing associate	450 practice hours required
Nurse and SCPHN	450 practice hours required
Midwife and SCPHN	450 practice hours required
Nurse and midwife (including Nurse/SCPHN and Midwife/SCPHN)[9] Or Nursing associate and nurse	900 practice hours required (to include 450 hours for nursing, 450 hours for midwifery, 450 hours for nursing associate)

A specialist community public health nurse (SCPHN) means a registered nurse, midwife or nursing associate who is also registered in the Specialist Community Public Health Nurses' part of the register.

34. If you have practised for fewer than the required number of hours in the three year period since your registration was last renewed or you joined the register, then you must successfully complete an appropriate return to practice programme approved by the NMC before the date of your application for renewal of registration.[10]

35. Registered nurses, midwives or nursing associates who are admitted to another part of the register since their registration was last renewed or they joined the register only need to meet the practice hours requirement for their initial registration. They will need to meet the practice hours requirements for registration in both parts in subsequent three year renewal periods.[11]

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The purpose of these requirements

36. The practice hours requirements are designed to help you to maintain safe and effective practice, and keep your skills up to date.

How to meet the requirements

37. You can only count practice hours that you undertook while you were registered with the NMC. You cannot count unregistered practice or hours completed when working in an entirely different regulated profession such as a paramedic or medical doctor.
38. Practice hours should reflect your current scope of practice. You must comply with The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates at all times. This includes the duty to recognise and work within the limits of your competence.
39. You must meet your practice hours in a role where you rely on your skills, knowledge and experience of being a registered nurse, midwife or nursing associate.

    This includes:

    - practice as a nurse, midwife, SCPHN and nursing associate, in roles that are likely to require registration
    - practice in roles where your employment contract does not expressly require you to be registered with us but you rely on your skills, knowledge and experience of being a registered nurse, midwife or nursing associate. For example, this could include roles in public health or nursing, midwifery, management, commissioning, policy and education
40. The following activities cannot be counted towards the practice hours requirement: hours undertaken in a healthcare, nursing or midwifery assistant or support worker role cannot be counted towards practice hours as a registered nurse, midwife or nursing associate.
    - Hours completed when working in a separate regulated profession for example when working as a paramedic or medical doctor.
    - Nurses undertaking an 18-month midwifery programme cannot use their midwifery training hours in order to maintain their registration as a nurse. They will be able to use any practice hours undertaken as a nurse, either before or after their midwifery course, during the three-year period.
    - Hours undertaken in any healthcare, nursing or midwifery assistant or support worker roles cannot be counted towards practice hours.
41. If you are working overseas (or have worked overseas for part of your three year renewal period) as a nurse, midwife or nursing associate you can count these hours towards the practice hours requirements for revalidation. Where possible, you should always register with the appropriate regulator in the country in which you are practising.
42. If you have had a career break, you will still be able to meet the practice hours requirement if you have completed the required hours of registered practice during your three year renewal period.
43. We have produced a guidance sheet for people with multiple registrations and additional qualifications. Please see our guidance and information on our website.

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Further information on working outside the UK and returning to practice can be found on our website **www.nmc.org.uk/registrations**

44. If you have not undertaken any type of work where you relied on your skills, knowledge or experience as a registered nurse, midwife or nursing associate, or if you are unable to meet the practice hours requirement, you have two options:
    - you can successfully complete an appropriate NMC-approved return to practice programme before the date of your revalidation application. These programmes are designed to allow you to renew your registration and return to practice after a break in practice. Further information about return to practice programmes is available on our website or
    - you can cancel your registration. You will continue to hold a nursing and/or midwifery qualification, but will not be registered with the NMC. You can apply for readmission to the register in future if you wish to practise as a registered nurse, midwife or nursing associate. Information on cancelling registration and seeking readmission to the register is available on our website.
45. If you do not renew your registration, you will lapse from the register. You will not be able to practise in the capacity of a registered nurse, midwife or nursing associate. You cannot rely on any hours of work you undertake when you were not registered with the NMC as part of any application for readmission to the register.

How to record practice hours

46. We strongly recommend that you maintain a record of practice hours you have completed.
47. This will form part of the discussion you have with your confirmer, and you will also need to have this information available in case we request to see it for verification of your application. We have provided a guidance sheet on practice hours and have a suggested template to help you record your practice hours. Your records should include:
    - dates of practice
    - the number of hours you undertook
    - name, address and postcode of the organisations
    - scope of practice
    - work setting
    - a description of the work you undertook, and
    - evidence of those practice hours, such as timesheets, job specifications and role profiles.
48. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks.

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What you need to tell us in your online application

49. When you apply for revalidation, you need to declare that you have met the practice hours requirement during the three year period since your last registration renewal or initial registration. You only need to tell us about the most recent hours you have undertaken to meet the minimum requirement for your registration(s). If you are currently practising in more than one setting, provide details of your main setting first.
50. You will also be asked to enter the following details:
    - whether you are currently practising
    - if you are currently in practice, where you undertake that practice, including details of your scope of practice and work setting, and
    - if you are not currently in practice, where you undertook your most recent practice, including details of your scope of practice and work setting.
51. To help you prepare for your online application we have listed the scope of practice and work setting options in the tip box below. These were designed to capture the wide breadth of types of practice that people on our register can undertake, and as such they will not apply to all roles.
52. If you have completed a return to practice course or been admitted to another part of the register since you last renewed your registration or joined the register, your practice hours declaration will be as follows:
    - If you have recently completed an approved return to practice course since you last renewed your registration or joined the register, you will be able to meet the practice hours requirement for that registration.
    - If you have been admitted to another part of the register since you last renewed your registration or joined the register (for example you are a nurse who has undertaken training as a midwife and gained a second registration as a midwife), you only need to meet the practice hours requirement for your initial registration. Please note that next time you apply for revalidation, if you wish to renew your registration on both parts of the register and continue practising as both a nurse and a midwife, you will need to meet the practice hours requirements for both registrations.
    - For further information about multiple registrations and additional qualifications please see our guidance sheet at guidance and information.

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Scope of practice

Direct clinical care or management: adult and general care nursing; children's and neo-natal nursing; mental health nursing; learning disabilities nursing; midwifery; health visiting; occupational health; school nursing; public health; other. Commissioning, Education, Policy, Quality assurance or inspection, Research, other.

Work setting

Ambulance service, Care home sector, Community setting (including district nursing and community psychiatric nursing), Consultancy, Cosmetic or aesthetic sector, Governing body or other leadership, GP practice or other primary care, Hospital or other secondary care, Inspectorate or regulator, Insurance or legal, Maternity unit or birth centre, Military, Occupational health, Police, Policy organisation, Prison, Private domestic setting, Public health organisation, School, Specialist or other tertiary care including hospice, Telephone or e-health advice, Trade union or professional body, University or other research facility, Voluntary or charity sector, other.

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CONTINUING PROFESSIONAL DEVELOPMENT

The requirements

53. You must have undertaken 35 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse, midwife or nursing associate, in the three year period since your registration was last renewed or you joined the register.[12]
54. Of those 35 hours of CPD, at least 20 must have included participatory learning.[13]
55. You must maintain accurate records of the CPD you have undertaken. These records must contain:
    - the CPD method
    - a description of the topic and how it related to your practice
    - the dates on which the activity was undertaken
    - the number of hours (including the number of participatory hours)
    - the identification of the part of the Code most relevant to the activity, and
    - evidence that you undertook the CPD activity.[14]

The purpose of these requirements

56. As a professional, you have a duty to keep your professional knowledge and skills up to date through a continuous process of learning and reflection.
57. The CPD requirements are designed to help you to maintain safe and effective practice, to improve practice or develop new skills where a gap has been identified and to respond to changes and advances in nursing and midwifery.
58. The participatory requirement also helps to challenge professional isolation by requiring learning through engagement and communication with others.

How to meet the requirements

59. CPD is a learning activity that you undertake separately from your normal practice. This is different from the everyday learning that all healthcare professionals will engage in as part of their ongoing practice.
60. Any learning activity you participate in should be relevant to your scope of practice as a nurse, a midwife or a nursing associate. When you plan, undertake and record your CPD you should focus on what you are learning, how it is linked to your scope of practice and how you can apply it to your practice.

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61. We do not prescribe any particular type of CPD. We think that you are better placed to decide what learning activities are the most suitable and beneficial to your individual scope of practice. We have produced a guidance sheet that suggests some individual and participatory CPD activities that you can undertake, which includes many activities other than training courses (see guidance and information). It is not an exhaustive list and we have only provided it as an example.

62. We know that many organisations require their staff to undertake mandatory training. You should not include mandatory training that is not directly related to your practice (for example, fire training or health and safety training) as part of your 35 hours of CPD. However, if you undertake any mandatory training that is necessary to your scope of practice and professional development, for example, mandatory training on equality legislation if you are in a policy role, you could include that.

63. Participatory learning includes any learning activity in which you personally interact with other professionals, including professionals working outside healthcare. It can be an activity undertaken with one or more professionals or in a larger group setting. The group does not always need to be in a common physical environment, such as a study group or conference. It could be a group in a virtual environment (such as an online discussion group).

64. The NMC publishes and regularly updates standards of proficiency for everyone on our register. These set out what we expect students to know, understand and be able to apply to join our register and practise safely and effectively. When you are considering what CPD to undertake we recommend that you review the latest standards of proficiency for your part of the register and reflect on how your scope of practice relates to the standards and consider CPD activities that would help you to develop your skills. This is particularly important if you supervise and/or assess students as part of your role.

How to record CPD

65. You must maintain accurate records of your CPD activities, and we have provided a template to help you with this. This will form part of the discussion you have with your confirmer. You will need to have this information available in case we request to see it for verification of your application. Your records should include:

    - the CPD method
    - a brief description of the topic and how it relates to your practice
    - dates the CPD activity was undertaken
    - the number of hours and participatory hours
    - identification of the part of the Code most relevant to the CPD, and
    - evidence of the CPD activity.

What you need to tell us in your online application

66. You need to declare that you have met the CPD requirement.

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PRACTICE-RELATED FEEDBACK

The requirement

67. You must have obtained five pieces of practice-related feedback in the three year period since your registration was last renewed or you joined the register.[15]

The purpose of this requirement

68. The practice-related feedback requirement is intended to encourage you to be more responsive to the needs of patients and service users and those who care for them. You need to seek feedback from people you work with and care for and importantly you need to use the feedback that you receive to assess and make improvements to you practice.

How to meet the requirement

69. We recommend that you try to obtain feedback from a variety of sources, for example:
    - feedback from patients, service users, carers or students as part of your day to day practice
    - feedback from colleagues such as nurses, midwives, nursing associates and other healthcare professionals
    - feedback from colleagues in management, on reception, in assistant positions, as well as fellow teachers, researchers, academics or policy colleagues
    - complaints
    - team performance reports
    - serious event reviews, and
    - feedback received through your annual appraisal.
70. Types of feedback:
    - feedback can be about your individual practice or about your team, ward, unit or organisation's practice (you should be clear about the impact the feedback had on your practice)
    - formal or informal
    - written or verbal, and
    - positive or constructive.

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71. It's likely that you will already receive a range of feedback. In many organisations, feedback is already collected in a variety of ways. You must seek consent to access or use your employer's information. Any information must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal accounts, or download and take copies of employer records. See the section on non-identifiable information on pages 15-17 for more information.

72. Should you choose to solicit feedback directly from colleagues, patients or service users, you must make clear in your request that no information identifying individuals should be included in any feedback provided. You should also inform them how you intend to use their feedback, and reassure patients and service users that any feedback they give will not affect the care they receive.

How to record feedback

73. We recommend that you keep a note of the content of any feedback you obtain, including how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts. We have provided a template to help you record your feedback.

74. You may choose to collect more feedback but to meet the revalidation requirement you only need to note the details of five pieces of feedback.

75. In any note you keep, you must not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

What you need to tell us in your online application

76. You need to declare that you have met the feedback requirement.

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WRITTEN REFLECTIVE ACCOUNTS

The requirement

77. You must have prepared five written reflective accounts in the three year period since your registration was last renewed or you joined the register. Each reflective account must be recorded on the approved form and must refer to:
    - an instance of your CPD and/or
    - a piece of practice-related feedback you have received and/or
    - an event or experience in your own professional practice and how this relates to the Code.

The purpose of this requirement

78. We want you to engage in reflective practice so that you identify any changes or improvements you can make to your practice based on what you have learnt.

79. This requirement should also raise awareness of the Code and encourage you to consider the role of the Code in your practice and professional development.

How to meet the requirement

80. Each reflective account can be about an instance of your CPD, feedback, an event or experience in your practice as a nurse, midwife or nursing associate, or a combination of these. Both positive and negative experiences should be reflected on. Any experience, including a conversation with a colleague, a significant clinical or professional event, or a period of time can generate meaningful reflections, insights and learning. For example, you could create a reflective account on a particular topic which may have arisen through some feedback your team received following an event, such as consent and confidentiality and identify how that relates to the Code.

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How to record your reflective accounts

81. We have provided a form that you must use to record your reflective accounts. You must explain what you learnt from the CPD activity, feedback, event or experience, how you changed or improved your practice as a result, and how this is relevant to the Code.
82. This form can be hand written, typed or, if necessary, dictated.
83. Your reflective accounts must not include any information that might identify an individual whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your reflective accounts do not contain any information that might identify an individual.
84. You do not need to submit a copy of the reflective accounts to the NMC for the purpose of revalidation. However, you should retain these as a record to inform your reflective discussion and to show your confirmer.

What you need to tell us in your online application

85. You need to declare that you have met the requirement for written reflective accounts.

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REFLECTIVE DISCUSSION

The requirement

86. You must have had a reflective discussion with another NMC registrant, covering your five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code.[16]

87. You must ensure that the NMC registrant with whom you had your reflective discussion signs the approved form recording their name, NMC Pin, email, professional address and postcode, as well as the date you had the discussion.[17]

The purpose of this requirement

88. This requirement will encourage a culture of sharing, reflection and improvement. It does this by requiring you to discuss your professional development and improvement, and by ensuring that you do not practise in professional isolation.

How to meet the requirement

89. You must discuss your five written reflective accounts with another person on our register as part of a reflective discussion. In the discussion you and your reflective discussion partner will be linking your reflective accounts to the Code, so it is important that both of you are familiar with, and working to, the professional standards presented in the Code.

90. The reflective discussion partner:

- must be a nurse, midwife or nursing associate with an effective registration with the NMC, by which we mean they cannot be subject to any kind of suspension, removal or striking-off order at the time of having the discussion
- could be someone you frequently work with or someone from a professional network or learning group
- does not need to be someone you work with on a daily basis
- does not need to undertake the same type of practice as you, and
- does not need to be on the same part of the register as you (so a nurse can have a reflective discussion with a midwife and vice versa).

91. If you practise in a setting with few or no nurses, midwives or nursing associates, you can reach out to peers, who are registered with the NMC, from your wider professional or specialty network in order to have your reflective discussion.

92. It is for you to decide the most appropriate person for you to have this conversation with, including whether they are senior or junior to you.

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93. If your confirmer is on our register, your reflective discussion can form part of the confirmation discussion. If your confirmer is not on our register, you will need to have your reflective discussion with an NMC-registered nurse, midwife or nursing associate before your confirmation discussion with your confirmer.

94. We expect the discussion to be a face-to-face conversation in an appropriate environment. If for some reason you cannot have a face-to-face discussion, then you could arrange a video conference.

95. During your discussion you should not discuss patients, service users or colleagues in a way that could identify them unless they expressly agree. For further information on reflective discussions please guidance and information.

How to record your reflective discussion

96. We have provided an NMC form that you must use to record your discussion. You must make sure that the nurse, midwife or nursing associate with whom you had your reflective discussion signs the form and records their name, NMC Pin, email, professional address including postcode, contact number and the date you had the discussion and a summary of the discussion.[18] You should keep the completed and signed form.

97. The discussion summary section of the form must not include any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

What you need to tell us in your online application

98. You need to declare that you have had a reflective discussion with another NMC-registered nurse, midwife or nursing associate.

99. You will also need to enter the name, NMC Pin, email, professional address including postcode and contact number of your reflective discussion partner, as well as the date you had the reflective discussion.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

HEALTH AND CHARACTER

The requirements

100. You must provide a health and character declaration.[19]

101. You must declare if you have been convicted of any police charge, police caution, conviction or conditional discharge.[20]

102. You will be asked to declare if you have been subject to any adverse determination that your fitness to practise is impaired by a professional or regulatory body (including those responsible for regulating or licensing a health and social care profession).[21]

The purpose of these requirements

103. These requirements will help to satisfy the Registrar that you are capable of safe and effective practice.

How to meet the requirements

104. You will need to complete these declarations as part of your revalidation application.

105. When making these declarations please refer to our guidance on health and character for nurses, midwives and nursing associates.

106. Your character is important and is central to the Code because nurses, midwives and nursing associates must be honest and trustworthy. Your character is based on your conduct, behaviour and attitude. When declaring that you are of good character you should consider whether you have been involved in conduct which would breach the requirements of the Code. You can read the Code on our website: **www.nmc.org.uk/standards/code**. See our guidance on health and character for further information.

107. You will also be asked to declare if you have been subject to any determination by a professional or regulatory body (including those responsible for regulating or licensing a health or social care profession) to the effect your fitness to practise is impaired.[22]

108. In accordance with the Code, we expect you to declare any police charges, cautions, convictions and conditional discharges to the NMC immediately, not wait until revalidation. [23] A caution or conviction includes a caution or conviction you have received in the UK for a criminal offence, as well as a conviction received elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence.[24] Please do not notify the NMC of motoring offences unless it led to a disqualification of driving or offences that have previously been considered by the NMC. See our guidance on health and character for further information.

109. We need to know that people applying to renew their registration meet our requirements for health to ensure they can practise safely and effectively.

110. It's important to remember that when we talk about 'good health' we mean that you are capable of safe and effective practice as a nurse, midwife or nursing associate either with or without reasonable adjustments and adjustments which your employer has made.

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111. Our focus is whether you have a health condition and/or disability which may affect your practice. This is because we need to be able to assess whether it may place at risk the safety of people in your care

112. It doesn't mean the absence of a health condition and/or disability. Many people with disabilities and health conditions are able to practise with or without adjustments put in place by their employer to support them.

113. It is up to you to decide whether your health allows you to be capable of safe and effective practice. If you are satisfied with your decision then you do not need to provide us with any further information apart from your declaration (see section below).

How to record health and character declarations

114. If your health and character enable you to practise safely and effectively in accordance with the Code, and you do not have any charges, cautions, convictions, conditional discharges or determinations to declare, you do not need to keep any information as part of this requirement. Your confirmer does not need to check that you have met this requirement.

115. If you do need to declare any charges, cautions, convictions, conditional discharges or determinations you will need to keep evidence of these to provide us with further information.

> Paragraph 23.2 of the Code states that you must inform us and any employers you work for as soon as you can of any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction).

What you need to tell us in your online application

116. You need to declare that your health and character enable you to practise safely and effectively in accordance with the Code. See our guidance on health and character.

117. You will be asked to declare if you have a charge, caution, conviction or conditional discharge other than those which are protected. You do not have to tell us about protected cautions and convictions. These are minor offences that will not be disclosed on a Disclosure and Barring Service (DBS) check. Listed offences are never protected and must always be declared to us. See the full list from the DBS for England, Wales and Northern Ireland. In Scotland, the checking and barring service is operated by Disclosure Scotland.

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PROFESSIONAL INDEMNITY ARRANGEMENT

The requirement

118. You must declare that you have, or will have when practising, appropriate cover under an indemnity arrangement.[25]

The purpose of this requirement

119. By law, you must have in place an appropriate indemnity arrangement in order to practise and provide care. While the arrangement does not need to be individually held by you, it is your responsibility to ensure that appropriate cover is in place.

How to meet the requirement

120. You will need to complete this declaration as part of your revalidation application.

121. Most employers provide appropriate indemnity cover for their employees. If you are employed you should check this with your employer(s). Further information is available from the NHS Employer's website.

122. Please refer to our information on professional indemnity arrangements when making this declaration This document defines 'appropriate cover' and sets out information for those who are employed, self-employed or undertake work in both employed and self-employed roles. It also sets out information for those who work in education, undertake voluntary work, or are having a break in their practice.

123. If it is discovered that you are practising as a nurse, midwife or nursing associate without an appropriate indemnity arrangement in place, you will be removed from the NMC register and unable to practise as a nurse, midwife or nursing associate.

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How to record your professional indemnity arrangement

124. Your declaration will be made as part of your revalidation application.

125. We strongly recommend that you retain evidence that you have an appropriate arrangement in place.

126. If your arrangement is provided through membership of a professional body or a private insurance arrangement, your declaration should be based on having an indemnity arrangement in place which provides 'appropriate cover' in relation to your individual scope of practice, as explained on our website and in the professional indemnity arrangement guidance. Please note that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. Your confirmer does not need to check that you have met this requirement.

127. Your confirmer does not need to check that you have met this requirement.

What you need to tell us in your online application

128. You need to inform the NMC whether your indemnity arrangement is through your employer, membership of a professional body, or a private insurance arrangement. Alternatively, you will be able to inform us that you are not practising at this time but that you intend to have appropriate cover in place before you practise.

129. You are required to have appropriate cover in place for all of your current practice settings. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting. Please then add other arrangements to cover all your current practice settings.

130. If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will be asked to provide the name of the professional body or provider.[26]

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CONFIRMATION

The process

131. We will ask you for information for the purpose of verifying the declarations you have made in your application.[27]
132. This will be a declaration that you have demonstrated to an appropriate confirmer that you have complied with the revalidation requirements. We have provided a form for you to use to obtain this confirmation.
133. We will ask you to provide the name, NMC Pin or other professional identification number (where relevant), email, professional address and postcode of the confirmer.

The purpose of confirmation

134. Confirmation encompasses several benefits for you. It will provide assurance, increase support and engagement between you and your confirmer, and make you more accountable for your own practice and improvement. It should support you by increasing access to appraisals.
135. The interactive nature of the confirmation process should reduce professional isolation and encourage a culture of sharing, reflection and improvement.
136. Ultimately, the confirmation process is designed to increase professionalism by making nurses, midwives and nursing associates more accountable for their practice and improvement. This requirement also gives us an additional layer of assurance that nurses, midwives and nursing associates are complying with the revalidation requirements.
137. Confirmation is not a new way for employers to raise fitness to practise concerns. Confirmation is not about employers judging whether a nurse, midwife or nursing associate is fit to practise or an assessment against the requirements of their current or former employment. Raising a concern about a nurse, midwife or nursing associate's fitness to practise should be raised promptly through our fitness to practise procedures. Information on our website about our fitness to practise processes.

How to obtain confirmation

138. The confirmation process involves having a discussion about your revalidation with an appropriate confirmer. We recommend that you obtain confirmation through a face-to-face discussion or video conference.
139. As part of that discussion, you will demonstrate to that confirmer that you have complied with all of the revalidation requirements, except those related to a professional indemnity arrangement and health and character, as set out in this guidance.
140. We recommend that you obtain your confirmation during the final 12 months of the three year renewal period to ensure that it is recent. If you obtain confirmation earlier, we may ask you to explain why.

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141. If your confirmer is a NMC-registered nurse, midwife or nursing associate, your reflective discussion can form part of the confirmation discussion. If your confirmer is not on the NMC register, you will need to have your reflective discussion with an NMC-registered nurse, midwife or nursing associate before you have your confirmation discussion with your confirmer.

142. We have provided further information about the role of confirmers in our guidance document Information for confirmers, which you should ensure your confirmer has read.

An appropriate confirmer

143. Your line manager is an appropriate confirmer, and we strongly recommend that you obtain confirmation from your line manager wherever possible. A line manager does not have to be an NMC-registered nurse, midwife or nursing associate. For example they could be a GP practice manager or care home manager at your place of work.

144. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is an NMC-registered nurse, midwife or nursing associate. It is helpful if they have worked with you or have a similar scope of practice, but this is not essential.

145. If that is not possible, you can seek confirmation from another healthcare professional that you work with and who is regulated in the UK. For example, you could ask a doctor, dentist or a pharmacist. You will need to record their profession and professional Pin or registration number.

146. If you do not have a line manager, or access to someone on the NMC register or another healthcare professional, please check our online confirmation tool for further guidance as to who can act as a confirmer in this situation at **revalidation.nmc.org.uk/what-you-need-to-do/confirmation**.

147. If your confirmer is an NMC-registered nurse, nursing associate, midwife, they must have an effective registration with the NMC. We will not be able to verify your application if your confirmation was provided by a person who was subject to any kind of suspension, removal or striking-off order at the time of making the confirmation.

Obtaining confirmation if you work wholly overseas

148. If you work wholly overseas, you can seek confirmation from your line manager where you undertake your work.

149. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is a nurse, midwife or nursing associate regulated where you practise, or another regulated healthcare professional. Our online confirmation tool provides further guidance as to who can act as a confirmer in this situation.

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Obtaining confirmation if you have more than one line manager

150. If you have more than one employer or undertake more than one role, you only need to obtain one confirmation. You will need to decide which line manager is most appropriate to provide confirmation that you have met the revalidation requirements.

151. We recommend that you have your revalidation discussion and obtain confirmation through the line manager where you undertake the majority of your work. You may choose to have a revalidation discussion with each of your line managers, and bring the outputs of those discussions to the line manager you think is most appropriate to be your confirmer.

Confirmation and appraisals

152. The revalidation process is designed so that it can form part of an appraisal process, and where possible we recommend that you use your annual appraisal to have your revalidation discussion and obtain confirmation.

153. If your line manager is an NMC-registered nurse or midwife, you might like to have your reflective discussion at the same time as your confirmation discussion as part of your annual appraisal.

154. However, it is not a requirement of revalidation that you obtain your confirmation as part of an appraisal.

How to record confirmation

155. You must use the NMC form to record your confirmation. Your confirmer will need to complete and sign this form.

156. You should keep the completed and signed form.

What you need to tell us in your online application

157. You will be asked to enter the name, NMC Pin or other professional identification number (where relevant), email, professional address including postcode and contact number of your confirmer. If your confirmer is not your line manager or an individual on the NMC register, you will also need to provide details of their profession and regulation.

158. We will also ask you whether you have a regular appraisal and whether you have a line manager who is an NMC-registered nurse, midwife or nursing associate so that we understand what level of support was available to you in completing your revalidation application.

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THE APPLICATION PROCESS

Before you apply

159. Set up an NMC Online account.
You will need to submit your application through NMC Online. You can also check your renewal date and revalidation application date on NMC Online. We have published a step-by-step guide to registering for NMC Online at **www.nmc.org.uk/registration/nmc-online**.

> Once you have set up your online account, you will receive all subsequent notifications by email. Please add the NMC as a safe sender and check your email (including any junk email folder) regularly during the revalidation process.

160. Keep your contact details up to date so that we can notify you when your revalidation application is due.
The most common reason for someone failing to revalidate is a failure to keep the NMC updated on your contact details.

161. Make sure you know when your revalidation application is due.
You must submit your application by the date we specify. You may affect our ability to process your revalidation application if you do not submit your application by this date, and the renewal of your registration may be at risk as a result.

162. Make sure that you have all your supporting evidence to hand when you start your online application.
Please contact the NMC well in advance of your revalidation application date if you require an adjustment for using NMC Online (see Support to help you revalidate section below).

The online application

163. Your online application opens 60 days before your revalidation application date.

164. During this 60 day period you will need to log into your application via NMC Online and address each of the requirements.

165. Do not submit your application until you have met all the revalidation requirements.

Contacting your employer or any other relevant third party

166. As part of your application process we may need to contact your employer or any other relevant third party who can verify the information that you have provided in your application.[28]

167. In your online application you will be asked to provide consent for this purpose.

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Equality and diversity information

168. As part of the online application process you will be asked to supply some equality and diversity information. We use this data to monitor our services so that we can support you and make sure we are treating everyone in a fair and equal way. The questions have been designed to gather data about our service users in relation to the characteristics protected by the law under the Equality Act 2010.

169. We will keep the information from this questionnaire confidential and store it in line with the Data Protection Act 2018 and the NMC's Data Protection Policy. By submitting this sensitive personal information to us, you explicitly consent to the collection and processing of your sensitive personal information in accordance with the NMC's Data Protection Policy.

170. Providing this information is optional and will not affect your revalidation application or registration renewal. If you would prefer not to disclose this information you can select the 'prefer not to say' option for any or all of the questions.

Details of our Data Protection Policy are included in our privacy notice at **www.nmc.org.uk/privacy.**

Paying your fee

171. Alongside your revalidation application you need to pay your annual registration fee every year to maintain your registration with the NMC. Your registration will not be renewed until we have received your payment.

172. Please refer to our guidance on paying your fees at **www.nmc.org.uk/registration/staying-on-the-register/paying-your-fee**. This sets out the different ways that you can pay, including by direct debit and by debit or credit card, as well as how to pay your fee in four quarterly instalments.

173. As a registered UK tax payer you can claim tax relief on the NMC registration fees. HM Revenue and Customs (HMRC) allows individuals to claim tax relief on professional subscriptions or fees which have to be paid in order to carry out a job. The registration fee you pay to us is included in this category. Please refer to our guidance on how to claim tax relief on your fee at **www.nmc.org.uk/registration/staying-on-the-register/tax-relief**.

After you have completed your application

174. After you have completed your online application you will be offered the option of printing a paper copy of your application for your records.

175. Once your application has been successfully processed and your payment has been received we will send you an email confirming that your registration has been renewed.

176. We advise you to search the register on our website at to double check your status.

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Support to help you revalidate

177. We understand that there may be circumstances that make it more difficult for you to meet the revalidation requirements. This may be as a result of a disability, an illness, pregnancy, a maternity period or any other life event that impacts on your ability to meet the revalidation requirements.

178. We can support you to meet the revalidation requirements in several ways, for example by:

- helping you to use NMC Online, or
- providing a short extension to your application date.[29]

For further information on the support we can offer and how to apply for this support please see our support to help you revalidate guidance sheet.

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VERIFICATION OF YOUR APPLICATION

179. Each year we will select a sample of revalidation applications and request further information so we can verify the information provided.[30] Such a request does not necessarily mean that there are any concerns about your application and you can continue to practise while we review the information that you provide.

180. We will contact you by email within 24 hours of you submitting your revalidation application if you have been selected to provide further information and where possible we will notify you immediately after you have submitted your application through NMC online. Please make sure to check your email during this time, including junk email folders.

181. If you are selected to provide further information, you will need to complete an online form where you will be asked to provide further information. We may also request further evidence. We will ask you to provide this information within 21 days of receiving your notice that you have been selected for verification.

182. Your registration will not lapse during the verification process, even if the process extends past your renewal date. We will hold your registration effective until the verification process is complete, and you can continue to practise as normal during this time.

183. The table below sets out the information that you will need to provide if you are selected to provide further information. You should already have this information so you should not need to seek any additional information.

184. We will contact your confirmer to request further information using the email address you provided in your application. Please contact us if your confirmer requires adjustments in the way we contact them. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your registration at risk. We may also contact your employer and reflective discussion partner.

185. If we identify that you have not met the revalidation requirements, or you have submitted fraudulent information, your registration might be at risk. Please note that if you do not engage fully with the verification process your registration could lapse and you would have to apply for readmission.

186. The verification process will be completed within three months of your renewal date.

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Verification information

Practice hours

You will need to provide the following information, starting with your most recent practice until you demonstrate the minimum number of practice hours during the three year revalidation period:

- dates of practice
- the number of hours you undertook
- name, address and postcode of the organisations
- scope of practice and work setting (see tip box on page 22)
- a description of the work you undertook, and
- if practising overseas, whether you are registered with the appropriate regulating body.

We may contact your employer for further information, and you may also be asked to provide further evidence of practice hours and how this relied on your knowledge, skills and experience as a nurse, midwife or nursing associate.

If you are using a completed return to practice course for your practice hours requirement, or you have been admitted to another part of the register since you last renewed your registration or joined the register, please see our guidance sheet on return to practice and new registration at **revalidation.nmc.org.uk/download-resources/guidance-and-information** for further information.

Continuing professional development

You will need to provide the following information:

- the CPD method
- a brief description of the topic and how it relates to your practice
- the dates the CPD activity was undertaken
- the number of hours and participatory hours, and
- identification of the part of the Code most relevant to the CPD.

You may also be asked to provide evidence of the CPD activity.

Reflective discussion

We will not ask you to upload a copy of the signed reflective discussion form; however, we may contact your reflective discussion partner about your discussion.

Professional indemnity arrangement

You are required to have appropriate cover in place for all of your current practice settings. If your arrangement is provided through membership of a professional body or a private insurance arrangement you will be asked to confirm a) that you have read and understood our information on professional indemnity arrangements; b) that you have in place an indemnity arrangement which provides "appropriate cover" in relation to your individual scope of practice, as explained in our guidance, Professional indemnity arrangements; and c) that you understand that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting, followed by any other arrangements to cover all your current practice settings.

Confirmation

We will not ask you to upload a copy of the signed confirmation form; however, we will contact your confirmer using the contact details you provided to us in your initial application so please ensure these are accurate. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your registration at risk.

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REVALIDATION AND NMC FITNESS TO PRACTISE PROCESSES

187. If an employer, a nurse, midwife or nursing associate, or any other individual becomes aware of a serious concern about the fitness to practise of a nurse, midwife or nursing associate they should raise it promptly through our fitness to practise procedures. All nurses, midwives and nursing associates have a professional duty to raise a concern about the practice of a person on our register either through their employer or directly with us.

188. Revalidation does not create a new way of raising a fitness to practise concern about a nurse , midwife or nursing associate. You should not wait until a nurse, midwife or nursing associate's renewal is due before raising a concern.

For more information on how to raise a fitness to practice concern see www.nmc.org.uk/concerns-nurses-midwives/concerns-complaints-and-referrals/

189. The confirmation stage of revalidation is not for the confirmer to make a judgment as to whether a nurse, midwife or nursing associate is fit to practise but rather to confirm that they have met the revalidation requirements.

190. If you are subject to an NMC investigation, condition(s) of practice order or a caution, you are still required to apply to renew your registration as long as you fulfil all the requirements for renewal. However, You will remain subject to NMC fitness to practise processes and the outcome of those processes.

191. If you have been struck off the register, you are not able to revalidate because you are no longer on the register. You will need to apply for restoration to the register.

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For more information on restoration please see www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/restoration

192. If you are suspended from the register, you are not able to revalidate during your suspension. At the end of your suspension, if your registration is effective, you will need to comply with the revalidation requirements at the time that your registration is due to be renewed. If your registration is not effective following the end of your period of suspension, you will need to follow the readmission process.

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CANCELLING YOUR REGISTRATION

193. You may not want to retain one or all your registrations with us.

- For example you may wish to cancel all of your registrations with us if you have moved abroad, have retired from practice, changed career or wish to take a break from practice due to your current health.
- Alternatively you may wish to cancel one of your registrations if you wish to continue practising in one but not the other. For example if you are registered as both a nurse and a midwife but only wish to continue practising as a midwife you may want to cancel your nursing registration.

Please note that if you are receiving pay as a nurse, midwife or nursing associate whilst on maternity leave, sick leave or annual leave you may need to maintain your registration with us throughout this period in order to receive it. Please speak to your employer about this.

194. If you want to cancel your registration at the time of your revalidation application, you can do this online through the online revalidation application.

195. If you want to cancel your registration when you are not due to revalidate, you must submit an 'application to lapse your registration' form.

196. You will need to provide your NMC Pin, full name, contact address, the reason for cancelling and a declaration stating that you are not aware of any matter which could give rise or has given rise to a fitness to practise allegation being made against you.

Information on cancelling your NMC registration is available on our website at **www.nmc.org.uk/registration/leaving-the-register/cancelling-registration/**

197. You will not be able to practise or present yourself as a registered nurse or midwife in the UK or nursing associate in England if you are no longer registered with the NMC. It is a criminal offence if with intent to deceive (whether expressly or by implication), you falsely represent yourself as being on the register, or on part of it, possess qualifications in nursing or midwifery or to use a title to which you are not entitled.[31]

198. If you choose to cancel your registration, and later wish to resume practising as a nurse or midwife in the UK, please refer to our guidance on readmission to the register at **www.nmc.org.uk/registration/returning-to-the-register**.

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199. If you apply for readmission within six months of lapsing your registration when your revalidation was due, you will have to meet some of the revalidation requirements in addition to the usual readmission requirements, unless you are able to demonstrate that exceptional circumstances apply. These additional revalidation requirements are:
    - 20 of your 35 CPD hours must be participatory
    - Five pieces of practice related-feedback
    - Five written reflective accounts
    - Reflective discussion
200. For further details of the revalidation readmission requirements and process please see **www.nmc.org.uk/registration/returning-to-the-register/readmission-register/details-of-the-requirements**.

Failure to revalidate and appeals

201. If you cannot meet the revalidation requirements, you can cancel your registration with us. By cancelling your revalidation and providing us with a reason for doing so, you are showing insight and it demonstrates to us that you are managing your situation in a responsible way. You will continue to hold a nursing, midwifery or nursing associate qualification, but will not be a registered nurse, midwife or nursing associate. When you are ready to practise again, you can apply for readmission. Information on cancelling registration and seeking readmission to the register is available on our website at **www.nmc.org.uk/registration**.
202. If you do not cancel your registration, but you fail to submit your revalidation application before the end of your three year renewal period, your registration will lapse (automatically expire). You will need to apply for readmission if you want to come back on to the register.
203. If your application for revalidation is refused because a decision is made that you have not met the revalidation requirements, you may appeal this decision within 28 days of the date on your decision letter.[32]
204. A notice of appeal should be sent to **registrationinvestigations@nmc-uk.org** made in writing and include:
    - your name, address and NMC Pin
    - the date, nature and other relevant details of the decision against which the appeal is brought
    - a concise statement of the grounds of the appeal
    - the name and address of your representative (if any) and a statement as to whether the NMC should correspond with that representative concerning the appeal instead of you
    - a statement that the notice is a notice of appeal
    - a signature by or on behalf of you, and
    - a copy of any documents that you propose to rely on for the purposes of your appeal.[33]

    Please contact us if you require support or assistance in completing this notice.
205. You do not have the right of appeal if you fail to pay the registration fee or submit a revalidation application form within the required timescale and your application to renew your registration is refused as a result.[34]
206. If your registration is not renewed because you cancelled your registration, did not complete your revalidation application, did not submit your application in time or your application for revalidation is refused, you will not be able to practise as a registered nurse, midwife or nursing associate. It is a criminal offence if you knowingly falsely represent yourself as being on the register, or on part of it or you use a title to which you are not entitled.

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REFLECTIVE ACCOUNTS FORM

You **must** and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC*.

Reflective account:
What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?
What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?
How did you change or improve your practice as a result?
How is this relevant to the Code? **Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust**

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REFLECTIVE DISCUSSION FORM

You **must** use this form to record your reflective discussion with another NMC-registered nurse, midwife or nursing associate about your five written reflective accounts. During your discussion you should not discuss patients, service users, colleagues in a way that could identify them unless they expressly agree, and in the discussion summary section below make sure you do not include any information that might identify an individual. Please refer to the section on non-identifiable information in *How to revalidate with the NMC* for further information. For more information about reflective discussion, please refer to our guidance sheet on reflective practice for revalidation.

To be completed by the nurse, midwife or nursing associate:

Name:	
NMC Pin:	

To be completed by the nurse, midwife or nursing associate with whom you had the discussion:

Name:	
NMC Pin:	
Email address:	
Professional address including postcode:	
Contact number:	
Date of discussion:	
Short summary of discussion:	
I have discussed five written reflective accounts with the named nurse, midwife or nursing associate as part of a reflective discussion. I agree to be contacted by the NMC to provide further information if necessary for verification purposes.	Signature: Date:

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CONFIRMATION FORM

You **must** use this form to record your confirmation.

To be completed by the nurse, midwife or nursing associate:

Name:	
NMC Pin:	
Date of last renewal of registration or joined the register:	

I have received confirmation from (select applicable):

- ☐ A line manager who is also an NMC-registered nurse, midwife or nursing associate
- ☐ A line manager who is not an NMC-registered nurse, midwife nursing associate
- ☐ Another NMC-registered nurse, midwife or nursing associate
- ☐ A regulated healthcare professional
- ☐ An overseas regulated healthcare professional
- ☐ Other professional in accordance with the NMC's online confirmation tool

To be completed by the confirmer:

Name:	
Title:	
Email address:	
Professional address including postcode:	
Contact number:	
Date of confirmation discussion:	

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If you are an NMC-registered nurse, midwife or nursing associate please provide:

NMC Pin:

If you are a regulated healthcare professional please provide:

Profession:
Registration number for regulatory body:

If you are an overseas regulated healthcare professional please provide:

Country of practice:
Profession:
Registration number for regulatory body:

If you are another professional please provide:

Name of regulating body:
Registration number for regulatory body:

Confirmation checklist of revalidation requirements

Practice hours

☐ You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has practised the minimum number of hours required for their registration

Continuing professional development

☐ You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has undertaken 35 hours of CPD relevant to their practice as a nurse, midwife or nursing associate

☐ You have seen evidence that at least 20 of the 35 hours include participatory learning relevant to their practice as a nurse, midwife or nursing associate.

☐ You have seen accurate records of the CPD undertaken.

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Practice-related feedback

☐ You are satisfied that the nurse, midwife or nursing associate has obtained five pieces of practice-related feedback.

Written reflective accounts

☐ You have seen five written reflective accounts on the nurse, midwife or nursing associate's CPD and/or practice-related feedback and/or an event or experience in their practice and how this relates to the Code, recorded on the NMC form.

Reflective discussion

☐ You have seen a completed and signed form showing that the nurse, midwife or nursing associate has discussed their reflective accounts with another NMC-registered individual(or you are an NMC-registered individual who has discussed these with the nurse, midwife or nursing associate yourself).

I confirm that I have read *Information for confirmers*, and that the above named NMC-registered nurse, midwife or nursing associate has demonstrated to me that they have met all of the NMC revalidation requirements listed above during the three years since their registration was last renewed or they joined the register as set out in *Information for confirmers*.

I agree to be contacted by the NMC to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse, midwife or nursing associate's registration application at risk.

Signature:

Date:

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PRACTICE HOURS LOG TEMPLATE

Guide to completing practice hours log

To record your hours of practice as a registered nurse, midwife and nursing associate, please fill in a page for each of your periods of practice. Please enter your most recent practice first and then any other practice until you reach 450 hours. You can only count practice hours during the three year period since your last registration renewal or initial registration. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks. For example if you work full time, please just make one entry of hours. If you have worked in a range of settings please set these out individually. You may need to print additional pages to add more periods of practice. If you are both a nurse and a midwife or a nursing associate and nurse you will need to provide information to cover 450 hours of practice for each of these registrations.[33]

Work setting

- Ambulance service
- Care home sector
- Community setting (including district nursing and community psychiatric nursing)
- Consultancy
- Cosmetic or aesthetic sector
- Governing body or other leadership
- GP practice or other primary care
- Hospital or other secondary care
- Inspectorate or regulator
- Insurance or legal
- Maternity unit or birth centre
- Military
- Occupational health
- Police
- Policy organisation
- Prison
- Private domestic setting
- Public health organisation
- School
- Specialist or other tertiary care including hospice
- Telephone or e-health advice
- Trade union or professional body
- University or other research facility
- Voluntary or charity sector
- Other

Scope of practice

- Direct clinical care or management
- Commissioning
- Education
- Policy
- Quality assurance or inspection
- Research
- Other

Registration

- Nurse
- Midwife
- Nurse/SCPHN
- Midwife/SCPHN
- Nurse and Midwife (including Nurse/SCHPN and Midwife/SCPHN) Nurse and nursing associate (including Nurse/SCPHN

Dates	Name and address of organisation	Your work setting (choose from list above)	Your scope of practice (choose from list above)	Number of hours	Your registration (choose from list above)	Brief description of your work

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CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

LOG TEMPLATE

Guide to completing CPD record log

Examples of learning method
- Online learning
- Course attendance
- Independent learning

What was the topic?
Please give a brief outline of the key points of the learning activity, how it is linked to your scope of practice, what you learnt, and how you have applied what you learnt to your practice.

Link to Code
Please identify the part or parts of the Code relevant to the CPD
- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Please provide the following information for each learning activity, until you reach 35 hours of CPD (of which 20 hours must be participatory).
For examples of the types of CPD activities you could undertake, and the types of evidence you could retain, please refer to our guidance sheet at **www.revalidation.nmc.org.uk/download-resources/guidance-and-information**.

Dates	Method Please describe the methods you used for the activity.	Topic(s)	Link to Code	Number of hours	Number of participatory hours
				Total	Total

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FEEDBACK LOG TEMPLATE

Guide to completing a feedback log

Examples of sources of feedback

- Patients or service users
- Colleagues – nurses, midwives, nursing associates other healthcare professionals
- Students
- Annual appraisal
- Team performance reports
- Serious event reviews

Examples of types of feedback

- Verbal
- Letter or card
- Survey
- Report

Please provide the following information for each of your five pieces of feedback. You should not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information in How to revalidate with the NMC provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

You might want to think about how your feedback relates to the Code, and how it could be used in your reflective accounts.

Date	**Source of feedback** Where did this feedback come from?	**Type of feedback** How was the feedback received?	**Content of feedback** What was the feedback about and how has it influenced your practice?

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www.nmc.org.uk

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

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

NMC Nursing & Midwifery Council

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Southern Health and Social Care Trust

Quality Care - for you, with you

Nursing and Midwifery Accountability and Assurance Framework

Heather Trouton
Executive Director of Nursing, Midwifery & AHPs
February 2022
Version 5

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1. PURPOSE

The Accountability and Assurance Framework for Nursing and Midwifery (hereafter referred to as the 'Framework') has been developed to ensure there are clear and effective lines of accountability and assurance for the professional governance of the Nursing and Midwifery workforce in the Southern Health and Social Care Trust (hereafter referred to as the 'Trust').

The Framework sets out the arrangements, which assure the standards of practice, conduct and professionalism of the workforce. It enables the Trust, through the Executive Director of Nursing, Midwifery and AHPs (EDoN) to assure itself that effective governance systems are in place to enable the achievement of the professional standards and regulation requirements that nurses and midwives must uphold in order to be registered to practice (NMC, 2015; NMC 2016) and that services provided by the Nursing and Midwifery workforce are safe and of a high quality.

The Framework creates an environment, which enables nurses and midwives to:

- Practice in accordance with The Code (NMC, 2015), the organisational vision and corporate objectives to ensure the best possible care and treatment experience for service users and families.
- Maintain the standards of conduct of practice and to provide high-quality services and promote public trust and confidence in Nursing and Midwifery services.
- Be responsible for their continuous learning and development.
- Highlight and address areas of concern and risk if required.

The Framework details the professional nursing structure and supporting mechanisms essential to the governance of the Nursing and Midwifery workforce. It may evolve in light of experience, learning and service reconfiguration or development.

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2. STRATEGIC CONTEXT

HSC Trusts have corporate accountability for maintaining and improving the quality of services in the form of Clinical and Social Care Governance. The responsibility of oversight and assurance for the quality of Nursing and Midwifery is devolved to the Executive Directors of Nursing and Midwifery. Individually, nurses and midwives are professionally accountable to the Nursing and Midwifery Council (NMC) but they also have a contractual accountability to their employer and are accountable, in law, for their actions.

This Framework sets out how the EDoN provides assurance to the Chief Executive, Trust Board and the Chief Nursing Officer (CNO) on the quality and professionalism of Nursing and Midwifery. When implemented, the Framework provides evidence that structures and processes are in place to provide the right level of support, scrutiny and assurance across all Nursing and Midwifery services.

This Framework reflects the five standards outlined in the Assurance Framework for Professional Nursing and Midwifery Practice in Northern Ireland (2019, draft version 5)

Standard 1: There must be explicit and effective lines of nursing and midwifery accountability from every registrant in every care and service setting to the EDoN and through to CNO.

Standard 2: There must be collective professional leadership across every care and service setting that maximises the unique contribution of Nursing and Midwifery to safe and effective care.

Standard 3: Person-centred practice must be prioritised and embedded across every care and service setting.

Standard 4: Practice environments must be conducive to promoting positive health and well-being in every care and service setting.

Standard 5: The Nursing and midwifery workforce must be supported and equipped for practice across every care and service setting.

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3. PROFESSIONAL REQUIREMENTS

As an aid to using the Professional Assurance Framework some of the underlying terminology is clarified below.

3.1 Accountability and Responsibility

The terms ‘responsibility’ and ‘accountability’ should not be used interchangeably.

Responsibility can be defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand.

Accountability can be defined as demonstrating an ethos of being answerable for all actions and omissions, whether to service users, peers, employers, standard-setting / regulatory bodies or oneself.

3.2 Scope of Practice

Nurses and midwives must work within the parameters of their designated role and capability. This was formerly known as the Scope of Professional Practice but guidance on this has subsequently been incorporated into the NMC Code.

3.3 Delegation Framework for Nursing & Midwifery Practice (NIPEC 2017)

The purpose of delegation is to ensure the most appropriate use of skills within a health and social care team to achieve **person-centred outcomes**.

Delegation is defined as the process by which a nurse or midwife (delegator) allocates clinical or non-clinical tasks and duties to a competent person (delegatee).
The delegator remains accountable for the overall management of practice (NIPEC, 2019).

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4. FRAMEWORK INTERVENTIONS

The Trust has a range of mechanisms in place to support assurance and accountability of the Nursing and Midwifery workforce.

Figure 1: Accountability and Assurance Interventions

Each of the interventions is explored in detail in the following chapters.

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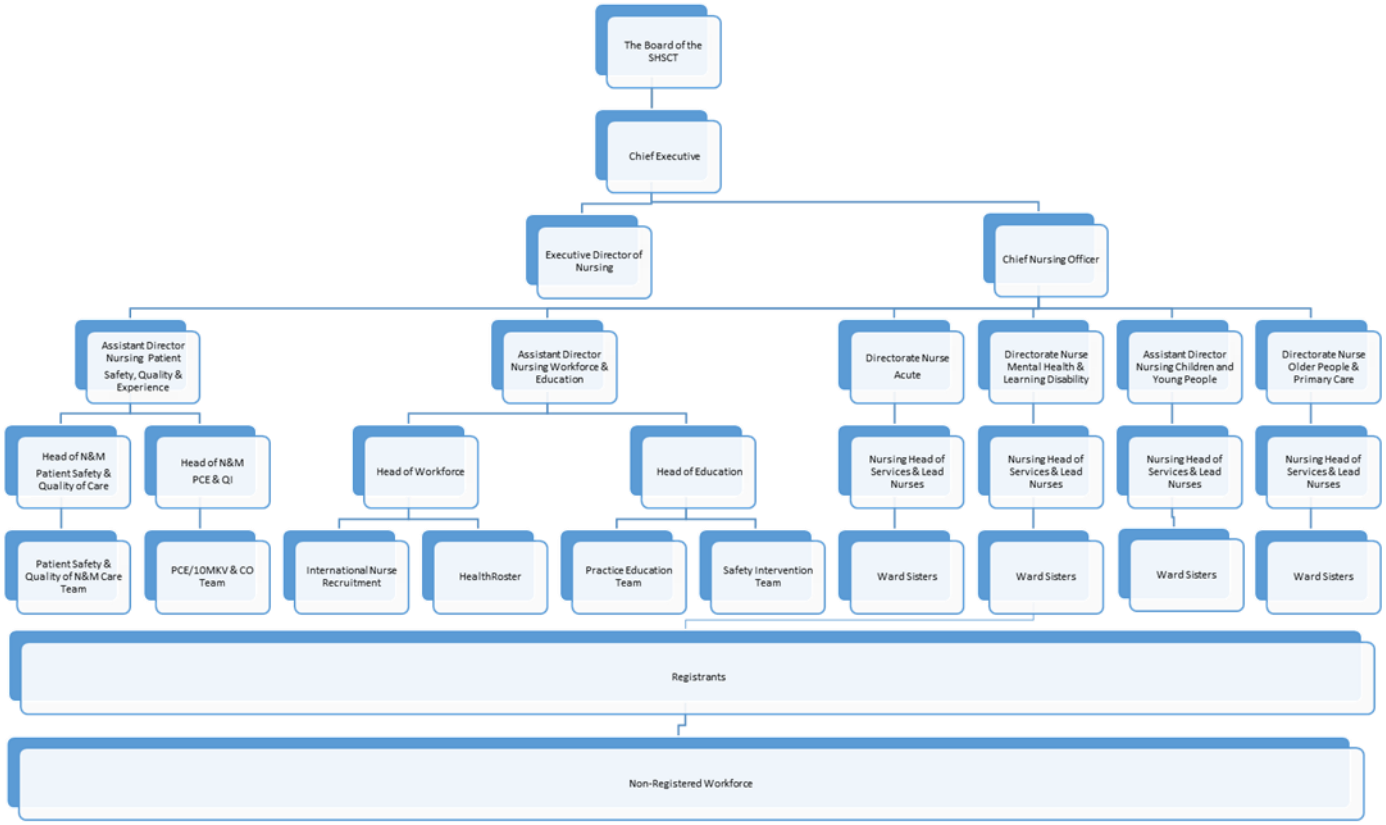
5. GOVERNANCE STRUCTURES, ROLES AND RESPONSIBILITIES

The professional Nursing and Midwifery accountability and leadership structures within the SHSCT are as outlined below.



The above configuration has potential for further change depending on the agreed Nursing structure in operational directorates

5.1 Professional Accountability Roles and Responsibilities

Trust Board

The Board of the Southern Health and Social Care Trust has a responsibility to ensure that safe, high-quality care is provided and is underpinned by the public service values of accountability, probity and openness (Southern Health and Social Care Trust, 2017).

Chief Executive

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The Chief Executive is the accountable officer of the Trust and holds ultimate accountability for the delivery of clinical, care and professional governance and adherence to the guidance issued by the Department of Health (DoH) in respect of governance.

Executive Director of Nursing, Midwifery & AHPs

The EDoN is responsible to Trust Board for providing robust triangulated evidence regarding the quality of professional nursing and midwifery practice, associated workforce issues and patient experience. This is done so that the Trust Board may make informed and sound decisions in fulfilling their joint responsibility regarding quality assurance and patient safety. That evidence should also include issues regarding escalation so that the Trust Board are informed of the risks and challenges the organisation faces. In addition, the EDoN is directly accountable to the CNO in respect of professional nursing and midwifery practice within the Trust.

In order to do this effectively, the EDoN is responsible for ensuring that there are robust and effective assurance structures and processes in place from every care and service setting through to the EDON. These structures and processes should drive improvement in the quality of nursing care and address any identified suboptimal standards of care.

The EDoN is responsible for ensuring that nursing care provided to patients is of a high standard meeting recognised professional standards and statutory requirements.

The EDoN provides professional leadership by ensuring professional issues are considered as part of strategic professional and operational service delivery.

Corporate Nursing Team

Assistant Director of Nursing and Midwifery (Patient Safety, Quality & Experience)

The Assistant Director of Nursing and Midwifery (Patient Safety, Quality & Experience) reports to the EDoN and is responsible for providing assurances that the Trust has robust arrangements in place to achieve high standards of professional governance to support the delivery of quality Nursing and Midwifery care. He / she works closely with the nursing operational Assistant Directors / Directorate Nurses to provide assurances.

The Assistant Director has oversight of established triggers and processes for the escalation of concerns about practitioner conduct, capability and / or fitness to practice and advise on legislation, rules, standards and guidance pertaining to nursing and midwifery.

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In addition, the Assistant Director develops and reviewing policies, procedures and protocols to ensure that these promote best Nursing and Midwifery practice and the delivery of high quality care.

The Assistant Director is responsible for ensuring that the EDoN is able to fulfil her / his role at Trust Board. This includes ensuring that robust assurance processes are implemented and their effectiveness monitored. He / she is responsible for ensuring that the EDoN is briefed about each clinical area and that issues of concern are escalated accordingly.

The Assistant Director will formulate a quarterly assurance paper that summarises the overall position in relation to Nursing and Midwifery assurance, including any action planned to address risks and areas of concern. This will be submitted to the Performance Committee via SMT.

He / she will ensure that the risk register accurately reflects the risk associated with the challenges nursing and midwifery are currently facing.

The Assistant Director is responsible for ensuring that nursing care provided to patients is of a high quality, meeting national standards and statutory requirements. Where significant quality and safety issues are identified, he / she in conjunction with the operational Nursing Assistant Director / Directorate Nurse will initiate a thorough assessment of the clinical / service area and formulation of an improvement plan and ensure that the EDoN is briefed regarding the situation.

The Assistant Director is responsible for leading on the improvement of patient experience in line with regional priorities and in response to patient / client experience feedback.

Head of Nursing & Midwifery (Patient Safety and Quality of Care)

This Head of Nursing (Patient Safety and Quality of Care) is responsible for providing professional leadership and has managerial responsibility for the safety and quality of nursing care across the Trust.

The Head of Nursing works collaboratively across operational directorates to ensure high standards of patient experience and compassionate care, whilst promoting compliance

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with relevant standards and indicators of the safety and quality of nursing and midwifery.

He/she supports the Assistant Director of Nursing, Patient Safety, Quality and Experience in strategic development of nursing and midwifery standards, policies and procedures, quality initiatives and the development and implementation of key performance indicators.

He/she is responsible for all aspects of the operational management of the Nurse Governance Team and Information Analysist, in addition to any temporary staff aligned to the team to support regional or local initiatives. He/she will provide clear leadership to all staff within their sphere of responsibility and will be responsible for effective financial management and the efficient use of all resources.

Head of Nursing & Midwifery (Patient & Client Experience & Quality Improvement)

Head of Nursing & Midwifery (Patient & Client Experience & Quality Improvement) is responsible for providing strong professional leadership and taking a lead role in ensuring high standards of quality and patient/client experience. Specifically, the Head of Nursing will support the Assistant Director with improving Nursing & Midwifery assurance using quality improvement methodology across the Trust, working collaboratively with internal and external stakeholders. They will help to build capacity and capability in improvement science across the nursing and midwifery workforce.

The Head of Nursing has managerial responsibility for the Patient and Client Experience (PCE) Team, including the PCE / 10,000 More Voices Facilitator, Care Opinion Facilitator, Virtual Visiting Service and provides oversight and support to the Patient Experience Feedback Pilot Manager and staff.

Assistant Director of Nursing and Midwifery, Workforce Development and Training

The Assistant Director of Nursing and Midwifery, Workforce Development and Training is responsible for all aspects of the Trust's arrangements for post registration Nursing and Midwifery training and education and for the Nursing and Midwifery pre-registration clinical placement oversight function. This requires the development and maintenance of partnership working with Department of Health (DoH), Public Health Agency (PHA), Health and Social Care Board (HSCB), universities, colleges and other training providers. They have a commissioning, performance management and quality assurance role for training,

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which will be provided both internally and externally to the Trust.

The Assistant Director of Nursing and Midwifery Workforce Development and Training contributes to the Trust's corporate workforce planning and development. This involves engaging with colleagues from human resources and other disciplines in designing and putting in place various training programmes and arrangements including Qualifications and Credit Framework (QCF).

Head of Nursing and Midwifery Education and Workforce Development

The Head of Nursing and Midwifery Education and Workforce Development is responsible for the development of a learning and assessment education governance framework to ensure the NMC requirements are met; providing strong professional leadership, and facilitating learning and development through effective education strategies. This includes leading on Trust-wide training needs analyses; coordinating post registration education requirements, pre-registration education requirements and the education and development of Nursing and Midwifery support staff with all internal and external stakeholders.

They are also responsible for leading and coordinating workforce development initiatives related to the Nursing and Midwifery workforce.

Head of Nursing and Midwifery Workforce Planning and Utilisation

The Head of Workforce Planning and Utilisation is responsible for the planning and utilisation of the Nursing and Midwifery Workforce across the Trust. He / she leads workforce planning and utilisation of the nursing and midwifery workforce using appropriate and relevant strategies for workforce measurement and appropriate use of skill mix, as well as contribute to the Trust's corporate workforce planning and development agenda. They provide support and leadership to Directorates in changing working practices in nursing roles to ensure the nursing and midwifery workforce is dynamic, responsive and adaptive to the needs of patients / clients and the public and will help to build capacity and capability to support workforce innovation and new role development. Working with a wide range of stakeholders key actions as outlined in the Trust's Nursing and Midwifery Workforce Action Plan (SHSCT 2019) will be completed through the implementation of effective workforce strategies.

Safe Staffing Nursing and Midwifery lead

The Safe Staffing Nursing and Midwifery Lead is responsible for the implementation of the

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Public Health Agency Delivering Care policy framework for nursing and midwifery workforce within the Southern Trust. He/she works in close collaborative partnership with regional and directorate colleagues to develop models for safe staffing across all programmes of care. They have a strong remit for implementation of workforce planning, recruitment and retention initiatives and raising the profile of the nursing and midwifery profession.

Operational Nursing Teams

Nursing Operational Assistant Directors / Directorate Nurses

The Directorate Nurses / Nursing Assistant Director in CYP are directly accountable and responsible for the professional nursing and midwifery practice within their Division / Directorate. They jointly report to the operational directors (operational issues) and EDoN (professional issues) and work in conjunction with the Assistant Directors of Nursing (Patient Safety, Quality and Experience and Workforce Development and Training) to provide assurances regarding nursing and midwifery practice and workforce and training within their areas of responsibility.

Nursing Heads of Service

Heads of Service who are registered nurses / midwives are accountable and responsible for the professional nursing and midwifery practice within their service areas. They will operationally report to the Operational Assistant Directors within their Division / Directorate and work in conjunction with the Directorate Nurse/Nursing Assistant Director in CYP and the Assistant Directors of Nursing (Patient Safety, Quality and Experience and Workforce Development and Training) and Heads of Nursing to provide assurances regarding nursing and midwifery practice and workforce and training within their areas of responsibility.

Lead Nurses / Nurse Managers / Ward Sisters / Charge Nurses / Team Leads

This group of senior nurses will provide clinical, professional and managerial leadership to ensure the objectives and quality standards of the Framework are met. They will inspire, motivate and empower nurses, midwives and wider health care teams to continually improve the patient experience and provide effective nursing care to enhance patient safety.

They are responsible for the quality of nursing / midwifery care in their area and will deliver on this by ensuring that their staff are inducted and trained to effectively and safely carry out their duties, facilitate supervision and the implementation of staff support policies. They

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will escalate concerns regarding practitioners' conduct, capability or fitness to practice as required, following discussion, they will progress actions agreed, monitor and feedback.

Nursing and Midwifery Staff

All Nursing and Midwifery registrants are responsible for meeting the regulatory standards of conduct and practice as set out for their profession by the Nursing and Midwifery Council (NMC) professional regulatory body. They are individually responsible to ensure they maintain their professional registration. They must comply with Trust policies and procedures and their on-going professional development designed to support them in the delivery of safe and effective care.

Nursing Assistants

Nursing Assistants are required to meet the Standards for Nursing Assistants (DoH, 2018) and, to comply with Trust policies and procedures designed to support them in delivering safe and effective care.

Maternity Support Workers

Maternity Support Workers are required to complete the Regional Maternity Support programme; to comply with Trust policies and procedures designed to support them in delivering safe and effective care.

5.1 Supporting Arrangements

N&M Patient Safety and Quality of Care Team

The N&M Patient Safety and Quality of Care Team support and facilitate teams to achieve improvements in Nursing and Midwifery care through a variety of approaches including quality improvement and practice development.

Practice Education Team

This team consists of Practice Education Facilitators, led by a Practice Education Coordinator. Under the direction of the Assistant Director of Nursing and Midwifery Workforce Development and Training, the team's remit is to develop and sustain an effective learning culture, infrastructure and environment for Nursing and Midwifery students on a Trust-wide basis within a NMC approved governance framework. They also evaluate the effectiveness of pre and post-registration learning and education activities to

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provide enhanced value added benefits reflected in improved quality of care of patients and clients. Another of the team's remit is to lead on the implementation, monitoring and evaluation of the Trust's new registrant Induction, Rotation and Preceptorship programmes.

Revalidation Team

The Nursing and Midwifery Revalidation Team support operational directorates and the corporate nursing team to provide the EDoN with oversight and assurance with regards to Nursing and Midwifery revalidation. The remit of this team will be extended to provide assurances around other aspects of the framework, including supervision.

5.2 Professional Governance Forums

There are a number of professional fora across directorates which support the EDoN in providing assurances regarding the quality of professional nursing and midwifery practice. These fora promote an ethos of awareness, continuous learning, accountability and improvement. They are essential in supporting corporate governance arrangements, specifically in relation to promoting continuous professional education and development and ensuring professional standards and regulatory requirements are in place and adhered to. They ensure professional processes are monitored and reviewed and that all risks related to the nursing and midwifery workforce are considered and where necessary mitigated against through timely and effective action planning and dissemination of learning.

6. AUDIT, ASSURANCE AND COMPLIANCE ARRANGEMENTS

The Trust monitors Nursing and Midwifery professional governance through a suite of performance and quality indicators designed to ensure that the care, treatment and support are of a consistently high quality throughout the system. These are communicated down through professional nursing and midwifery structures and action plans developed as required to provide assurance.

6.1 Accountability Reporting

The EDoN compiles an Executive Director of Nursing and Midwifery report twice yearly to Trust Board to provide assurances regarding professional nursing and midwifery practice. In

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addition, the EDoN will table a performance report to the Performance Committee on a quarterly basis.

6.2 Monitoring Arrangements

Nursing and Midwifery practice is reviewed and monitored through a range of processes and fora as outlined in the table below.

Key Performance / Quality Indicator and Reports	Description	Frequency of Review	Reviewed / Monitored through
Executive Director of Nursing, Midwifery and AHPs Reporting	A summary of activity and developments within the Nursing and Midwifery profession.	Twice Yearly reports to Trust Board Quarterly reports to the Performance Committee	• Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Senior Management Team • Performance Committee • Trust Board
Induction status reporting	Compliance with Trust Nursing and Midwifery Induction Requirements - New registrants - Registrants - Role specific	Biannual	• EDON Assurance meetings with Directorates • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Performance Committee
Preceptorship requirements reporting	Compliance Nursing and Midwifery preceptorship requirements	Quarterly	• EDON Assurance meetings with Directorates • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Senior Management Team • Performance Committee
Audit of Compliance with Mandatory Training	Scorecards of mandatory training performance	Quarterly	• EDON Assurance meetings with Directorates • Local and Directorate management meeting • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF)
Nursing and Midwifery Supervision Audit	Audit of supervision practice against Supervision Standards.	Quarterly	• EDON Assurance meetings with Directorates • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Performance Committee
Audit of Compliance with Annual KSF and Personal Development Plans	Sample audit of Personal Development Plan completion	An annual audit of PDP completion	• EDON Assurance meetings with Directorates • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery

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Key Performance / Quality Indicator and Reports	Description	Frequency of Review	Reviewed / Monitored through
			Governance Forum (SNMGF)
Compliance with Standards for Learning and Assessment in Practice (NMC, 2008)	Mentor register reports Placement evaluation reports Educational Audits	Biannual Biannual Biannual	• EDON Assurance meetings with Directorates • Practice Education Team • Directorate Nursing and Midwifery Governance Fora. • Senior Nursing and Midwifery Governance Forum (SNMGF) • Performance committee
Post registration Education service level agreement usage , including DNA rate	Post registration Education service level agreement usage , including DNA rate	Bi annual	• EDON Assurance meetings with Directorates • Operational director • SNMGF • Performance committee
Audit of Compliance with Normative Staffing	Monitoring report Phases 1-11	Biannual	• EDON Assurance meetings with Directorates • Directorate Nursing and Midwifery Governance Fora. • Office of Chief Executive and Executive Director of Nursing
Revalidation and Registrations Status Reporting	Compliance with NMC registration requirements	Quarterly	• EDON Assurance meetings with Directorates • Directorate management and governance Fora • Directorate Nursing and Midwifery Governance Fora • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Performance committee
Fitness to Practice	Summary of Nursing and Midwifery staff referred to NMC	Bi annual	• EDON Assurance meetings with Directorates • Performance committee • SNMGF • Operational Directorates
Compliance with regional and locally agreed clinical NQI's and KPIs including PACE and Patient Safety Thermometer data.	Compliance with regional clinical NQI Bundles and other relevant safety / practice indicators	Monthly	• Ward Sisters / Charge Nurses • Lead Nurses
		Quarterly	• EDON Assurance meetings with Directorates • Directorate Nursing and Midwifery Governance Fora • Operational Director • Senior Nursing and Midwifery Governance Forum (SNMGF) • Trust Performance Committee
Patient Experience Feedback	Utilise the feedback of service users and / or carers to improve services. Includes 10,000 voices feedback.	Monthly	• Directorate Governance Fora • Operational Director
		Quarterly	• EDON Assurance meetings with Directorates • Trust Senior Management Team • Patient and Client Experience Steering Group • Trust Patient and Client Experience Committee

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Key Performance / Quality Indicator and Reports	Description	Frequency of Review	Reviewed / Monitored through
Nursing Quality in the Independent Sector	Monitored via the Trust Independent Sector Governance Forum	Bi annual	• Operational Director • Trust performance committee • Monthly meetings with AD PSQE

The EDoN and Corporate Nursing Team meet with the Operational Directors and Assistant Directors on a quarterly basis to review performance data and agree priority actions.

In addition the Head of Nursing (Patient Safety and Quality of Care) attends the weekly Corporate Governance meeting taking forward any issues relevant to nurses and midwives.

6.3 Information Systems

To support the Nursing and Midwifery Accountability and Assurance Framework there are a number of information systems alongside the need to manually collate information:

- HRPTS Workforce Information System
- DATIX Complaints and Incident Management System
- Allocate HealthRoster System, including SafeCare
- Easy Information Management System (EIMS) – Mentor Register
- E-CATS – Health Visiting and District Nursing
- Filemaker
- HCAT System
- Revalidation register

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7. LEARNING, DEVELOPMENT AND SUPPORT

There are systems in place to monitor workforce volumes, highlight issues and to ensure that the Nursing and Midwifery workforce have the appropriate knowledge, skills and support needed to provide high-quality care.

Corporate Induction

The Trust Induction Policy (SHSCT, 2016) requires all newly appointed staff to attend a Corporate Induction (in addition to a Departmental Induction / orientation). The programme comprises of information of common interest across all staff groups and contributes to building a commonality of understanding amongst the workforce. New employees are required to attend Corporate Induction ideally within three months of commencement but no longer than six months following appointment.

Corporate Professional Welcome

The Corporate Nursing Team deliver a Corporate Professional Welcome programme to all newly appointed nursing and midwifery registrants taking up post in the Southern Trust. The programme is facilitated on a monthly basis and focuses on HSC values and Professional roles and responsibilities, and provides the new appointees with an opportunity meet members of the Corporate Nursing team.

Nursing Assistant Induction and Developmental pathway

An induction and development pathway is available for Nursing Assistants who have taken up post in the Trust. The programme, facilitated by the Trust's Vocational Workforce Assessment Centre team, is underpinned by the DoH (2018) Standards for Nursing Assistants, and supports both the role and career progression of Nursing Assistants, equipping them with the necessary knowledge, skills and attitudes to fulfil their role.

Specialty / Departmental Induction

The Trust Induction Policy (2016) requires all new employees to undertake specialty / departmental induction commencing on the first day in the workplace and ending when the

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individual becomes fully integrated into the department to ensure they have the information they may need to undertake the requirements of the post and to undertake the requirements of the job / professional role.

Preceptorship Programme

The Practice Education Team delivers a Preceptorship Programme to new registrants. The duration of the programme is six months and runs concurrently with induction and the probationary period. A Preceptorship procedure (SHSCT, 2020) details the requirements for the Preceptorship Programme. The Trust reports annually to the Chief Nursing Officer (CNO) and quarterly to Trust Board regarding compliance with the Preceptorship Framework (DHSSPS, 2013).

Nursing and Midwifery Supervision & Annual Appraisal

The learning and development requirements of the Nursing and Midwifery workforce are identified through the Trust supervision and appraisal systems. The Trust considers the implementation of supervision and KSF processes as a critical priority in valuing staff and supporting their development to help achieve the key objective of safe, high-quality health and social care. The outcome of supervision activities informs the individual's KSF and Personal Development Plans, including identification of training requirements.

Corporate Mandatory Training

The Trust Corporate Mandatory Training Policy (Southern Health and Social Care Trust, 2021) details the training requirement that is essential for the roles and responsibilities of posts, as well as meeting the Trust corporate targets. The policy denotes the mandatory training requirements for nursing, midwifery and nursing assistant staff groups.

Role Specific Training

All clinical areas ensure Nursing and Midwifery staff undertake role specific training to deliver safe and effective care. This is managed locally by the Ward Sister / Charge Nurse / Team Lead and all registrants.

Continuous Professional Development (CPD) Maintenance

All nursing and midwifery registrants have access to educational programmes provided through the Clinical Education Centre Level Agreement and the Education

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Commissioning Plan which provides them with opportunities to maintain Post Registration Training and Learning and gain recognition for learning.

Clinical Education Centre (CEC) – Service Level Agreement (SLA)

All nursing and midwifery registrants have access to the CEC which provides them with a range of programmes to maintain continuous professional development. Monitoring and uptake is ongoing throughout the financial year through monthly reports from the CEC. The procedure for the Management of the Nursing and Midwifery SLA with the CEC provides guidance on all courses available and with the CEC (SHSCT, 2021)

Education Commissioning Cycle – Training Needs Analysis

As part of the Regional Education Commissioning Group chaired by the DoH funds are allocated for education to each HSC Trust. The completion of an annual Training Needs Analysis facilitates Nursing and Midwifery staff to undertake further education including stand-alone modules, short courses and specialist practice to facilitate the development of skills, knowledge and expertise for practitioners. The procedure for the Management of Nursing and Midwifery Post-Registration Education Commissioning provides guidance on all aspects of the Nurse Education Commissioning process (SHSCT, 2021)

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8. WORKFORCE

The Trust recognises that ensuring appropriate nurse staffing is a key element in influencing the quality of care. Given this, a comprehensive Nursing and Midwifery Workforce Action Plan 2019 – 21 was implemented, this plan is currently under review for the period 2022 - 24.

8.1 Recruitment

Active recruitment of Nursing and Midwifery staff occurs on an ongoing basis via an open advertisement with the Business Services Organisation (BSO). Targeted recruitment via International Nurse Recruitment, UK wide recruitment fairs and local recruitment is managed by the HR Trust's recruitment team and the Corporate Nursing Team in a planned process. Monthly vacancy reports are reviewed by Directorates and escalation processes are in place to address staff shortages.

8.2 Delivering Care Project (Normative Staffing).

The Delivering Care Project continues to be implemented (DHSSPS, 2014). It aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the Nursing and Midwifery workforce in a range of major specialties. Bi annual monitoring reports are completed and the Trust works closely with the PHA in all stages of implementation and review. This includes the monitoring of the ongoing Delivering Care Investment 2021- 2026.

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9. REGISTRATION / REVALIDATION

The Trust has developed an infrastructure to support the registration of the Nursing and Midwifery workforce which enhances the professional regulation of the workforce and reinforces the individual's responsibility to provide quality Nursing and Midwifery services.

Monitoring at Operational Level

While the responsibility to maintain registration lies with the registrant, line managers are responsible for ensuring that registered nurses and midwives have a valid registration and are on the NMC Register (SHSCT, 2017c).

HRPTS Oversight & NMC Registration Employer Centralised Oversight

The Trust has a dedicated Revalidation Team which record and monitor Nursing and Midwifery workforce registration and renewal status. The regional HRPTS system is used for central recording and monitoring of workforce registration and renewal status. Monthly reports are issued to managers on registration and renewal status.

Pre-Employment Checks

The Trust Recruitment and Selection Procedure (SHSCT, 2010) stipulates a pre-recruitment phase which involves the development and approval of personnel specifications and a range of checks to be undertaken pre- employment.

NMC Registration and Renewal Processes

The Trust Policy on the Validation and Monitoring of Registration with a Professional Regulatory Body (SHSCT, 2017d) defines the approach for registration and the maintenance of Nursing and Midwifery professional registration.

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10. RAISING AND HANDLING CONCERNS

The Trust has a range of mechanisms for raising and handling concerns which are designed to ensure the Nursing and Midwifery workforce achieve and maintain appropriate standards of conduct, performance and behaviour.

Identification of Poor or Variable Performance

Concerns about poor or variable performance are identified through supervision, probationary reviews, incidents, complaints, patient feedback, whistleblowing and managerial engagement with front-line teams. Depending on the severity and potential impact of the issues identified a line manager may seek to resolve locally through identification of further training and development needs, increased supervision or enact the Trust's management of probationary, capability or disciplinary procedures.

Probationary

All Nursing and Midwifery appointments are subject to a probationary period which is normally 6 months duration, during which time progress is monitored. In the event of unsatisfactory progress, despite appropriate support and / or counselling, employment will be terminated with appropriate notice either during or at the end of the probationary period in accordance with the Trust's procedure for probationary periods (SHSCT, no year).

Management of Capability, Conduct or Health Concerns

The Trust Capability Procedure (SHSCT, 2015a) has been designed for use in situations where there is evidence of '*a genuine lack of capability rather than a deliberate failure on the part of the employee to perform to the standards of which he / she is capable'*.

The Trust Disciplinary Procedure (SHSCT, 2015b) is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behavior.

Line managers work very closely with the Trust Occupational Health Department and Attendance Management Team to appropriately manage health concerns related to the Nursing and Midwifery workforce.

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Management of Fitness to Practice Referrals to NMC and NMC Investigation Process

Trust Procedures for initiating and managing a referral to a Professional Regulatory Body and the Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT (SHSCT, 2015c) outline the processes to be followed should this be required. All referrals to NMC for fitness to practice and requested for a CNO alert to be issued should be discussed with and quality assured by the Assistant Director of Nursing (Patient Safety, Quality and Experience) and approved by the EDoN.

The corporate nursing team are in the process of setting up a pilot of 'Nurses in Difficulty Clinics' to support both nurses and midwives involved in internal HR and other investigations and NMC investigations and hearings and their line managers.

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11. NURSING QUALITY IN THE INDEPENDENT SECTOR

There are robust processes in place for assuring the quality and safety of services commissioned from third or independent sector providers.

Contracts

Where externally provided services are commissioned by the Trust, the same high levels of compliance with Trust safety and quality standards are required to be implemented by the Provider through adherence to robust, descriptive contracts. The contracts stipulate clear arrangements for monitoring that these standards are met. Advice and guidance can be sought from the Operational Assistant Directors or Assistant Directors of Nursing as required.

If concerns are identified regarding the conduct, capability or fitness to practice of a registrant not employed by the Trust the Trust Procedures for initiating and managing a referral to a Professional Regulatory Body and the Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT (SHSCT, 2015c) should be followed.

Contract Management and Monitoring

There are identified contract managers who undertake both formal and informal contract management and monitoring. At a minimum, an Independent / 3rd Party Contractor is subject to an annual formal Contract Management meeting.

The majority of Independent / 3rd Party Contractors engaged with by the Trust are registered with RQIA and subject to their ongoing monitoring and inspection.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

12. REFERENCES

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Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Appendix 1

Southern Health and Social Care Trust

Quality Care - for you, with you

Nursing and Midwifery Accountability and Assurance

Logic Models

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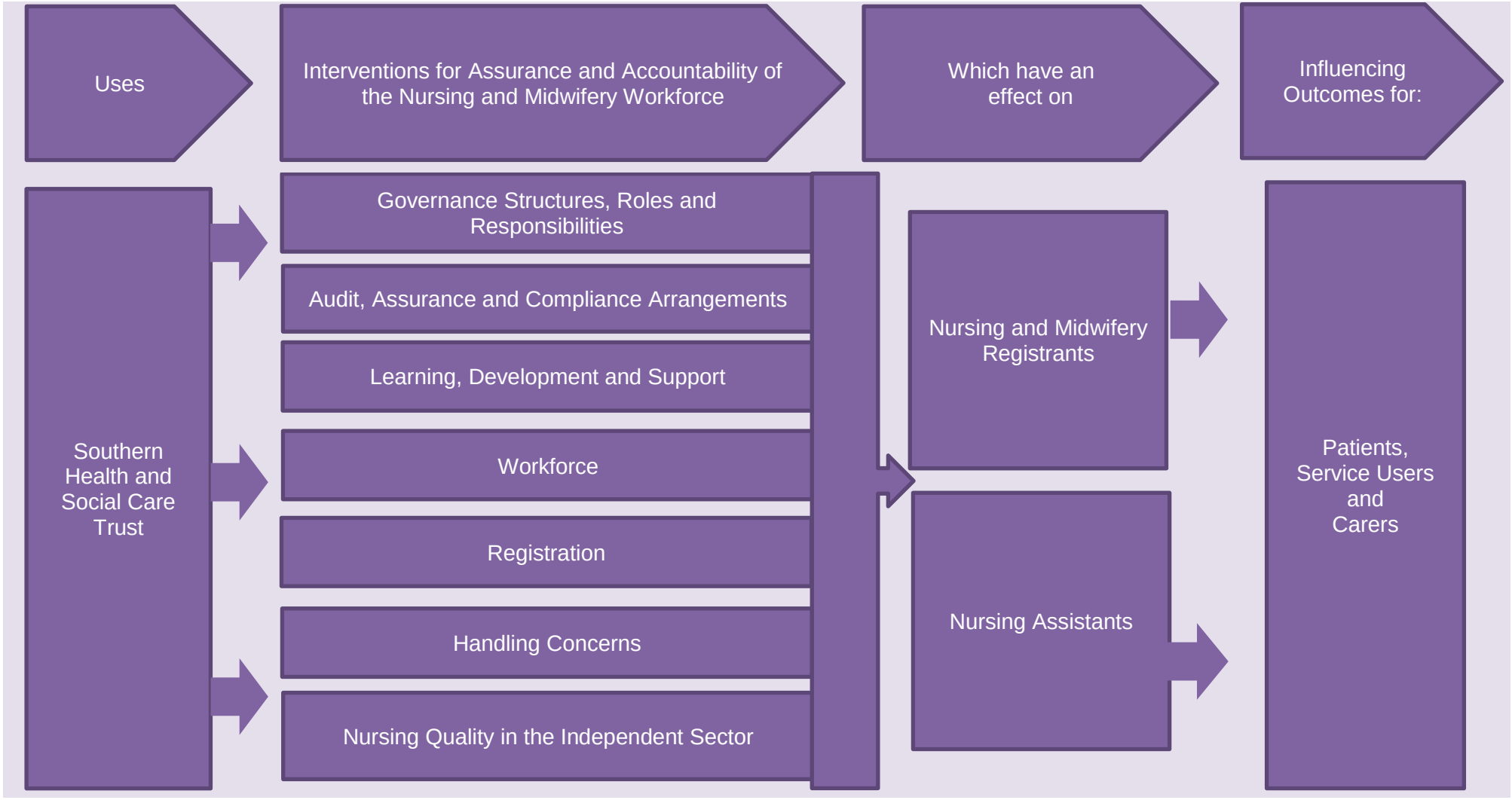
Southern Health and Social Care Trust

Quality Care - for you, with you

Accountability and Assurance Framework
Nursing and Midwifery



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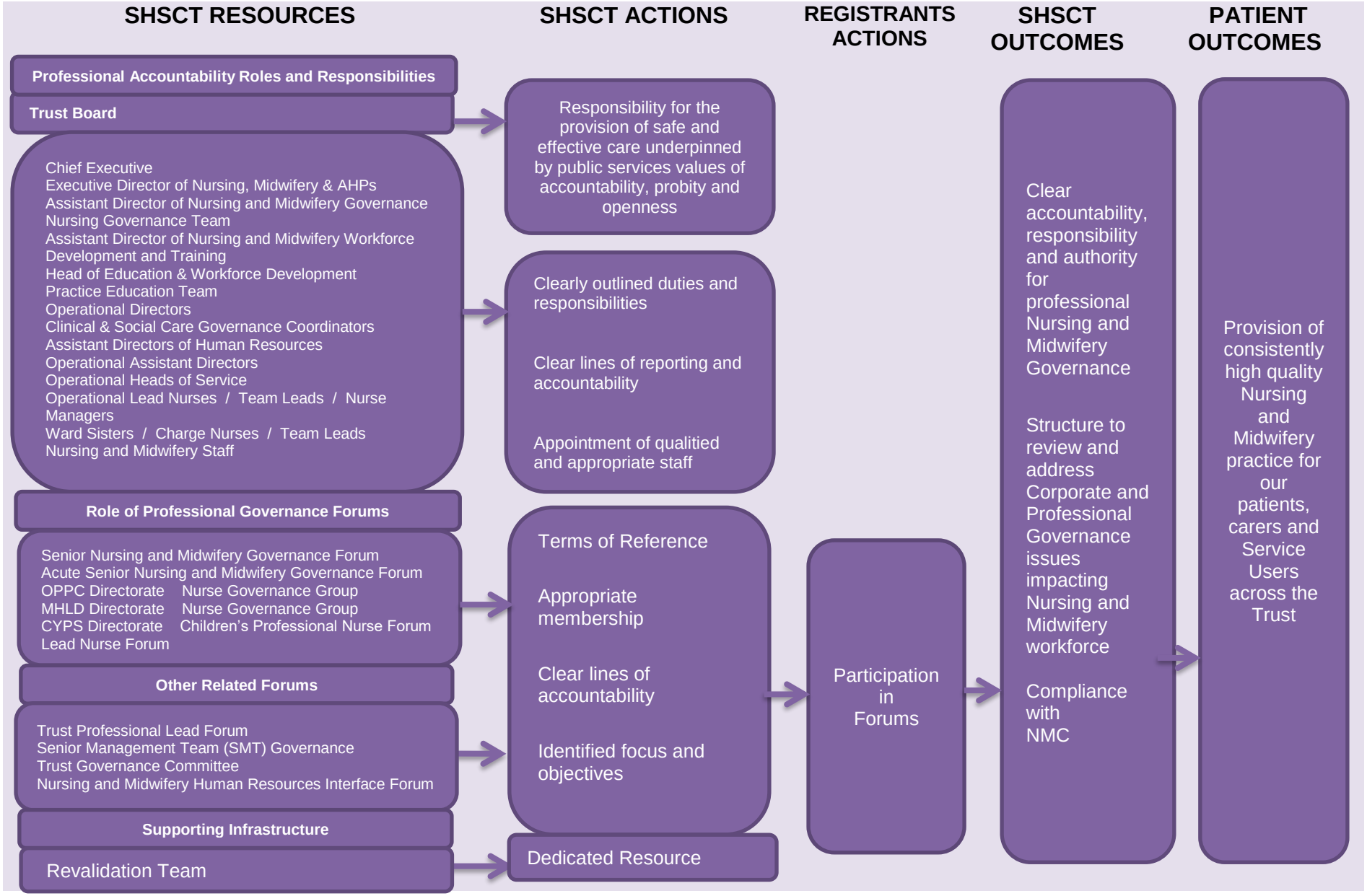
Accountability and Assurance Framework
Nursing and Midwifery

Governance Structures, Roles and Responsibilities



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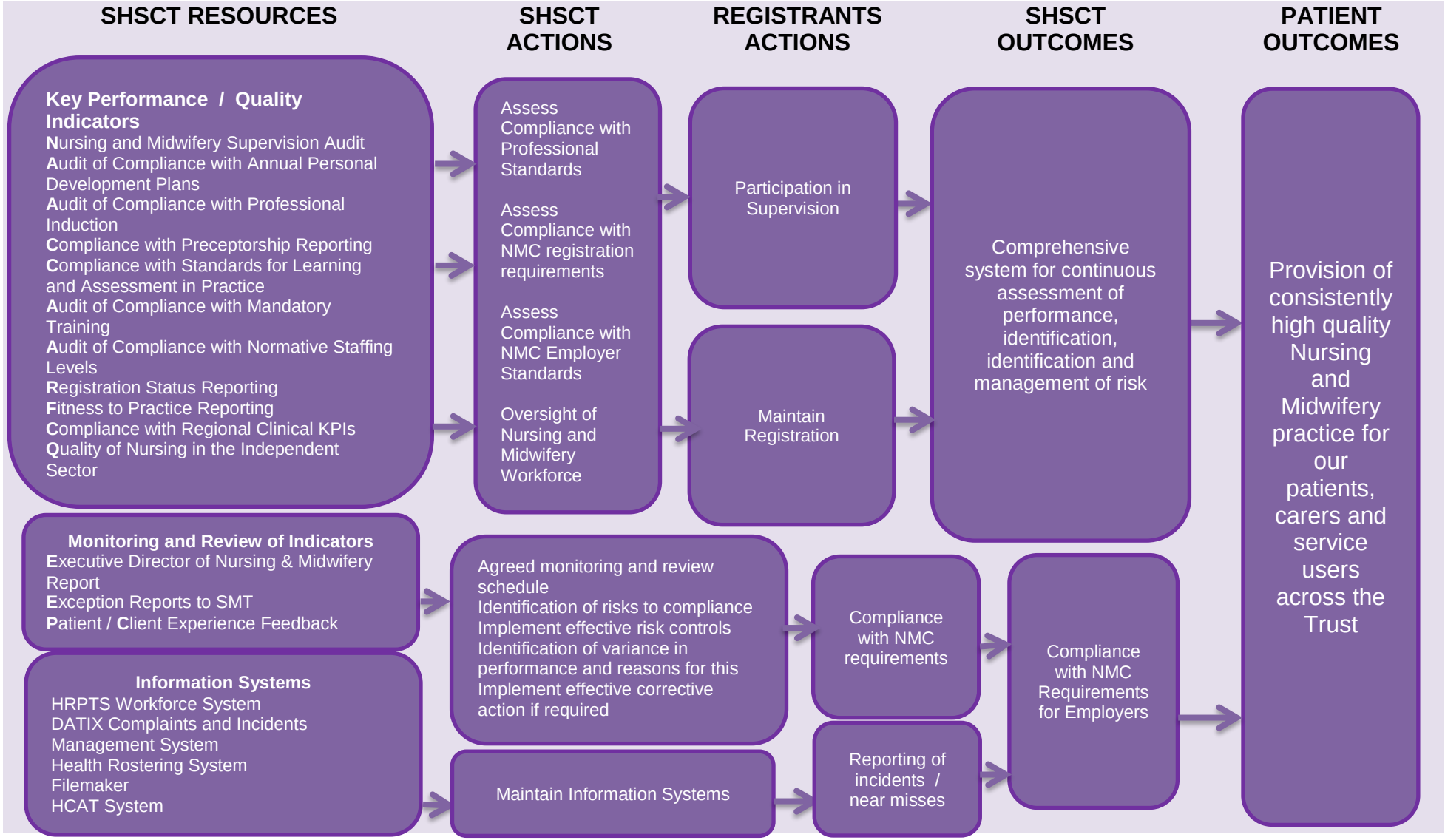
Accountability and Assurance Framework
Nursing and Midwifery

Audit, Assurance and Compliance Arrangements



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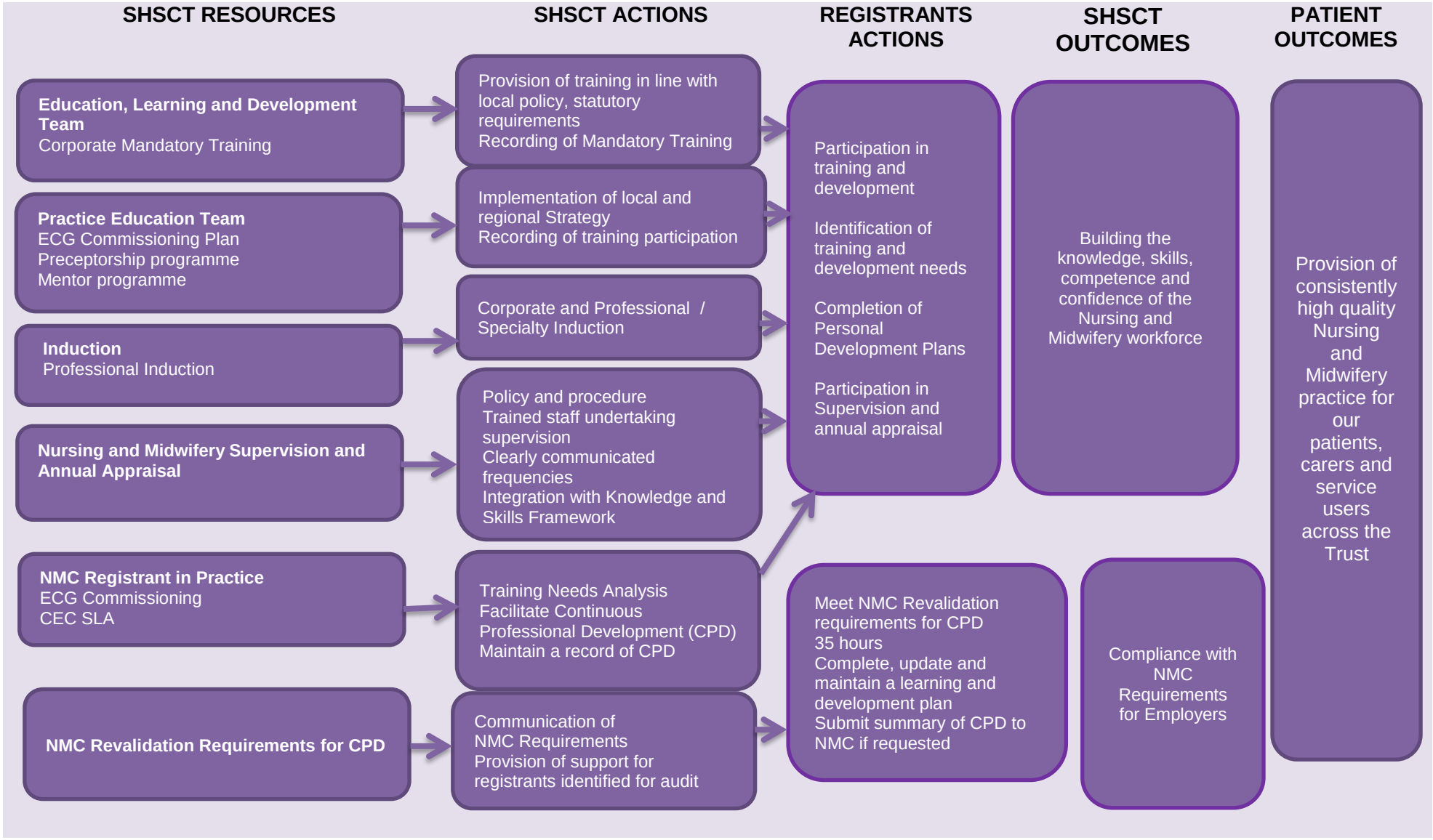
Accountability and Assurance Framework
Nursing and Midwifery

Learning, Development and Support



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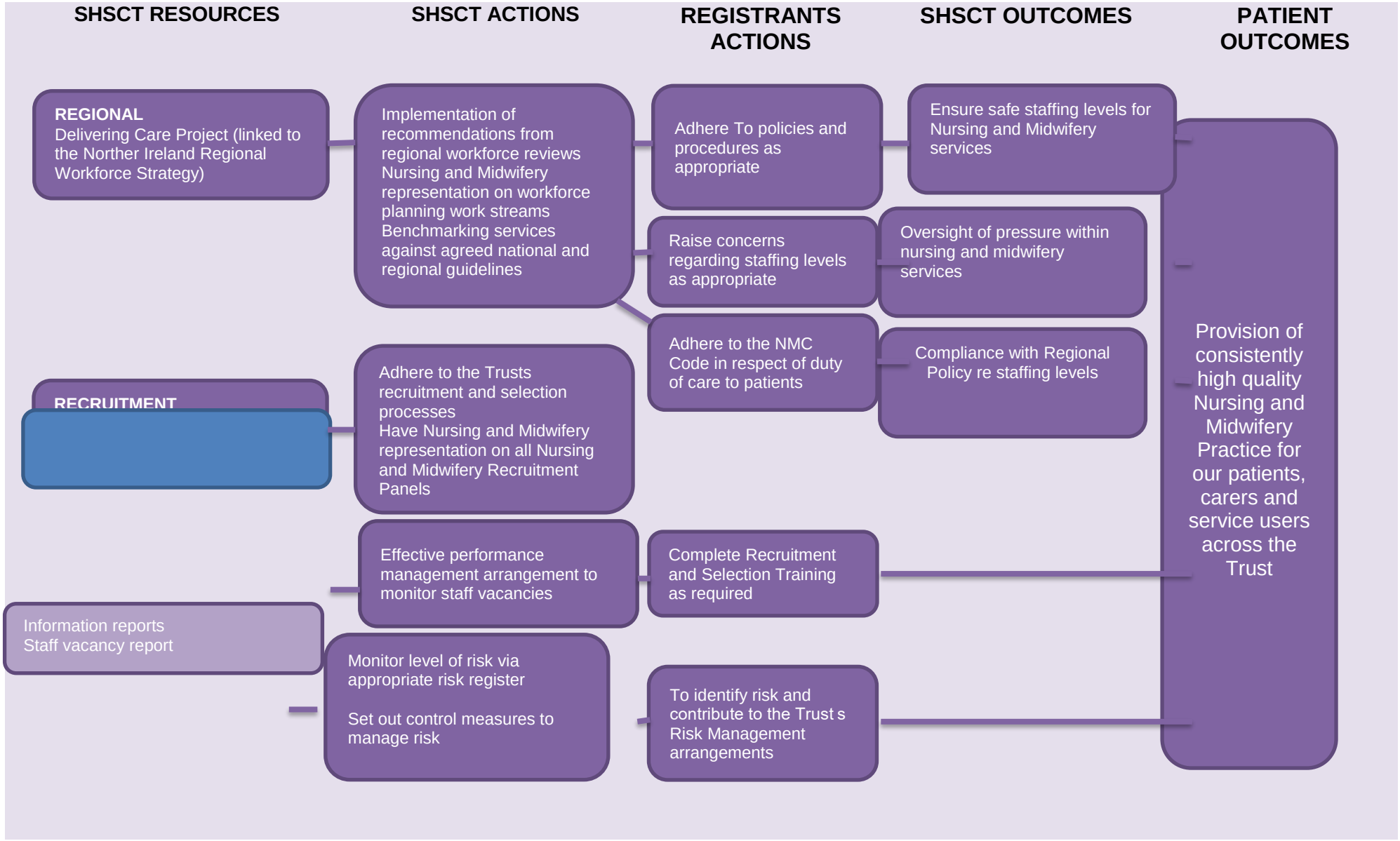
Accountability and Assurance Framework
Nursing and Midwifery

Workforce



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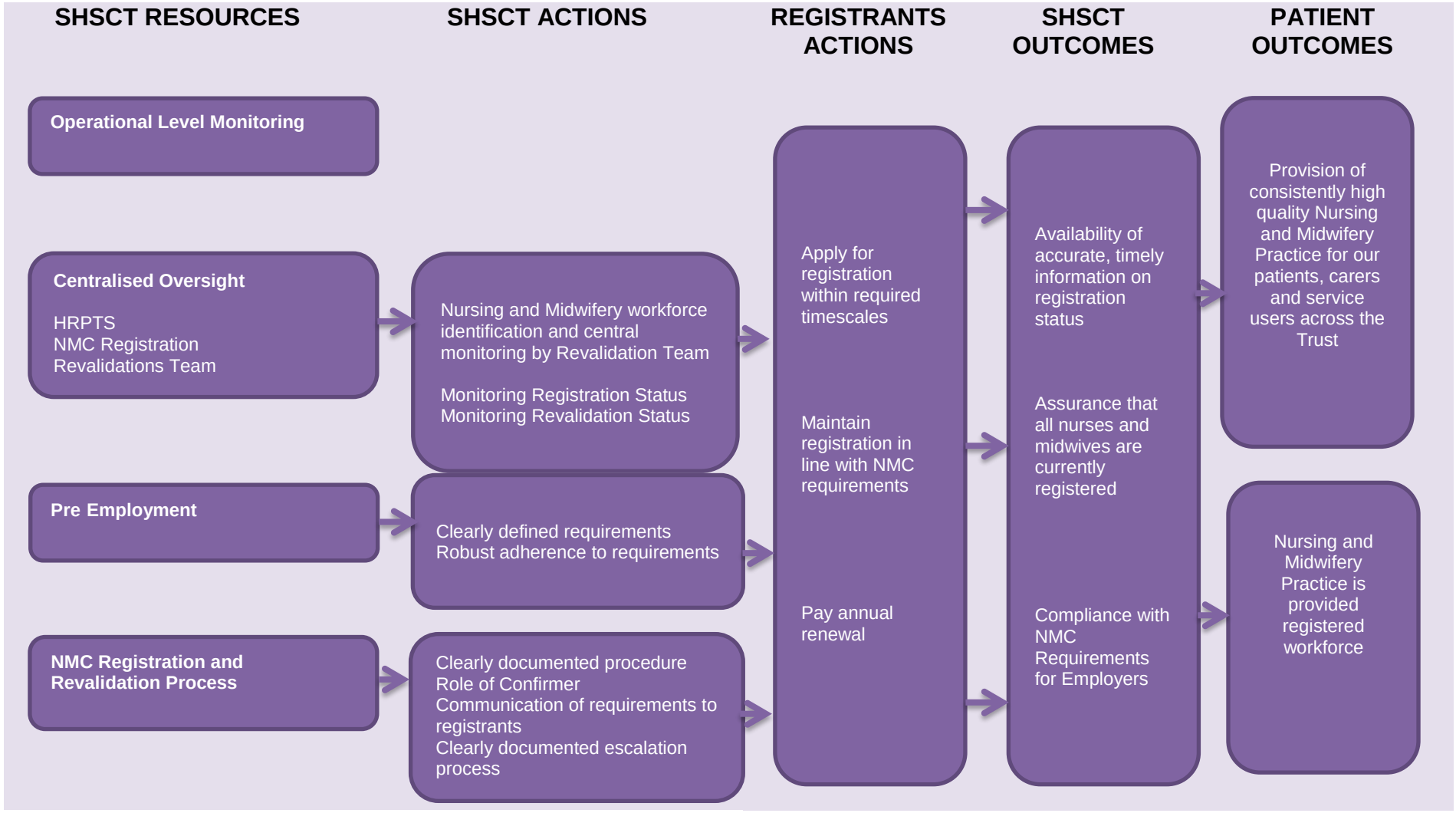
Accountability and Assurance Framework
Nursing and Midwifery

Registration



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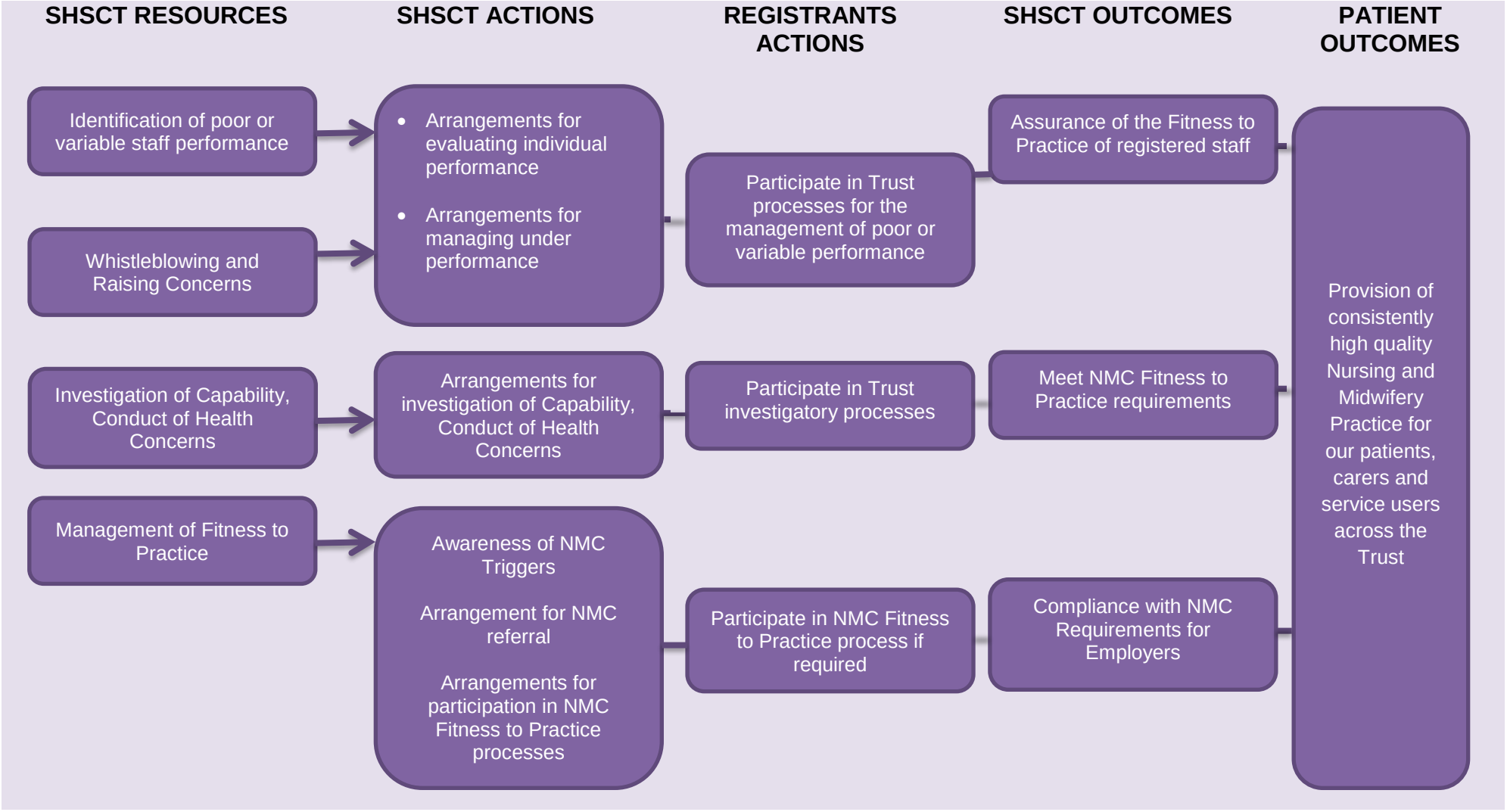
Accountability and Assurance Framework
Nursing and Midwifery

Handling Concerns



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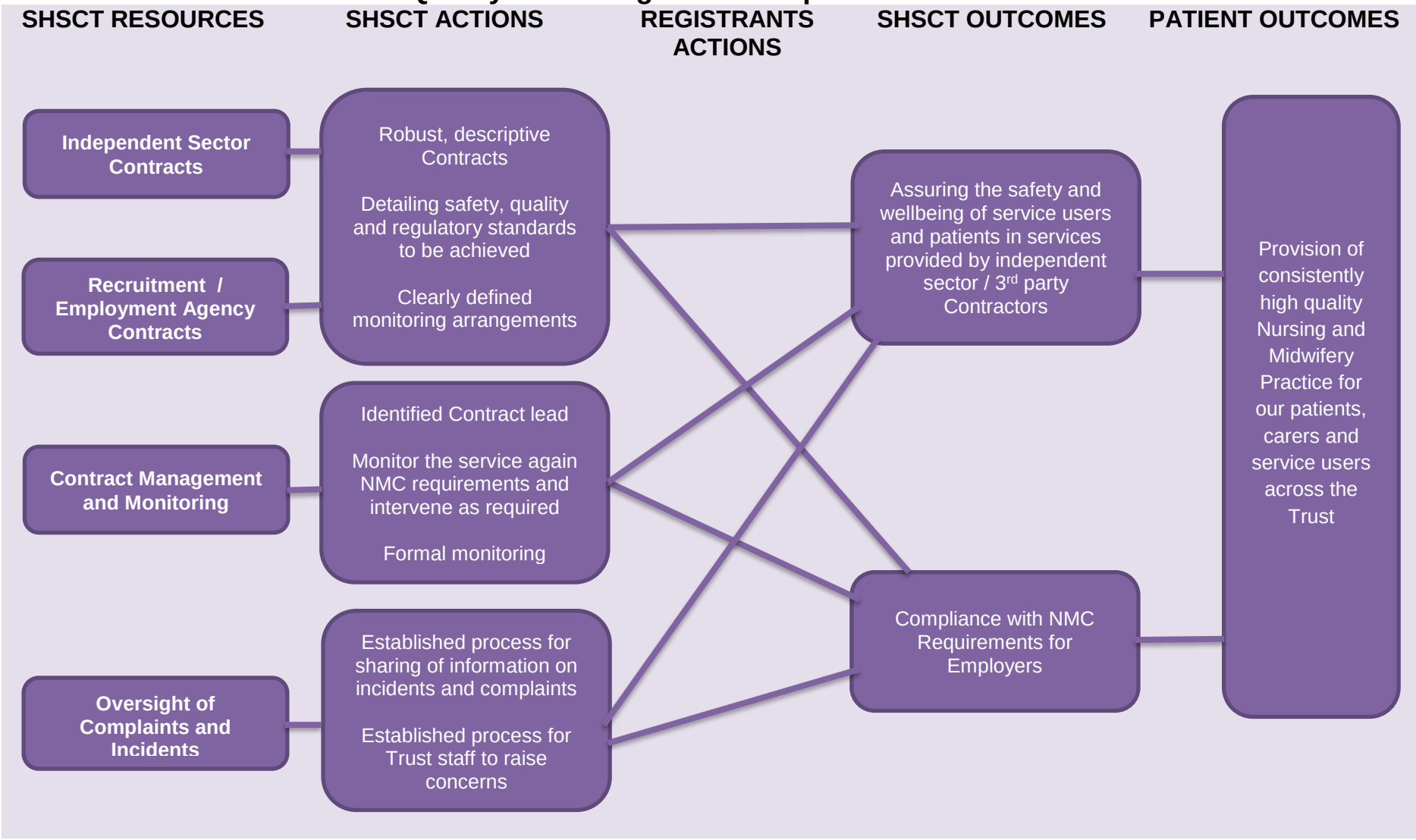
Accountability and Assurance Framework

Nursing and Midwifery

Quality of Nursing in the Independent Sector



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Nursing & Midwifery Council

Standards for competence for registered nurses

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

The Nursing and Midwifery Council (NMC) is the nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland. We exist to protect the public. We achieve this by:

- maintaining a register of nurses, midwives and nursing associates
- setting standards for education, training and conduct;
- ensuring that registered nurses, midwives and nursing associates keep their skills and knowledge up to date; and
- having clear and transparent processes to investigate nurses, midwives and nursing associates who fall short of our standards or breach their professional code.

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WIT-65209

Introduction

We publish the *Standards for pre-registration nurse education* (NMC, 2010) which includes standards for competence that clearly state what nurses must achieve before being registered with us. This is achieved by undertaking an NMC-approved three-year degree programme which includes learning taking place equally in the university and practice-placement settings.

In the UK, nurses study a specific field of practice as part of their nursing degree and each field has a specific type of registration with us. There are four fields of nursing:

- adult nursing
- children's nursing
- learning disabilities nursing
- mental health nursing.

Although these are different fields of nursing, registered nurses will be expected to meet the essential mental and physical health needs of people of all ages and conditions including those needing end-of-life care. Some nurses qualify in multiple fields and so will be registered with us in more than one field.

Nurses must maintain these standards for competence throughout their careers to remain on our register. Nurses must also practise in line with the most recent version of *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*.

Failing to consistently meet our standards can result in us investigating a nurse, midwife or nursing associate's fitness to practise and whether they are suitable to remain on our register.

We are now making the standards for competence its own document. We are doing this to make these standards more accessible to the public and nurses to make it clear that these are the standards that nurses must meet when they qualify. This will also reinforce that all nurses must maintain these standards by keeping their knowledge and skills up to date as long as they are on our register.

This is to respond to calls made by the *More Care, Less Pathway* report into the workings of the Liverpool Care Pathway (Department of Health, 2013). This report called for information about the standards that patients and the public should expect from nurses in areas such as end-of-life care, hydration and nutrition to be published as its own document.

Publishing this document also meets our commitments in response to the Francis report (Department of Health, 2012) and other recent reports on a range of healthcare issues that focused on patient safety and improving communication with patients and the public. It also comes as a result of ongoing contact with our key stakeholders representing patients and the public across the four countries to improve access to information on the standards for competence expected of nurses.

It is important to note that the standards for competence have not changed and remain exactly the same as those outlined in *Standards for pre-registration nursing education* (NMC, 2010).

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WIT-65210

About the Standards for competence

The standards for competence apply to all fields of nursing and are set out in four main areas of professional nursing practice. These are:

- professional values;
- communication and interpersonal skills;
- nursing practice and decision making; and
- leadership, management and team working.

Within these four areas there are two main aspects to the standards. All nurses must demonstrate their knowledge and competence in both in order to register as a nurse. These aspects are:

- the competencies that all nurses across all fields must know and demonstrate; and
- the specific competencies of each field that an individual nurse is registered in.

The combination of both aspects across all four areas is in place to ensure that patients and the public can be confident that all registered nurses will:

- deliver high quality essential care to all persons in their care;
- deliver complex care to service users in their field of practice;
- act to protect the public, and be responsible and accountable for safe, person-centred, evidence-based nursing practice;
- act with professionalism and integrity, and work within agreed professional, ethical and legal frameworks and processes to maintain and improve standards;
- practise in a compassionate, respectful way, maintaining dignity and wellbeing and communicating effectively;
- act on their understanding of how people's lifestyles, environments and where care is delivered influence their health and wellbeing;
- seek out every opportunity to promote health and prevent illness;
- work in partnership with other health and social care professionals and agencies, service users, carers and families ensuring that decisions about care are shared; and
- use leadership skills to supervise and manage others and contribute to planning, designing, delivering and improving future services.

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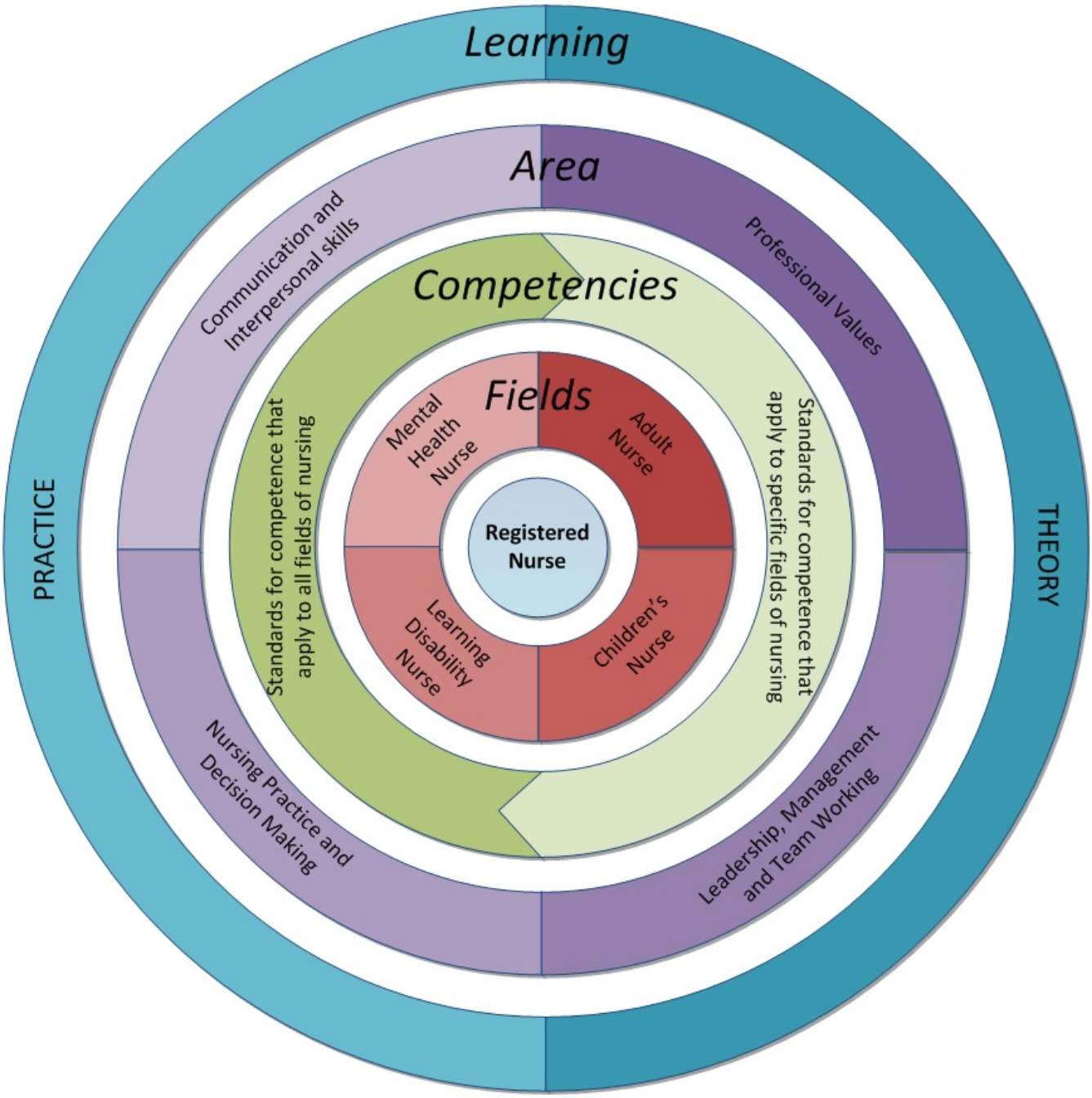
WIT-65211

The diagram below shows how this all fits together.



The rest of this document will explain:

- the standards for competence which all registered nurses must meet in their professional nursing practice; and
- the standards for competence which registered nurses in adult, child, learning disability, and mental health fields of nursing must meet.

Standards for competence that apply to all fields of nursing

All nurses in all four fields of nursing must demonstrate competencies across the four areas; professional values, communication and interpersonal skills, nursing practice and decision making and leadership, management and team working. All areas (known formally as domains) are explained fully for clarity.

Professional values

All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.

Professional values competencies that all nurses will demonstrate

All nurses must:

- practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*, and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.
- practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.
- support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, inability to engage, ageing or death. Nurses must act on their understanding of how these conditions influence public health.
- work in partnership with service users, carers, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.
- fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.
- understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.
- be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.
- practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.
- appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

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WIT-65213

Leadership, management and team working

Leadership, management and team working competencies that all nurses will demonstrate

All nurses must be professionally accountable and use clinical governance processes to maintain and improve nursing practice and standards of healthcare. They must be able to respond autonomously and confidently to planned and uncertain situations, managing themselves and others effectively. They must create and maximise opportunities to improve services. They must also demonstrate the potential to develop further management and leadership skills during their period of preceptorship and beyond.

All nurses must:

- act as change agents and provide leadership through quality improvement and service development to enhance people's wellbeing and experiences of healthcare.
- systematically evaluate care and ensure that they and others use the findings to help improve people's experience and care outcomes and to shape future services.
- be able to identify priorities and manage time and resources effectively to ensure the quality of care is maintained or enhanced.
- be self-aware and recognise how their own values, principles and assumptions may affect their practice. They must maintain their own personal and professional development, learning from experience, through supervision, feedback, reflection and evaluation.
- facilitate nursing students and others to develop their competence, using a range of professional and personal development skills.
- work independently as well as in teams. They must be able to take the lead in coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given.
- work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care. They must know when and how to communicate with and refer to other professionals and agencies in order to respect the choices of service users and others, promoting shared decision making, to deliver positive outcomes and to coordinate smooth, effective transition within and between services and agencies.

Nursing practice and decision making

All nurses must practise autonomously, compassionately, skilfully and safely, and must maintain dignity and promote health and wellbeing. They must assess and meet the full range of essential physical and mental health needs of people of all ages who come into their care. Where necessary they must be able to provide safe and effective immediate care to all people prior to accessing or referring to specialist services irrespective of their field of practice. All nurses must also meet more complex and coexisting needs for people in their own nursing field of practice, in any setting including hospital, community and at home. All practice should be informed by the best available evidence and comply with local and national guidelines. Decision-making must be shared with service users, carers, families and informed by critical analysis of a full range of possible interventions, including the use of up-to-date technology. All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

WIT-65214

Nursing practice and decision making competencies that all nurses will demonstrate

All nurses must:

- use up-to-date knowledge and evidence to assess, plan, deliver and evaluate care, communicate findings, influence change and promote health and best practice. They must make person-centred, evidence-based judgments and decisions, in partnership with others involved in the care process, to ensure high quality care. They must be able to recognise when the complexity of clinical decisions requires specialist knowledge and expertise, and consult or refer accordingly.
- possess a broad knowledge of the structure and functions of the human body, and other relevant knowledge from the life, behavioural and social sciences as applied to health, ill health, disability, ageing and death. They must have an in-depth knowledge of common physical and mental health problems and treatments in their own field of practice, including co-morbidity and physiological and psychological vulnerability.
- carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.
- ascertain and respond to the physical, social and psychological needs of people, groups and communities. They must then plan, deliver and evaluate safe, competent, person-centred care in partnership with them, paying special attention to changing health needs during different life stages, including progressive illness and death, loss and bereavement.
- understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. They must use a range of information and data to assess the needs of people, groups, communities and populations, and work to improve health, wellbeing and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion.
- practise safely by being aware of the correct use, limitations and hazards of common interventions, including nursing activities, treatments, and the use of medical devices and equipment. The nurse must be able to evaluate their use, report any concerns promptly through appropriate channels and modify care where necessary to maintain safety. They must contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes.
- be able to recognise and interpret signs of normal and deteriorating mental and physical health and respond promptly to maintain or improve the health and comfort of the service user, acting to keep them and others safe.
- provide educational support, facilitation skills and therapeutic nursing interventions to optimise health and wellbeing. They must promote selfcare and management whenever possible, helping people to make choices about their healthcare needs, involving families and carers where appropriate, to maximise their ability to care for themselves.
- be able to recognise when a person is at risk and in need of extra support and protection and take reasonable steps to protect them from abuse.
- evaluate their care to improve clinical decision-making, quality and outcomes, using a range of methods, amending the plan of care, where necessary, and communicating changes to others.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

WIT-65215

Communication and interpersonal skills

All nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful. They must communicate effectively using a wide range of strategies and interventions including the effective use of communication technologies. Where people have a disability, nurses must be able to work with service users and others to obtain the information needed to make reasonable adjustments that promote optimum health and enable equal access to services,

Communication and interpersonal skills competencies that all nurses will demonstrate

All nurses must:

- build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs.
- use a range of communication skills and technologies to support person-centred care and enhance quality and safety. They must ensure people receive all the information they need in a language and manner that allows them to make informed choices and share decision making. They must recognise when language interpretation or other communication support is needed and know how to obtain it.
- use the full range of communication methods, including verbal, non-verbal and written, to acquire, interpret and record their knowledge and understanding of people's needs. They must be aware of their own values and beliefs and the impact this may have on their communication with others. They must take account of the many different ways in which people communicate and how these may be influenced by ill health, disability and other factors, and be able to recognise and respond effectively when a person finds it hard to communicate.
- recognise when people are anxious or in distress and respond effectively, using therapeutic principles, to promote their wellbeing, manage personal safety and resolve conflict. They must use effective communication strategies and negotiation techniques to achieve best outcomes, respecting the dignity and human rights of all concerned. They must know when to consult a third party and how to make referrals for advocacy, mediation or arbitration.
- use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.
- take every opportunity to encourage health-promoting behaviour through education, role modelling and effective communication.
- maintain accurate, clear and complete records, including the use of electronic formats, using appropriate and plain language.
- respect individual rights to confidentiality and keep information secure and confidential in accordance with the law and relevant ethical and regulatory frameworks, taking account of local protocols. They must also actively share personal information with others when the interests of safety and protection override the need for confidentiality.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Standards for competence that apply to specific fields of nursing: Adult

Professional values competencies that adult nurses will demonstrate

Adult nurses must also be able at all times to promote the rights, choices and wishes of all adults and, where appropriate, children and young people, paying particular attention to equality, diversity and the needs of an ageing population. They must be able to work in partnership to address people's needs in all healthcare settings.

Adult nurses must also:

- understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.

Communication and interpersonal skills competencies that adult nurses will demonstrate

Adult nurses must demonstrate the ability to listen with empathy. They must be able to respond warmly and positively to people of all ages who may be anxious, distressed, or facing problems with their health and wellbeing.

Adult nurses must also:

- promote the concept, knowledge and practice of self-care with people with acute and long-term conditions, using a range of communication skills and strategies.

Nursing practice and decision-making competencies that adult nurses will demonstrate

Adult nurses must be able to carry out accurate assessment of people of all ages using appropriate diagnostic and decision-making skills. They must be able to provide effective care for service users and others in all settings. They must have in-depth understanding of and competence in medical and surgical nursing to respond to adults' full range of health and dependency needs. They must be able to deliver care to meet essential and complex physical and mental health needs.

Adult nurses must also:

- be able to recognise and respond to the needs of all people who come into their care including babies, children and young people, pregnant and postnatal women, people with mental health problems, people with physical disabilities, people with learning disabilities, older people, and people with long term problems such as cognitive impairment.
- safely use a range of diagnostic skills, employing appropriate technology, to assess the needs of service users.
- safely use invasive and non-invasive procedures, medical devices, and current technological and pharmacological interventions, where relevant, in medical and surgical nursing practice, providing information and taking account of individual needs and preferences.
- recognise and respond to the changing needs of adults, families and carers during terminal illness. They must be aware of how treatment goals and service users' choices may change at different stages of progressive illness, loss and bereavement.

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WIT-65217

- recognise the early signs of illness in people of all ages. They must make accurate assessments and start appropriate and timely management of those who are acutely ill, at risk of clinical deterioration, or require emergency care.
- understand the normal physiological and psychological processes of pregnancy and childbirth. They must work with the midwife and other professionals and agencies to provide basic nursing care to pregnant women and families during pregnancy and after childbirth. They must be able to respond safely and effectively in an emergency to safeguard the health of mother and baby.
- work in partnership with people who have long-term conditions that require medical or surgical nursing, and their families and carers, to provide therapeutic nursing interventions, optimise health and wellbeing, facilitate choice and maximise self-care and self-management.

Leadership, management and team competencies that adult nurses will demonstrate

Adult nurses must be able to provide leadership in managing adult nursing care, understand and coordinate interprofessional care when needed, and liaise with specialist teams. They must be adaptable and flexible, and able to take the lead in responding to the needs of people of all ages in a variety of circumstances, including situations where immediate or urgent care is needed. They must recognise their leadership role in disaster management, major incidents and public health emergencies, and respond appropriately according to their levels of competence.

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Standards for competence that apply to specific fields of nursing: Children's

Professional values competencies that children's nurses will demonstrate

Children's nurses must understand their role as an advocate for children, young people and their families, and work in partnership with them. They must deliver child and family-centred care; empower children and young people to express their views and preferences; and maintain and recognise their rights and best interests.

Children's nurses must also:

- understand the laws relating to child and parental consent, including giving and refusing consent, withdrawal of treatment and legal capacity.
- recognise that all children and young people have the right to be safe, enjoy life and reach their potential. They must practise in a way that recognises, respects and responds to the individuality of every child and young person.
- act as advocates for the right of all children and young people to lead full and independent lives.
- work in partnership with children, young people and their families to negotiate, plan and deliver child and family-centred care, education and support. They must recognise the parent's or carer's primary role in achieving and maintaining the child's or young person's health and wellbeing, and offer advice and support on parenting in health and illness.

Communication and interpersonal skills competencies that children's nurses will demonstrate

Children's nurses take account of each child and young person's individuality, including their stage of development, ability to understand, culture, learning or communication difficulties and health status. They will be able to communicate effectively with them and parents and carers.

Children's nurses must also:

- work with the child, young person and others to ensure that they are actively involved in decision-making, in order to maintain their independence and take account of their ongoing intellectual, physical and emotional needs.
- understand all aspects of development from infancy to young adulthood, and identify each child or young person's developmental stage, in order to communicate effectively with them. They must use play, distraction and communication tools appropriate to the
- child's or young person's stage of development, including for those with sensory or cognitive impairment.
- ensure that, where possible, children and young people understand their healthcare needs and can make or contribute to informed choices about all aspects of their care.

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WIT-65219

Nursing practice and decision-making competencies that children's nurses will demonstrate

Children's nurses are able to care safely and effectively for children and young people in all settings, and safeguard them. Children's nurses will be able to deliver care to meet essential and complex physical and mental health needs informed by deep understanding of biological, psychological and social factors throughout infancy, childhood and adolescence.

Children's nurses must also:

- be able to recognise and respond to the essential needs of all people who come into their care including babies, pregnant and postnatal women, adults, people with mental health problems, people with physical disabilities, people with learning disabilities, and people with long term problems such as cognitive impairment.
- use recognised, evidence-based, child-centred frameworks to assess, plan, implement, evaluate and record care, and to underpin clinical judgments and decision-making. Care planning and delivery must be informed by knowledge of pharmacology, anatomy and physiology, pathology, psychology and sociology, from infancy to young adulthood.
- carry out comprehensive nursing assessments of children and young people, recognising the particular vulnerability of infants and young children to rapid physiological deterioration.
- include health promotion, and illness and injury prevention, in their nursing practice. They must promote early intervention to address the links between early life adversity and adult ill health, and the risks to the current and future physical, mental, emotional and sexual health of children and young people.
- have numeracy skills for medicines management, assessment, measuring, monitoring and recording which recognise the particular vulnerability of infants and young children in relation accurate medicines calculation.
- use negotiation skills to ensure the best interests of children and young people in all decisions, including the continuation or withdrawal of care. Negotiation must include the child or young person, their family and members of the multidisciplinary and interagency team where appropriate.
- understand their central role in preventing maltreatment, and safeguarding children and young people. They must work closely with relevant agencies and professionals, and know when and how to identify and refer those at risk or experiencing harm.

Leadership, management and team competencies that children's nurses will demonstrate

Children's nurses must listen and respond to the wishes of children and young people. They must influence the delivery of health and social care services to optimise the care of children and young people. They must work closely with other agencies and services to ensure seamless and well-supported transition to adult services.

Children's nurses must also:

- understand health and social care policies relating to the health and wellbeing of children and young people. They must, where possible, empower and enable children, young people, parents and carers to influence the quality of care and develop future policies and strategies.

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WIT-65220

- ensure that, wherever possible, care is delivered in the child or young person's home, or in another environment that suits their age, needs and preferences.
- use effective clinical decision-making skills when managing complex and unpredictable situations, especially where the views of children or young people and their parents and carers differ. They must recognise when to seek extra help or advice to manage the situation safely.
- work effectively with young people who have continuing health needs, their families, the multidisciplinary team and other agencies to manage smooth and effective transition from children's services to adult services, taking account of individual needs and preferences.

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Standards for competence that apply to specific fields of nursing: Learning disabilities

Professional values competencies that learning disabilities nurses will demonstrate

Learning disabilities nurses must promote the individuality, independence, rights, choice and social inclusion of people with learning disabilities and highlight their strengths and abilities at all times while encouraging others do the same. They must facilitate the active participation of families and carers.

Learning disabilities nurses must also:

- understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.
- always promote the autonomy, rights and choices of people with learning disabilities and support and involve their families and carers, ensuring that each person's rights are upheld according to policy and the law.
- use their knowledge and skills to exercise professional advocacy, and recognise when it is appropriate to refer to independent advocacy services to safeguard dignity and human rights.
- recognise that people with learning disabilities are full and equal citizens, and must promote their health and wellbeing by focusing on and developing their strengths and abilities.

Communication and interpersonal skills that learning disabilities nurses will demonstrate

Learning disabilities nurses must use complex communication and interpersonal skills and strategies to work with people of all ages who have learning disabilities and help them to express themselves. They must also be able to communicate and negotiate effectively with other professionals, services and agencies, and ensure that people with learning disabilities, their families and carers, are fully involved in decision making.

Learning disabilities nurses must also:

- use the full range of person-centred alternative and augmentative communication strategies and skills to build partnerships and therapeutic relationships with people with learning disabilities.
- be able to make all relevant information accessible to and understandable by people with learning disabilities, including adaptation of format, presentation and delivery.
- use a structured approach to assess, communicate with, interpret and respond therapeutically to people with learning disabilities who have complex physical and psychological health needs or those in behavioural distress.
- recognise and respond therapeutically to the complex behaviour that people with learning disabilities may use as a means of communication.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

WIT-65222

Nursing practice and decision-making competencies that learning disabilities nurses will demonstrate

Learning disabilities nurses must have an enhanced knowledge of the health and developmental needs of all people with learning disabilities, and the factors that might influence them. They must aim to improve and maintain their health and independence through skilled direct and indirect nursing care. They must also be able to provide direct care to meet the essential and complex physical and mental health needs of people with learning disabilities.

Learning disabilities nurses must also:

- be able to recognise and respond to the needs of all people who come into their care including babies, children and young people, pregnant and postnatal women, people with mental health problems, people with physical health problems and disabilities, older people, and people with long term problems such as cognitive impairment.
- use a structured, person-centred approach to assess, interpret and respond therapeutically to people with learning disabilities, and their often complex, pre-existing physical and psychological health needs. They must work in partnership with service users, carers and other professionals, services and agencies to agree and implement individual care plans and ensure continuity of care.
- lead the development, implementation and review of individual plans for all people with learning disabilities, to promote their optimum health and wellbeing and facilitate their equal access to all health, social care and specialist services.
- work in partnership with people with learning disabilities and their families and carers to facilitate choice and maximise self-care and self-management and co-ordinate the transition between different services and agencies.

Leadership, management and team competencies that learning disabilities nurses will demonstrate

Learning disabilities nurses must exercise collaborative management, delegation and supervision skills to create, manage and support therapeutic environments for people with learning disabilities.

Learning disabilities nurses must also:

- take the lead in ensuring that people with learning disabilities receive support that creatively addresses their physical, social, economic, psychological, spiritual and other needs, when assessing, planning and delivering care.
- must provide direction through leadership and education to ensure that their unique contribution is recognised in service design and provision.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Standards for competence that apply to specific fields of nursing: Mental health

Professional values competencies that mental health nurses will demonstrate

Mental health nurses must work with people of all ages using values-based mental health frameworks. They must use different methods of engaging people, and work in a way that promotes positive relationships focused on social inclusion, human rights and recovery, that is, a person's ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying.

Mental health nurses must:

- understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.
- practise in a way that addresses the potential power imbalances between professionals and people experiencing mental health problems, including situations when compulsory measures are used, by helping people exercise their rights, upholding safeguards and ensuring minimal restrictions on their lives. They must have an in depth understanding of mental health legislation and how it relates to care and treatment of people with mental health problems.
- promote mental health and wellbeing, while challenging the inequalities and discrimination that may arise from or contribute to mental health problems.
- work with people in a way that values, respects and explores the meaning of their individual lived experiences of mental health problems, to provide person-centred and recovery-focused practice.
- have and value an awareness of their own mental health and wellbeing. They must also engage in reflection and supervision to explore the emotional impact on self of working in mental health; how personal values, beliefs and emotions impact on practice, and how their own practice aligns with mental health legislation, policy and values-based frameworks.

Communication and interpersonal skills that mental health nurses will demonstrate

Mental health nurses must practise in a way that focuses on the therapeutic use of self. They must draw on a range of methods of engaging with people of all ages experiencing mental health problems, and those important to them, to develop and maintain therapeutic relationships. They must work alongside people, using a range of interpersonal approaches and skills to help them explore and make sense of their experiences in a way that promotes recovery.

Mental health nurses must also:

- use skills of relationship-building and communication to engage with and support people distressed by hearing voices, experiencing distressing thoughts or experiencing other perceptual problems.
- use skills and knowledge to facilitate therapeutic groups with people experiencing mental health problems and their families and carers.

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WIT-65224

- be sensitive to, and take account of, the impact of abuse and trauma on people's wellbeing and the development of mental health problems. They must use interpersonal skills and make interventions that help people disclose and discuss their experiences as part of their recovery.
- use their personal qualities, experiences and interpersonal skills to develop and maintain therapeutic, recovery-focused relationships with people and therapeutic groups. They must be aware of their own mental health, and know when to share aspects of their own life to inspire hope while maintaining professional boundaries.
- foster helpful and enabling relationships with families, carers and other people important to the person experiencing mental health problems. They must use communication skills that enable psychosocial education, problem-solving and other interventions to help people cope and to safeguard those who are vulnerable.

Nursing practice and decision-making competencies that mental health nurses will demonstrate

Mental health nurses must draw on a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions to provide person-centred support and care across all ages, in a way that supports self-determination and aids recovery. They must also promote improvements in physical and mental health and wellbeing and provide direct care to meet both the essential and complex physical and mental health needs of people with mental health problems.

Mental health nurses must also:

- be able to recognise and respond to the needs of all people who come into their care including babies, children and young people, pregnant and postnatal women, people with physical health problems, people with physical disabilities, people with learning disabilities, older people, and people with long term problems such as cognitive impairment.
- be able to apply their knowledge and skills in a range of evidence-based individual and group psychological and psychosocial interventions, to carry out systematic needs assessments, develop case formulations and negotiate goals.
- be able to apply their knowledge and skills in a range of evidence-based psychological and psychosocial individual and group interventions to develop and implement care plans and evaluate outcomes, in partnership with service users and others.
- work to promote mental health, help prevent mental health problems in at-risk groups, and enhance the health and wellbeing of people with mental health problems.
- help people experiencing mental health problems to make informed choices about pharmacological and physical treatments, by providing education and information on the benefits and unwanted effects, choices and alternatives. They must support people to identify actions that promote health and help to balance benefits and unwanted effects.
- provide support and therapeutic interventions for people experiencing critical and acute mental health problems. They must recognise the health and social factors that can contribute to crisis and relapse and use skills in early intervention, crisis resolution and relapse management in a way that ensures safety and security and promotes recovery.

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WIT-65225

- work positively and proactively with people who are at risk of suicide or self-harm, and use evidence-based models of suicide prevention, intervention and harm reduction to minimise risk.
- practise in a way that promotes the self-determination and expertise of people with mental health problems, using a range of approaches and tools that aid wellness and recovery and enable self-care and self-management.
- use recovery-focused approaches to care in situations that are potentially challenging, such as times of acute distress; when compulsory measures are used; and in forensic mental health settings. They must seek to maximise service user involvement and therapeutic engagement, using interventions that balance the need for safety with positive risk-taking.

Leadership, management and team competencies that mental health nurses will demonstrate

Mental health nurses must contribute to the leadership, management and design of mental health services. They must work with service users, carers, other professionals and agencies to shape future services, aid recovery and challenge discrimination and inequality.

Mental health nurses must also:

- actively promote and participate in clinical supervision and reflection, within a values-based mental health framework, to explore how their values, beliefs and emotions affect their leadership, management and practice.
- help raise awareness of mental health, and provide advice and support in best practice in mental health care and treatment to members of the multiprofessional team and others working in health, social care and other services and settings.
- contribute to the management of mental health care environments by giving priority to actions that enhance people's safety, psychological security and therapeutic outcomes, and by ensuring effective communication, positive risk management and continuity of care across service boundaries.
- contribute to the management of mental health care environments by giving priority to actions that enhance people's safety, psychological security and therapeutic outcomes, and by ensuring effective communication, positive risk management and continuity of care across service boundaries.

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WIT-65226

Essential skills clusters

Essential skills clusters support the achievement of the standards for competence. There are five essential skills clusters:

- care, compassion and communication
- organisational aspects of care
- infection prevention and control
- nutrition and fluid management
- medicines management.

Each essential skill cluster provides further detail to assist the development of the nursing degree programme and further details can be found at essential skills clusters

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APPENDIX 5

RECORD OF 1:1 SUPERVISON

Date 29/11/2021. Venue CAH Time from 9 to 10 AM

SUPERVISEE	
PRINT NAME:	CHRIS WAMSLEY
SIGNATURE	Personal Information redacted by the USI

SUPERVISOR	
PRINT NAME:	MELANIE McCLEMENTS
SIGNATURE	Personal Information redacted by the USI

Review of Action Points from Previous Supervision Session

Personal Information redacted by the USI

Issues / Topics for Discussion

Personal Information redacted by the USI

Key Points from Discussion

Personal Information redacted by the USI

Agreed Action Plan for Supervisee

Actions	Timescale
Personal Information redacted by the USI	

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The Regulation and Quality Improvement Authority

RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland

June 2022

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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Health and Social Care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors who are either experienced practitioners or experts by experience. RQIA reports are submitted to the Department of Health (DoH) and are available on the RQIA website at www.rqia.org.uk.

Acknowledgements

RQIA wishes to thank all those who facilitated this review by participating in discussions, meetings, surveys and by providing relevant information.

Membership of the Expert Review Team

Maria Dineen	Managing Director of Consequence UK, Consultant to the National Patient Safety Agency 2001-2003, approved investigator - NHS England's serious incident framework and author of Six Steps to Root Cause Analysis.
Dr David Evans	Former Medical Director and Interim Chief Executive Northumbria Healthcare National Health Service Foundation Trust, England.
Dr Lourda Geoghegan	Former Director of Improvement and Medical Director, Regulation and Quality Improvement Authority (role in review ceased March 2020)
Emer Hopkins	Director of Hospital Services, Independent Healthcare, Audit and Reviews, RQIA (role in review commenced March 2020)
Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority.
Mrs Vivien Jess	Lay Representative and Independent Expert Advisor to the review
Mr Brian O'Hagan	Lay Representative and Independent Expert Advisor to the review
Dr Richard Wright	Former Medical Director of Southern Health and Social Care Trust and Professional Medical Advisor, Regulation and Quality Improvement Authority.

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Glossary of Terms

Belfast Trust	Belfast Health and Social Care Trust
CAMHS	Children and Adolescent Mental Health Services
CQC	Care Quality Commission
DoH	Department of Health
DRO	Designated Review Officer
HSC	Health and Social Care
HSCB	Health and Social Care Board
IHRD	Inquiry into Hyponatraemia-related Deaths
Multidisciplinary	Involving professionals from different disciplines who have different professional skills, expertise and experience.
NIAS	Northern Ireland Ambulance Service
Northern Trust	Northern Health and Social Care Trust
PCC	Patient Client Council
PHA	Public Health Agency
PPI	Personal and Public Involvement
RCA	Root Cause Analysis
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
SPPG	Strategic Performance and Planning Group (formerly Health and Social Care Board)
Western Trust	Western Health and Social Care Trust

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Foreword

This Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland resulted from the independent Public Inquiry led by Justice O'Hara which investigated the deaths of five children in hospitals in Northern Ireland. After hearing evidence from a wide range of individuals and organisations, it concluded that deaths had been avoidable and that the culture of the health service at the time, arrangements in place to ensure the quality of services and behaviour of individuals had contributed to those unnecessary deaths.

A key finding of the Public Inquiry was that the internal investigations into the deaths and their surrounding circumstances were inadequate. They had failed to identify the underlying causes. It also found that, as guidance on fluid management on children became available, it was not disseminated and actioned effectively across the Health and Social Care (HSC) system.

The reality is that similar situations, where events leading to harm have been inadequately investigated and examples of recognised good practice have not been followed, have been, and are likely to be repeated in current practice.

Such inadequacies bring distress and suffering to the individuals affected and their loved ones; and the staff whose efforts to provide good and safe care are undermined.

Serious Adverse Incident (SAI) reviews are a fundamental part of how the whole system should learn from harm, and make improvements to Health and Social Care services in Northern Ireland.

This Review, commissioned by the Department of Health (DoH), in its response to the recommendations of the Inquiry, and undertaken by the RQIA, has assessed the effectiveness of the current SAI process.

It has been one of our most significant Reviews, which has benefited from engagement with a wide range of individuals, organisations and groups across the Health and Social Care system.

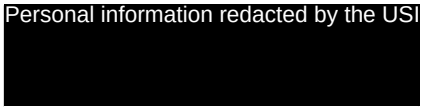
We would especially like to thank all families who contributed to the Review, as their experience of the reality from a patient and family perspective has been a key feature in shaping the Review's findings.

The Expert Review Team found that neither the SAI review process nor its implementation is sufficiently robust to consistently enable an understanding of what factors, both systems and people, have led to a patient or service user coming to harm.

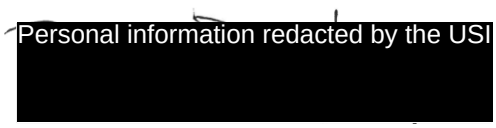
HSC leaders and managers must work to make sure that if something goes wrong, all staff are confident to speak up, through a competent and independent review process, knowing that doing so will help them keep their patients and service users safe and improve the quality of care they are able to deliver.

Patients and service users, and their loved ones and advocates, must be able to take part freely and fully in the process, so they find out what happened and can help make sure it won't happen again.

On behalf of RQIA, we hope that the recommendations in this Review, which have been produced with the assistance of a wide range of patients, service users, families, clinicians and managers from across HSC, will be accepted, implemented fully, and drive improvement in safety and quality throughout the system.



Christine Collins MBE
Chair



Briege Donaghy
Chief Executive

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Executive Summary

Background and Context

Serious Adverse Incident (SAI) reviews are a fundamental component of how we learn from harm and subsequently make improvements to the systems for the delivery of safe patient care. Regional guidance for the reporting and follow-up of SAIs in Northern Ireland has been in place since 2004. However, over the last decade, the SAI process and its implementation has come under scrutiny both regionally and nationally. Concerns have been raised around the current procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs) in Northern Ireland (November 2016)[1] (here-after the SAI procedure). It has also been highlighted that there is a clear need for improvement in terms of how patients, their families and staff are engaged in reviews and how subsequent learning is derived and implemented. These issues are not unique to Northern Ireland or indeed the United Kingdom. Ensuring the effective implementation of SAI reviews and subsequent learning is a considerable undertaking. Not only does the procedure itself need to be robust, but its effective application necessitates an open and supportive learning culture with SAI reviewers who are trained in the necessary skill set to undertake effective SAI reviews.

In April 2018, the Regulation and Quality Improvement Authority (RQIA) was commissioned by the Department of Health (DoH) to examine the application and effectiveness of the SAI procedure. Terms of Reference for this review were approved by the Department of Health in October 2019 and fieldwork on this review concluded in January 2021. The time taken to complete and publish this review has been significantly impacted by the system response to Covid-19 Pandemic.

Terms of Reference

The terms of reference for this review, as agreed with the DoH, were as follows:

1) To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAIs) across the six Health and Social Care (HSC) Trusts, the HSCB and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

2) To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.

3) To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.

4) To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.

5) To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.

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6) To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.

7) To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.

8) To assess the level of professional support provided to (i) staff who were delivering care at the time of the SAIs, as well as (ii) staff conducting the review of the SAIs.

9) To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response to SAIs, their assessment and review, and the learning arising through these processes.

Methodology

The Expert Review Team developed a methodology specific to this review incorporating extensive engagement with a range of key individuals and organisations and patients their relatives and representative groups. Focus Groups and individual interviews were undertaken. The engagement was supported by the development of a number of semi-structured questionnaires. An important aspect of this review was the undertaking of a rigorous assessment of 66 serious adverse incident reports from all HSC Trusts in Northern Ireland.

Findings

The Expert Review Team determined that the current SAI procedure and its implementation in Northern Ireland **does not** support:

- Fulfilment of the statutory duty of Personal Public Involvement as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.
- Reasonable application of the principles of effective SAI review practice.
- Confidence in the independence of chairs of SAI reviews at Level 2, or Level 3. Particularly in the case of Level 3 reviews, where the appointed chair is a former employee of an HSC Trust.
- Accountability of Health and Social Care organisations for:
    - decisions made regarding the level of review conducted
    - involvement and engagement with a patient and/or relatives
    - the quality of the review conducted and the acceptance of its findings and approval processes
    - evidencing that HSC Trust services have improved and are safer because of the reviews conducted
    - ensuring that issues requiring regional action to improve safety are appropriately identified and then escalated to the right people in the right organisations

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- The formulation of evidence-based recommendations.
- The design of action plans that will enhance the safety and quality of healthcare provision across the region both in the short and longer term.
- The production of SAI review reports that are well-formulated, evidence-based and readable.

The Expert Review Team identified a number of reasons for this:

- The implementation of the SAI procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently conducting these reviews to a high standard.
- There was an absence of clear regional guidance on how to execute Personal Public Involvement duties and in relation to patient rights as part of an SAI review.
- There was no regional patient safety training strategy and curriculum.
- There were not clearly defined competencies required of lead investigating officers and SAI review panel chairs.
- There were not sufficient numbers of trained independent advocates for families and patients.
- There was a lack of effective training in how to execute an effective and meaningful SAI review.
- Furthermore, even where training had been delivered, the appointed chair or review leads, they did not always have sufficient authority to independently devise a review plan that fully delivers the required quality of review.
- There were also a large number of reviews identified as requiring an in-depth review but which did not require this, which was creating an unsustainable work pressure within the system.

The conclusion of the Expert Review Team is that current practice for reviewing and learning from SAIs in Northern Ireland is not achieving the intended purpose of the SAI procedure. Improving this situation will require both the SAI procedure and the system in which it operates to be re-designed.

Summary of Recommendations

The following recommendations are made to support the delivery of a new regional policy/procedure for reporting, investigating and learning from adverse events.

Number	Recommendation	Priority
1	The Department of Health should work collaboratively with patient and carer representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.	**2**

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2	Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.	**3**
3	The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.	**3**
4	The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by 'just culture' principles and a clear evidence-based framework that delivers measurable and sustainable improvements.	**3**
5	The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.	**3**

Key Benefits

The Expert Review Team concluded that, should these recommendations be fully implemented and embraced by the Health and Social Care system in Northern Ireland, they would deliver the following key benefits:

- A clear regional framework which provides for learning from unexpected harm.
- Greater flexibility in the SAI review process, which is aligned to international best practice and allows a better opportunity for learning and safety improvement.
- A single, new report template and regional style guide that supports consistency across the region but is flexible enough to allow reviewers to add and remove sections as required.
- A lower number of in-depth Root Cause Analysis (RCA) reviews, where early case assessment shows that this level of review is not required or proportionate.
- Increased capacity within HSC to deliver structured, in-depth reviews, where early assessment indicates this is necessary.
- An appropriate amount of time to conduct a review well and involve patients and families in a way that is meaningful.
- A review process that does not cause further harm to patients, their families or staff.
- A culture of safety, openness and compassion.

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1.0 Background and Context

1.1 Introduction

Health and Social Care services are used extensively across Northern Ireland daily, and most patients and their families are satisfied with their care. However, it is inevitable that some will not have a satisfactory experience while others may even experience harm. When harm occurs, there is a moral, ethical and professional duty on those involved in the delivery of care to review what happened.

When such an incident is identified, the process of reviewing an event in an effort to learn is known as an Adverse Incident (AI) review, and some will warrant a Serious Adverse Incident (SAI) review. The SAI review aims to:

- Determine if any element of the care delivery or treatment plan contributed to the harm and any underlying systemic reasons for this.
- Ensure that the necessary improvements are made to the standard of care delivered and to the underlying systems and processes that support patient safety.
- Facilitate the recovery of the patient and their family from the harming experience, so that reconciliation can occur, including continuing trust in the Health and Social Care services.

Fundamental to achieving these aims is a clear, regionally agreed approach to identifying, reporting, reviewing and learning from incidents of harm, including serious near-miss events or apparent near-miss events. Furthermore, this approach must be clearly articulated within policies and procedures.

Throughout this report, the term 'patient and family' is used to represent those that would fall under the category of patient, service user, carer, family, or family member. The Expert Review Team recognises that users of mental health and learning disability services are normally referred to as service users rather than patients.

1.2 Context

Regional guidance for the reporting and follow-up of SAIs has been in place in Northern Ireland since 2004. Over the last decade, the SAI process has come under scrutiny both regionally and nationally. Following the Public Inquiry into Mid-Staffordshire NHS Foundation Trust in 2014[2] the Chief Medical Officer in Northern Ireland wrote to HSC Trusts to remind them of their statutory duty in relation to the review and reporting of SAIs. This correspondence outlined a need for candour alongside meaningful engagement with patients and their families when incidents of harm have occurred.

The Donaldson Report in 2014[3] highlighted concerns around the reporting of adverse incidents, ineffective processes for review, lack of expertise amongst reviewers (particularly in relation to human factors) and a failure for learning to translate into improvements in systems and patient safety. Donaldson also outlined

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a need for a 'just culture' for healthcare staff participating in SAI reviews, in addition to a need for candour and openness with patients and families.

In 2018, Justice O'Hara published his long-awaited inquiry report; Hyponatraemia-related Deaths (IHRD) in Northern Ireland[4]. It called for a statutory duty of candour and made a number of recommendations in relation to reporting, investigating and sharing of learning from SAIs, including a need to increase the involvement of families in these processes. This served to further highlight a need for a review of the regional procedure for SAI reviews in Northern Ireland.

In April 2018, the RQIA was commissioned by the Department of Health (DoH) to examine the effectiveness of the current procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs) (November 2016) and its implementation within Health and Social Care services and make recommendations for improvement. A final Terms of Reference for this work was agreed with the DoH in October 2019 and fieldwork on this review concluded in January 2021.

The review was conducted in phases, with interim reports submitted to DoH upon completion of each phase. This document is the culmination of this work and is an overall assessment of the effectiveness of the SAI procedure and its implementation across Health and Social Care in Northern Ireland

1.3 Overview of Regional SAI Procedure

The system for reporting adverse incidents was first introduced in Northern Ireland in 2004 by the former Department of Health, Social Services and Public Safety (DHSSPS), now known as the DoH. Reporting arrangements were transferred to the Health and Social Care Board (HSCB), now the Strategic Planning Performance Group (SPPG) within the DoH, in partnership with the Public Health Agency (PHA), in 2010. Updates to this procedure were implemented in 2010, 2013 and 2016.

The current version of the regional SAI procedure which was last updated in 2016, advises that SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

Incidents which meet the following criteria may be classified as an SAI.

- Serious injury to, or the unexpected/unexplained death of:
    - a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
    - a staff member in the course of their work
    - a member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and/or member of the public.
- Unexpected or significant threat to provide service and/or maintain business continuity.

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- 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 Children and Adolescent Mental Health Services (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.

Three levels of review are described in the regional procedure. The expectation in respect of each level is summarised below:

Level 1 Review: Significant Event Audit (SEA)

For Level 1 reviews, membership of the SEA review team should include all relevant professionals, yet be appropriate and proportionate to the type of incident and professional groups involved.

The review panel undertakes an SEA of the incident to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local or regional learning.

Level 2 Review: Root Cause Analysis (RCA)

For Level 2 reviews, the level of review undertaken will determine the degree of leadership, overview and strategic review required. A core review panel should be comprised of a minimum of three people of appropriate seniority and objectivity. Review panels should be multidisciplinary and have no conflict of interest with the incident concerned. The review should have a chairperson who is independent of the service area involved, while possessing relevant experience of the service area in general and of chairing reviews.

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The chairperson should also not have been directly involved in the care or treatment of the individual or be responsible for the service area under review.

The review panel undertakes a RCA to a high level of detail, using appropriate analytical tools to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning.

Level 3 Review: Independent Review

For Level 3 reviews, the same principles as Level 2 reviews apply; however, team membership must be agreed upon between the reporting organisation and the HSCB/ PHA (PHA) Designated Review Officer (DRO) prior to the review commencing.

The 2016 procedure states that: "The review panel undertakes an in-depth review of the incident, to a high level of detail, using appropriate analytical tools to assess: what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning."

In 2016, the Regional SAI procedure was updated to guide SAI review panels in relation to providing patients and families with an opportunity to contribute to the SAI review.

The guidance outlined that:

- The level of involvement depended on the nature of the SAI and the patient and family's willingness to be involved.
- Teams involved in the review of SAIs should ensure sensitivity to the needs of the patient and family/carer involved.
- Teams should agree on appropriate communication arrangements with the patient and family/carer involved.

To support the involvement process, an SAI leaflet[5] was designed by the HSCB and PHA for organisations to give to patients and families prior to their initial discussion regarding the SAI which had occurred.

1.4 Patient and Family Involvement and Engagement

Health and Social Care services across Northern Ireland have a legal duty to involve service users and their carers. Personal and Public Involvement (PPI) is a legislative requirement for Health and Social Care organisations as set out in the Health and Social Services (Reform) Northern Ireland Act 2009[6].

The Act states that service users and carers must be involved in and consulted on:

- The planning of the provision of care.
- The development and consideration of proposals for changes in the way that care is provided.

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- Decisions to be made by the body that has the responsibility for the provision of that care.
- The efficacy of that care.

PPI is the active and meaningful involvement of service users and carers in the planning, commissioning, delivery and evaluation of Health and Social Care (HSC) services, in ways that are relevant to them. It is the process of empowering and enabling those who use services and their carers to make their voices heard, ensuring that their knowledge, expertise and views are listened to.

Given this statutory duty, service user and family involvement were considered a pivotal aspect of this review. Throughout the review, the effectiveness and extent of patient and family engagement have been examined from the perspective of patients and families, frontline staff and managers.

2.0 Terms of Reference

The terms of reference for this review, as agreed with the Department of Health, were as follows:

1) To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAIs) across the six HSC Trusts, the HSCB and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

2) To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.

3) To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.

4) To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.

5) To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.

6) To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.

7) To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.

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8) To assess the level of professional support provided to (i) staff who were delivering care at the time of the SAIs, as well as (ii) staff conducting the review of the SAIs.

9) To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response to SAIs, their assessment and review, and the learning arising through these processes.

3.0 Review Methodology

The review used a range of methodologies to ensure each term of reference was addressed. Each methodology aimed to optimise the quality of information sought by the expert panel to ensure a robust evidence-base for their recommendations.

The methods included:

1) The assessment of SAI review reports, by the Expert Review Team. The criteria for assessment as agreed with the Department of Health.

2) The design of a structured assessment questionnaire which was applied by the Expert Review Team to all SAI review reports submitted by the participating HSC Trusts.

3) Questionnaires issued to a range of Trust staff, from senior management to frontline practitioners, and SAI panel chairs, seeking their views of their involvement in the SAI review process.

4) Engagement of patients and families who had experienced healthcare-induced harm and the offer of face-to-face conversations to learn about their experiences and hear their views as to how these experiences could have been improved.

5) Focus groups involving staff involved in an SAI, as well as staff involved in the SAI review process.

6) Meetings with individuals and groups of staff in HSC organisations involved in SAI reviews.

7) Engagement with other relevant organisations.

It was intended that the effectiveness of implementation of SAI recommendations would be examined in specific detail by the Expert Review Team to explore further the arrangements within services to deliver on sustained and measurable improvements to patient safety. However due to the COVID-19 pandemic, this aspect of the methodology was unable to be performed in full, but was explored though other aspects of the methodology.
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3.1 The Identification and Selection of SAIs

For the aspect of this review SAIs selected had been conducted between 30 November 2016 and 31 March 2018 and fell within the following categories:

- Deaths of women and babies related to pregnancy and childbirth: maternal deaths, stillbirths and neonatal deaths. Serious illness of women and babies where this has been related to pregnancy and childbirth.
- Sepsis
- Choking on Food
- Never Events[1]
- Cases where private hospitals or private nursing homes feature in the care pathway.
- People with a learning disability who have died from a treatable physical condition.
- People with a learning disability in residential care.
- Primary Care
- Any other categories RQIA considered appropriate for inclusion the review.

The information relating to these SAIs was obtained from the HSCB. After validation, 54 SAIs were identified for inclusion. A total of 12 additional SAIs were subsequently selected, comprised of Level 2 and Level 3 reviews, resulting in a total of 66 SAIs being selected for expert review (Appendix A).

3.2 The Structured Assessment of SAI Reports

A structured assessment tool was developed and applied to each SAI report reviewed. The assessment captured the perspectives of members of the Expert Review Team who were:

- Experienced investigators.
- Clinicians.
- Lay and family representatives.

Two distinct types of structured assessment tools were developed, one for use by the lay members of the Expert Review Team and one for the technical assessment of the SAI reports by other Expert Review Team members. This approach ensured consistent and objective assessment of each SAI report.

Due to the differences in templates used and levels of review required, for Level 1 and Level 2 SAI reviews set out in the regional procedure, the core assessment tool, which applies to Level 2 SAIs, was modified to meet the requirements of a Level 1 SAI report.

[1] Never Events are serious, wholly preventable safety incidents that should not occur if the available preventative measures are implemented. They include things like wrong site surgery or foreign objects left in a person's body after an operation. The full scope of Never Events is detailed in the Care Quality Commission report, Learning from Never Events (July 2018).

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To ensure a robust approach, members of the Expert Review Team with either a clinical qualification or extensive prior experience in the conduct of SAI review were grouped in pairs. This resulted in each pair reviewing a total of 33 SAI reports.

The lay members of the Expert Review Team reviewed all 66 SAI reports individually before comparing their assessments and discussing any differences of opinion. This resulted in three subgroups with two members of the Expert Review Team in each, assessing the SAI review reports.

Table 1 below shows the breakdown of trusts and reports allocated to each technical team.

Table 1: Breakdown of trusts and reports allocated to each technical team

Team	Organisation	Number of SAI reports for review
Team 1	Northern Trust	10
	South Eastern Trust	13
	Western Trust	10
Team 2	Belfast Trust	11
	Southern Trust	14
	NIAS	4
	Integrated Care Team, HSCB	4
TOTAL		**66**

Source: RQIA Structure Assessment Exercise

3.2.1 Quality Assurance of the Structured Assessments

The structured assessment tool developed by the Expert Review Team considered the extent to which the SAI report described:

- The incident under review and why it was being reviewed.
- The level of independence of the review panel members and the competencies and skills they had to conduct the review.
- The degree of patient and family engagement with the review process.
- The nature of the recommendations made and their relevance to improving patient safety.
- The robustness of the action plans constructed to deliver the recommendations and whether they would deliver a measurable and sustained improvement in quality and safety.

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3.2.2 Technical Assessment

To ensure reliable and accurate assessments of the SAI reports, two quality assurance exercises were undertaken.

Firstly, for each of the three technical teams referenced above, an intra-team reliability exercise was undertaken. This required the assessors to submit a sample of four assessments to each other for a repeat assessment to ascertain the similarity or differences in assessment outcome. This process demonstrated a high level of consistency between the assessments. Where there were significant differences in the assessments, these were presented and discussed at a round table conversation between the technical assessors to reach consensus. A lay member of the Expert Review Team was included in this process.

The second quality assurance exercise was undertaken upon completion of the assessment of all SAI reports.

This involved a sample of four completed assessments being selected from each technical assessment team and reassessed by the other team. Following this, the technical assessment teams met to compare findings. There were few discrepancies between the teams which confirmed a high level of consistency. Any discrepancies were discussed, and a consensus position was reached.

3.2.3 Lay Assessment

The lay members of the Expert Review Team assessed all 66 SAI reports adopting the perspective of a family member who might receive these reports. To achieve a comparable process of quality assurance, each lay member assessed all 66 reports and subsequently met with their lay counterpart to discuss each report, including any differences in perspective.

As with the technical assessments, there were few discrepancies between the assessments conducted by the two lay members of the Expert Review Team, and any differences were resolved by discussion thereby reaching a consensus view.

3.2.4 Analysis of the SAI Report Assessments

Themes were extracted from SAI report assessments and collated to inform key findings. These findings informed engagement with the HSC organisations during subsequent phases of this review. During the review, emerging findings and key messages were shared with the Department of Health via interim reports.

3.3 How each Trust responds to Significant Unexpected Harm Events

Questionnaires were developed for and issued to each HSC Trust, the HSCB and the PHA. These were designed to gather information from each organisation about their respective approaches to SAI review and the related structures and processes in place, including the extent of patient and family involvement.

A thematic analysis of the responses received was subsequently undertaken.

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3.4 Patient and Family Engagement

Initially, it was intended that the Expert Review Team would make direct contact with those patients and/or families affected by the 66 SAIs which were included in the structured review undertaken in the first phase of this review. Recognising the potential for further psychological impact, the Expert Review Team agreed the following patients and/or family members would not be contacted:

- Where there had been an expressed wish by the patient and family not to be contacted further or where there were issues of confidentiality.
- Families of cases who were subject to a coroner's investigation.
- Patients/families of cases which were subject to legal proceedings.
- Patients/families of those involved in significantly distressing SAIs (including suicide of a family member).

This resulted in 38 out of the 66 patients/families being contacted to seek their involvement in the review process. Of the invitations sent to each patient and family, only six responses were received. Following this, two decided not to be involved. This resulted in four out of 38 individuals contacted agreeing to become involved. Individuals subsequently met with RQIA staff members. This number was considered too few for the purposes of this review. As such a decision was made to supplement the engagement and further seek experiences via several additional routes, including approaching the Department of Health and the Patient Client Council (PCC) to supplement the experiences of those four initially contacted. Both organisations had previously engaged with patients/families who have had an experience of the SAI process following an incident of unexpected harm.

The PCC agreed to meet with the Expert Review Panel to share the views of patients/families with whom they had engaged. Communication with the Department of Health also resulted in three additional families agreeing to participate and share their experiences.

3.4.1 Additional information considered on engagement with patients and families

Experiences of patients and families involved in SAI reviews were also ascertained through engagement with other groups and work streams:

- In November 2019, the Inquiry into Hyponatraemia-related Deaths Implementation Programme (Work stream 5, Serious Adverse Incidents), held a workshop in conjunction with the PCC to engage with families on their experience of the region's SAI review process. The findings from the workshop were shared with RQIA and considered by the Expert Review Team.

- In October 2019, the PCC shared its Serious Adverse Incident Complaints A Thematic Review of Client Support Service Cases 2014-2018 report. It outlined the experiences of families who had been through the region's SAI review process and the findings were considered by the Expert Review Team.

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- In December 2020, the Expert Review Team met with staff from Cause NI[2] who shared the experiences of families they had supported through the SAI review process and provided insight into how to achieve quality family engagement in the process.

These findings were articulated in the Expert Review Team's interim report on Patient and Family Engagement. .

3.5 Staff Engagement

As part of this review, the Expert Review Team engaged with those staff involved in the care of the 66 patients who were the subject of the SAI review reports involved in the structured assessment undertaken in the earlier phase of the review. Several methods of staff engagement were utilised:

- Focus group meetings using a café style approach.
- A private post box method.
- An online survey.
- One-to-one telephone interviews.

3.5.1. Focus Groups

Focus groups were held between 5 November and 21 November 2019. To accommodate the range of staff involved in the SAI process, each focus group had a different emphasis:

- Staff involved in the care of the patient who was harmed.
- Staff involved in the SAI review process.
- Staff involved in a named SAI review.

The focus groups focused on three primary areas:

- The experience of staff who had been involved in the SAI process.
- Their experience of engaging and involving patients/families in the SAI process.
- The views of staff in relation to how the SAI process could be improved.

Table 2 below shows the number of staff who attended each of the focus groups.

[2] Cause NI is an organisation which supports people with a mental health problem and their family members.

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Table 2: Staff Engagement Focus Groups by Participation and Organisation

Source: Information recorded by RQIA during the focus groups

	Focus Group 1	Focus Group 2	Focus Group 3	
Organisation	Staff involved in an incident	Staff involved in reviewing an incident	Team involved in reviewing an incident	Total number of staff by organisation
Belfast Trust	5	12	4	21
Northern Trust	19	16	2	37
South Eastern Trust	14	15	4	33
Southern Trust	12	10	3	25
Western Trust	5	19	4	28
NIAS	2	8	n/a	10
Integrated Care	n/a	8	n/a	8
Total number of staff by focus group	**57**	**88**	**17**	**162**

3.5.2 Confidential Post-Box Feedback

At each staff focus group, a confidential post-box was provided to enable staff to share their experiences of the SAI process should they not be comfortable with speaking out in front of a group.

3.5.3 Online Survey

The third method to support staff engagement was via an online survey. All staff working within HSC Trusts were offered an opportunity to respond, provided they had experienced the SAI review process.

Overall, 201 staff completed the survey. However, 114 of those had not been involved in an SAI process, either as a member of a care team involved in an incident or as a member of the SAI review panel. Their responses were therefore not included in these analyses.

Of 87 respondents who had an experience of the SAI review process, 40 staff members had been involved in care and treatment related to an incident and 47 staff members had been part of the panel reviewing an incident.

3.5.4 Telephone Interview

All staff who attended the focus group meetings were also offered the opportunity to speak confidentially with a member of the Expert Review Team by telephone interview. Four staff members were subsequently interviewed.

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3.6 Meetings with HSC Organisations

The Expert Review Team met with Senior Managers in each of the HSC Trusts. The meetings focused on the management and oversight of the SAI review process within the organisations and included a discussion on potential improvements to the SAI review process.

The Expert Review Team also met with the HSCB and PHA to discuss their regional responsibilities, their roles in oversight of the SAI review process and the role of the Designated Review Officer. This meeting also included a discussion on potential improvements to the SAI review process.

3.7 Engagement with other Organisations

The Expert Review Team met with representatives of the RQIA's Mental Health inspection team and the Coroners Service in NI, both of which were identified as having had frequent engagement with the SAI process. The purpose of this discussion was to gain an insight into their experience of the SAI process and what improvements they considered could be made.

A broad range of organisations are involved and impacted by the regional SAI review process. Engagement with these organisations focussed on those that had most frequently experienced the process. Other organisations, such as other regulatory bodies, trade unions, and the Police Service for Northern Ireland were provided with information about the review and asked if they would like to make a written submission regarding their views and opinions in relation to the current SAI process and their suggestions for change to the SAI process.

Of the organisations contacted, the following eight responded. These were; the Royal College of Nursing, the Eastern Local Medical Committee, the Pharmacy Forum, the Coroner's Service, the Northern Ireland Public Sector Alliance, the Northern Ireland Medical and Dental Training Agency, the Information Commissioners Office and the Health and Safety Executive Northern Ireland.

The full list of organisations contacted is outlined in Appendix B.

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4.0 Findings

4.1 Overall findings of the Expert Review Panel

After full consideration of all the evidence gathered from each of the contributors to this review, the Expert Review Team was confident in their determination that the current regional policy for SAI review in Northern Ireland must change. It was clear that the current procedure and its implementation does not support:

- Fulfilment of the statutory duty of PPI as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.
- Reasonable application of the principles of effective review practice.
- Confidence in the independence of Chairs of SAI reviews at Level 2, or Level 3 - particularly so for Level 3 reviews where the appointed chair is a former employee of an HSC Trust.
- Health and Social Care organisations embracing their accountability for:
    - decisions made regarding the level of review conducted
    - how they involve and engage with a patient and family
    - the quality of review conducted, acceptance of its findings and approval processes
    - demonstrating how HSC Trust services have improved and are safer because of the reviews conducted
    - ensuring that issues requiring regional attention to improve safety are escalated to the right people/organisations.
- The formulation of evidence-based recommendations.
- The design of action plans that will enhance the safety and quality of healthcare provision across the region both in the short and longer-term.
- Review reports that are well-formulated, evidence-based and readable.

The Expert Review Team identified a number of reasons for this:

- The implementation of the regional procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently delivering the practice of conducting high quality SAI reviews.
- There was an absence of clear regional guidance on PPI duties in relation to patient rights within the serious adverse incident process.
- There was no defined regional patient safety training strategy and curriculum.
- There were not defined competencies required of lead investigating officers and serious adverse incident panel chairs.
- There were insufficient numbers of trained independent advocates to support family involvement in the process.
- There was a regional lack of effective training in how to conduct a meaningful review. Furthermore, even where training had been delivered, the appointed chair or investigative leads did not have sufficient authority to independently devise a review plan that fully delivers the required quality of a review.

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The evidence underpinning these findings was derived across a broad range of engagements and is detailed further in the following sections under three key themes.

1) Patient and family engagement.
2) Staff engagement.
3) The effectiveness of the procedure and approach for delivery of SAI reviews.

4.2 Patient and Family Engagement

A hallmark of success in any approach to the review and learning from incidents of unexpected and avoidable harm is the manner in which a health provider organisation engages with the patient and their family through the review process. The families who provided information to the Expert Review Team, the PCC and the lay members of the Expert Review Panel (who themselves have lived experience of healthcare induced harm) provided consistent reflections on how this aspect of SAI Reviews is delivered in Northern Ireland.

The Expert Review Team identified several of themes after listening to the views and experiences of patients and families:

- There was inconsistency in the practice of HSC Trusts in when and how they informed families about:
    - the incident
    - the decision to conduct an incident review process
    - the rights of patients and families to be engaged at all stages of the review, including shaping the terms of reference or lines of enquiry
    - sharing of the interim findings of the review process to allow commenting and feedback from the patient and family to be incorporated.

- There was inconsistency in the quality and frequency of communications with the patient and their family. This includes written correspondence as well as verbal communications. A common concern was the level of empathy, respect in the nature and tone of communications and levels of planning with the patient and their family about what mode of communication was best and with what frequency.
- Families reported there was not sufficient transparency about the process.
- There was a deficit in the availability of independent support or advocacy for patients and families.
- There were concerns about the timeliness and amount of information provided about the plan for the review process and its intended conclusion date.
- They described HSC organisations across the region were unable to apologise for the harm that had occurred. In their words, it was not enough to say, “sorry, we are at fault”. Rather, the apology should say: “Sorry this has happened to you. We will look after you and help you understand what happened”.

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- They experienced an unwillingness to seek the testimony of the patient and family members as an integral component of the review process, thus diminishing the status of the patients and their families.
- Many stated that the interim findings of the review process were not shared with the patient or their family members so that they could contribute constructive comments and ensure their voice is appropriately represented and heard.
- There was not a sufficient level of openness and candour about what had happened and why. They described the shrouding of the SAI review findings in technical language which was not accessible and perceived it to be defensiveness.
- There were some who were concerned about potential 'cover-ups' and a lack of transparency in the process, as well as in the report subsequently written.
- Several described Chairs of the SAI review whose communication skills and ability to work constructively with a family were poor.
- Several were not confident in the independence of Chairs of the SAI review.

Of particular note was the view expressed by Cause NI, a charity that specialises in offering practical and emotional support to families whose loved ones have experienced harm as a result of serious mental illness or suicide. They considered that the current requirement within the SAI procedure, for the investigation of all deaths that have occurred as a result of mental illness (where the individual who dies was known to Mental Health Services in the preceding 12 months), was not the best approach. It was suggested SAI reviews would be most appropriate in those cases where it was suspected there were care deficits preceding the death.

The Expert Review Team reflected, that overall, the expressed views of patients of families in Northern Ireland regarding their experiences of involvement, were similar to findings of independent reviews and inquiries elsewhere in the UK, such as the Care Quality Commission (CQC) review, '*Learning, Candour and Accountability 2016*[7], the *Mid Staffordshire NHS Foundation Trust Inquiry* and *The Report of the Morecambe Bay Investigation.* It was therefore disappointing that in Northern Ireland, more progress had not been made in implementing best practice in how HSC organisations work with families after unexpected harm.

The Expert Review Team was impressed with the attitude of staff who expressed a willingness to have greater engagement and involvement with the patient and their family in the process. Most staff appreciated that patients and families are an important component of a successful approach to learning from harm. They reported feeling constrained by an overly bureaucratic process, which they perceived placed completion of arbitrary timescales and narrow performance targets above the requirement for meaningful involvement.

The most significant barriers to achieving meaningful involvement of patients and their families were described as:

- Uncertainty about what staff could and could not say to a family and what constitutes an acceptable level of disclosure.
- How to achieve realistic expectations with a patient and their family about what the SAI process can and cannot deliver.

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- The time allowed for the delivery of the SAI process, and the time available to an SAI review panel chair, who would have additional managerial or frontline clinical duties and which is not conducive to meaningful patient and family engagement.
- The availability of dedicated support for patients and their families through the SAI process. Without support, it is difficult for Chairs of SAI reviews to also attend properly to the needs of the patient and family.
- Absence of constructive guidance on how to capture family involvement and engagement within the SAI review report, exacerbated by lack of space within the review report template to record the level of family involvement.
- Staff were concerned about legal issues and reported anxiety about how to describe the findings that then might result in a claim for damages. A small number of staff described instances where legal services have requested modifications to a report which diluted the findings of the SAI review panel.

The Expert Review Team is clear that concerns regarding future claims for damages must not interfere with conduct of an SAI review or with the integrity of the resulting report. It is wholly unacceptable that report authors could be asked by a manager or by legal services to dilute their findings. Furthermore, such action should have serious implications for health professionals who have breached their professional duty of candour.

However, there are good reasons for a legal services team to review an internal SAI review report document:

- To sense check the use of language.
- To test the strength of the evidence base underpinning the report's findings and conclusions.
- To determine a report's readability.

Feedback made to a report author in the context of the above must be considered and acted upon.

Across the HSC, it was not the cultural norm to share interim findings of an SAI review with a patient and their family. Enabling the patient and family to have a voice in the report, to comment on the report content, and to influence the content and tone of the final report appears not to be a primary consideration. Ineffective and insufficient patient and family engagement can cause further harm. Families report having experienced some of the following adverse effects:

- Increase in stress.
- Delay in starting the grieving process.
- Post-traumatic stress disorder.
- Loss of income.
- Feelings of anger.
- Loss of life enjoyment.

The Expert Review Team considered that, for many families, it is possible to avoid causing further harm if HSC organisations engage in a compassionate process. The

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founders of the Harmed Patients Alliance[8], a campaign group founded to raise awareness of harmed patients and families, effectively communicate the kind of compassion families need following healthcare harm.

"In the aftermath of our loss, we needed healthcare to fully acknowledge and thoroughly understand our experience of what had happened to our children and the impact it had on us. We needed answers to all of the questions that we had, that were important to us, and we needed those regardless of whether anyone else felt our question relevant or important. We needed staff to be supported to give us honest accounts of their actions and their reflections. We needed a collaborative approach to reach a truthful and evidence based explanation of events. We needed help and support to understand what all the processes were that were happening and how to engage with them. We needed the system to learn and to see meaningful change, but we also needed the system to help us heal, recover, and restore our trust. Meaningful engagement coming from a place of care could have provided that."

Harmed Patients Alliance

4.2.1 Working with patients and their families in a way that delivers a restorative process and maintains candour

The Expert Review Team determined that the Department of Health with associated stakeholders must describe the region's statement of intent regarding how patients and families are involved in the SAI review process and the core objectives in relation to patient and family involvement for which each HSC provider must evidence achievement.

Examples of objectives relating to patient and family involvement are:

- Families and patients are supported as active partners in the review process as much as they wish to be engaged, including the involvement of an appointed advocate.
- Patients/families experience a compassionate and empathetic approach, which is demonstrated by the nature and frequency of contact throughout the review process.
- The voice of the patient and family is heard, their testimony captured, and they have the same status as any professional contributing information to the review process.
- The patient and family has a named source of support, outside of the review panel. The role of this individual is clearly defined, including the basis authority to act as advocates in the best interests of the family.

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- Questions asked by the patient and family are responded to fully, with honesty, integrity and candour.
- The patient and family are encouraged to contribute to the terms of reference for incidents identified as requiring in-depth review.
- Patients/families are taken through the interim findings of the review and are provided with enough time to read, comment on, and influence the content of the final report.

In the event of new information becoming available after the conclusion of an SAI review, or if there is a change in conclusion or material findings from such review, then this information must be shared with the patient/families as soon as possible.

How individual HSC organisations undertake to deliver the objectives should be for them to determine. However, what is required from all HSC organisations is clear evidence that they have achieved the objectives. In particular, they should provide evidence that patients and families are given the same opportunity for involvement in an SAI review as the staff and others involved in an incident. This evidence should be validated by patients and families who have experienced unexpected healthcare harm of the nature that warrants an SAI review. The Expert Review Team considered that a co-production model for development and further improvement of the SAI procedure, involving frontline staff and patients and their families, should be adopted going forward.

4.3 Staff Engagement (staff engaged in the care and management of the patient who experienced harm)

Every SAI review must involve the collection and analysis of a sufficient amount of information from multiple sources. This requires the active engagement of staff involved in the care and treatment of the harmed patient and the engagement of a wider sphere of individuals who have experience in the field and understand the system at work.

The purpose of the SAI review process is to:

- Find out what happened.
- Understand how and why it happened.
- Implement any appropriate early remedial actions to address any identified deficits in care.
- Identify areas for improvement in order to support the delivery of safe patient care.
- Implement appropriate improvements based on the findings of the SAI review.

In circumstances where patients have been harmed, it is understandable that frontline staff may feel vulnerable and experience emotional pain, as well as feelings of anger, shame, fear, sorrow or regret.

To enable HSC staff to fully inform the review process, they must feel safe to do so. They must also have confidence in both the competence the appointed review panel and feel secure that the information they provide will be used fairly.

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What staff employed within Health and Social Care trusts across the region had to say

Comments about the SAI procedure and its implementation:

In the online survey completed by HSC staff:

- 89% (179) said they agreed, or strongly agreed, that SAI reviews were an essential activity for a learning organisation.
- 74% of respondents (149) said SAI reviews generated improvement for safety within their organisations.
- 64% (129) said they agreed or strongly agreed that they were aware of more than one improvement resulting from an SAI review.
- 61% (123) said outcomes from SAI reviews were regularly discussed at team or service meetings.

While the survey results cannot definitively conclude whether or not SAI reviews enabled the collection of quality information upon which to formulate evidence-based findings, face-to-face meetings conducted with staff in HSC organisations did, however, provide a useful insight into the experiences of staff involved in SAI reviews.

The information gathered at staff focus groups, for example, highlighted that the principle of a 'just culture' was not embedded across the region.

Staff consistently reported:

- Insufficient openness about the process and the standards of conduct expected of the SAI review panel members.
- Insufficient communication about the progress of an SAI review and why it was being conducted. The key lines of enquiry, progress, findings, and recommendations were frequently unknown by staff who had been involved in the care and treatment of the patient to which the SAI review related.
- The experience of the review felt like it was designed to apportion blame.
- Terms of reference for SAI reviews did not suggest they were grounded in a constructive or learning process.
- There was variable engagement in the process, with some staff unaware the SAI review was even being conducted, only to find out at a later point in time. Some staff described an over-emphasis on the collection of written submissions and a lack of detailed exploratory conversations being conducted by SAI review panels.
- Some staff described insufficient notice of, or information about, SAI panel meetings or interviews staff were asked to attend.
- Some staff did not have an opportunity to read the interim findings before these were finalised in the SAI report.

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- Some staff said they were not able to respond to any criticisms made in the SAI report before it was signed off as completed.

Regarding the constitution of the SAI review panel, and how those panels operated, the following concerns were described by frontline staff who participated in this review:

- Concerns about the appropriateness of members of the panel in terms of technical and subject matter competency and insight.
- Concern about the lack of factual accuracy checking by review panels, both in terms of the sequence of events leading to the incident under review, but also regarding the accuracy of notes of face-to-face meeting. Staff said that this meant they were unable to correct the SAI review panel's misinterpretation of words spoken at interviews, or during panel meetings.
- Some staff described too narrow a field of focus by SAI review panels, with little consideration of the system within which frontline staff work. For example, workload, workplace design, task design, skill mix, staffing issues, team dynamics, and cultural factors, leadership and factors which may contribute to an incident.

Although negative experiences were reported, some staff reported a more positive experience and had been involved fully throughout the SAI review. These staff reported that they felt they had been involved throughout the SAI review, in terms of being kept up to date with progress of the SAI review and were able to contribute to the learning from the SAI review.

During discussions with the Expert Review Team, frontline staff reflected on the support mechanisms available to them in coming to terms with the SAI event and its subsequent review. Although we received many comments about a lack of support, a small number of staff did share positive experiences of being supported by both managers and colleagues. These staff highlighted that the people who had provided the support, had themselves been previously part of a SAI review. The overwhelming message from all focus groups across all Trusts was that staff had experiences of inadequate support as they went through the SAI process.
Frontline staff acknowledged that it was not the role of the chair of the SAI panel or the Trust staff member who oversees the review to provide appropriate support for staff as their role was to deliver an effective, unbiased review process. However, they did consider that better quality support ought to be forthcoming from:

- Their own line managers.
- Independent providers of psychological support.
- Their employer via staff supports and counselling services.

In several focus groups, the Expert Review Panel members were struck by the level of emotion expressed by staff who had participated in an SAI reviews. It was evident that these staff had not been through a supportive, reflective process of learning.

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4.3.1 Achieving a way of working with staff that delivers a supportive, learning-orientated process within a 'Just Culture'.

The Expert Review Team determined that the Department of Health, working with appropriate stakeholders, must set out, in its strategic direction, its expectations for how staff in HSC organisations and those they report to are engaged and when participating in an SAI review. As with family engagement, the principles for effective staff engagement must be developed and defined before an effective process can be designed.

An example of a statement of success could be:

'*Staff are treated well, their voice is heard, and they actively contribute to the SAI review process.'*

The core objectives for HSC organisations which will ensure this is delivered could be:

1) Staff experience a compassionate and empathetic approach.
2) The voice of the staff involved in an incident is heard, including their experience of the incident, and the context in which it occurred.
3) Staff are well informed throughout the review process.
4) Staff are treated fairly and equitably, in line with the principle of a 'just culture', including having the opportunity to read any criticisms made about them and to respond.
5) Staff involved in the incident (and other key staff) are given the opportunity to read the interim findings of the SAI review panel and to provide feedback in relation to factual accuracy, tone, and style.
6) Staff involved in the incident and service in which the incident occurred are actively engaged in designing the action plan to deliver measurable and sustained improvement.

Again, individual HSC organisations should determine for themselves how to deliver these objectives but should be able to evidence achievement of the objectives. This evidence should be validated by staff that have experienced the SAI process. Perspectives of staff who have delivered the SAI process should also be gathered and evaluated. The Expert Review Team again advises that a cooperative approach be adopted for involving frontline staff, patients and their families in designing of these improvements.

4.4 Staff Engagement (staff with experience undertaking SAI reviews)

A robust SAI review requires staff delivering the process to have the right technical knowledge, along with a range of non-technical skills and attributes. At the time of this review there was no competency framework in place to ensure the required competencies to deliver the review process. It cannot be assumed individuals have these skills simply because of their professional background or seniority. Implementing an effective approach for SAI reviews will require upskilling of staff before it can be practised and evaluated.

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For the implementation of the review procedure to be effective and for optimal learning to be achieved, a structured and feasible policy framework needs to be embedded alongside cultural change.

The consistent messages provided to the Expert Review Panel from staff engaged in the delivery of the SAI procedure and its implementation were:

- It was challenging to undertake the SAI reviews alongside their pre-existing professional duties. There was no protected time for this, nor any account taken of their day-to-day workloads or frontline patient care duties.
- There was insufficient supervision and mentorship by experienced reviewers who hold the necessary technical and non-technical skills and attributes.
- There was a lack of training in conducting SAI reviews and related methodologies.
- There were challenges in engaging with staff involved in the care giving, such as established off duty rotas, the need to provide a 6–8-week lead time to medical staff before meeting with them, challenges in locating agency and locum staff, and the delay between the incident occurring and the SAI review being commissioned.
- Communication with all relevant parties was described as a persistent challenge.
- The classification of an SAI, and how it was determined that an incident met Level 1 or Level 2 criteria, was difficult for staff to understand. There was not always full understanding that the current procedure directs reviews should be conducted at a level appropriate and proportionate to the complexity of the incident and significance of event under review rather, that the impact or outcome for the patient. Most staff considered that the criteria for classification were not clear.
- The current approach of imposed regional terms of reference does not support an effective review practice. Staff understood effective reviews require the right technical questions to be asked about the patient's care and treatment; this is not supported by the current process. When asked why the terms of reference were not changed to something more relevant, staff reported that they did not believe they had the authority to do so.
- The regional report template did not support the formulation of an evidence-based, well-structured or readable report. Participants reported that the design of the regional template made it difficult to reflect the level of an engagement that an SAI review panel may have achieved with the family. Overall, the template was considered to be not fit for purpose.
- Recommendations were a particular source of concern for participating staff, with many reporting their perspective that recommendations often did not get implemented due to a lack of resources. Staff also displayed some frustration members of review panels felt obliged to make recommendations even if they suspected that nothing would happen as a result.

In addition to the above, staff with experience in conducting SAI reviews provided insights into the review methodology of Root Cause Analysis (RCA) and the extent to which learning is implemented. The information provided by staff indicated that there is confusion about what constitutes an RCA method. The fact that many staff believed completion of the regional report template constituted a valid review and an

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RCA is concerning. Staff did not demonstrate an informed understanding of what constituted a review and were not aware of the broad range of tools and approaches they could employ to deliver this. The tools that participating staff were aware of were simple chronology, the 'five-whys' technique, and the 'fishbone' diagram.

The Expert Review Team was left with an impression that HSC Trusts across Northern Ireland are using the language of RCA without an embedded understanding of what this means, or where RCA fits into a structured and auditable review. The regional guidance does not address this, nor does it provide practical advice on how to conduct a review to an acceptable standard.

The Expert Review Team could not be confident that across the HSC Trusts, consistent systems based learning was happening, and that changes were embedded or that there was a robust system in place for sharing learning beyond the investigating organisation. The issuing of regional learning letters by the HSCB was referred to, but most frontline staff were not aware of this and only two of those interviewed had ever seen a learning letter.

Staff with experience as an SAI reviewer understood why staff asked to provide information to the review panel may suspect the existence of a 'blame culture'. They considered that most of the staff they interviewed often appeared anxious about the process and were sometimes defensive when questioned. Some staff who had undertaken several SAI reviews considered that the level of anxiety among staff being interviewed had increased over time.

The Expert Review Team considers from their assessment of the 66 review reports that the language used in SAI review reports might also contribute to a sense of blame. For example, root causes of incidents were described as 'human error', which may unfairly suggest that an individual member of staff is responsible. This is further compounded by the lack of deconstruction of events from a systems perspective, meaning that the true root causes and contributory factors which underlie errors in care and treatment are not identified, placing an unreasonable weight of responsibility on frontline staff.

Staff acting as SAI reviewers on behalf of their employer also considered the way the media in Northern Ireland reported on incidents that had reached the public domain. Subsequent media interest and commentary fuelled their feeling of a blame-driven approach and culture, alongside concerns about medico-legal consequences.

As with staff involved in care delivery, those who had an experience of conducting SAI reviews also believed that there was a lack of constructive support. Staff asked to chair SAI review panels were particularly concerned. They considered that there was no account taken of the true time required to deliver the role well, or how the time required conflicted with their other professional responsibilities. Some staff reported having to write SAI reports in their own time and late into the night, which then impacted their wellbeing and concentration levels at work the next day.

The Expert Review Team considers this situation to be wholly unacceptable. If the objective is to learn and improve safety, the system cannot overload staff already working at full capacity. Failing to provide protected time to lead the SAI review

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process infers that it lacks importance. In the rail, marine, and airline industries, where an incident merits careful analysis, only trained individuals with time to undertake the work are appointed to the task.

The lack of administrative assistance for review chairs was also cited by staff as evidence of lack of support. There is considerable administration associated with the conduct of an SAI review. The Expert Review Team considers that it is not appropriate for a frontline clinician, who has been asked to lead an SAI review process, to also be responsible for administering it.

4.4.1 How to ensure chairs and members of SAI review panels are equipped to deliver the job adequately and with enough time

The Expert Review Team considers that the first step in achieving a sustainable situation across the region is to review how decisions are made regarding the level of SAI review required. This should be informed by:

- The frequency by which the incident type occurs.
- Whether there is a safety review already ongoing to explore and address any safety issues.
- Whether the conduct of the review is likely to deliver more learning than has already been achieved by previous reviews.
- Whether there is a safety improvement plan already underway.

It is widely recognised that many individual reviews involving the same incident type often do not lead to tangible safety improvements. Therefore, the practice of defining the need for an SAI review on the basis of adverse patient outcomes should be discouraged and is not in line with the current guidance contained within the SAI procedure which states,

"SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event".

An approach that allows a sensible period of time for the early assessment of 'what happened', and consideration of early information gathered about the care and incident, might enable a more structured and evidence-based approach to deciding which cases require an in-depth systems analysis. Treating the review as a process, where reviewers and chairs can determine an evidenced-based stop point, might be more successful than a static approach which assumes that all incidents can be treated the same. One of the expert review panel members has supported several NHS Trust mental health teams to implement such an approach. As a result, mental health teams reported a reduction in the number of in-depth reviews, greater engagement from staff and a formalised process whereby the review is led by the team lead; now recognised to be an important aspect of the process.

A more flexible approach is required to enable families to understand the process and what it can deliver. For example, it can deliver learning and provide answers to questions but it cannot provide justice.

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In terms of the time allocated to conduct an SAI review, it will always be necessary to stipulate timescales, but it is important that they are realistic. They must allow at least to six-months for complex cases, and it would be reasonable to require a structured project management approach that can be monitored and quality assured.

The second step is to define the core competencies required of:

- People acting as review leads and/or chairs of review panel.
- The subject advisors supporting the process.

Furthermore, a regional training curriculum and certification process must be agreed. All training providers across the region should meet the minimum content requirement in order to enable competency achievement. For such an approach to work well, all HSC Trusts and independent providers responsible for delivering training should be required to demonstrate their competency and knowledge in order to be approved as training providers. Requiring all training providers to apply to be on a regional register or preferred provider list would support the achievement of this.

Finally, to support the implementation of a training curriculum it was considered that a mentorship and coaching approach could also be adopted. A person independent of the HSC Trust in which the incident occurred could provide external support to the lead reviewer/chair. This has the added advantage of providing an independent quality assurance check of the process and its outcomes.

4.5 SAI Reports: The extent they demonstrated a reasonable standard of review and positive contribution to patient safety in Northern Ireland

As previously outlined in the methodology in section 3.0, the Expert Review Team reviewed 66 SAI reports as part of this review.

In undertaken the review of reports, it was evident to the Expert Review Team that having two separate report templates for Level 1 and Level 2 reviews is not working. The design of the templates also does not support staff to write up their findings in a way that delivers confidence in the standard of the review or in the appropriateness of the level of review undertaken. Furthermore, the templates are designed in a way that limits important information being included, such as the questions that have been asked by patients and family members.

Upon assessing the report of a significant adverse incident review, the expectation is that it demonstrates that an effective method has been used to underpin the review. Indicators of an effective methodology are:

- The methods, tools and techniques used by the SAI review panel are clearly stated and appropriate to the incident under examination.
- The evidence upon which findings and conclusions are based have been clearly triangulated.
- An appropriate range of subject advisers have been engaged in the review process

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- The SAI review report outlines the key elements of the processes and procedures relevant to the expected standards of care and treatment.
- There is a clear account of:
    - what happened
    - where policy, process or procedural expectations were met
    - where there was a deviation from procedural expectations.
- Where deviation from procedural expectations is identified, there is an explanation of:
    - whether the deviations were reasonable and justified based on the presentation of the patient, their clinical needs at the time, and the unfolding situation
    - whether the deviations were not reasonable and therefore not justifiable.
- In the instance of a non-justifiable deviation from the expected standard of care, there should be an indication of whether this contributed to or caused the harm to the patient, and whether the deviation represents a breach in standards to such an extent as to pose an ongoing threat to the safety of another patient should it reoccur.
    - In all such instances, a report should outline a human factor and systems-based explanation of how and why the deviation(s) occurred.
- Recommendations should address the most significant factors identified which contributed to or directly caused the incident.

In addition to the above, all significant adverse incident reports should deliver the following:

- Clarity about the questions posed by the family. The answers to these questions should be included in the findings section of the report.
- A good standard of writing with correct use of grammar, punctuation, and syntax. There should be no abbreviations, unless already in common usage in Northern Ireland.
- A readable report written in non-technical language.

4.5.1 Expert Review Team Findings following review of 66 significant adverse incident reports, comprising Level 1 and Level 2 reviews

The Expert Review Team found that all HSC Trusts utilised the relevant regional templates for the Level 1 or Level 2 review reports. Therefore, the Expert Review Team's findings are as much a reflection of the design of the templates as the quality of the reports assessed.

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Style and structure of the reports

The Expert Review Team considered the presentation of the review reports and there was consensus that both report templates would benefit from a basic front page that simply states the name of the reviewing organisation, the title of the report and the publication date. It was proposed that any demographic information required for regional collection purposes could be accommodated within an appendix.

In both the Level 1 and level 2 report templates, space is provided to record 'what happened'. Mostly, this was comprehensively completed. However, in many reports, the sequence of events was recorded in too much detail and at the expense of the detailed analysis expected in the findings section of both reports, accepting that the Level 1 report is intended to be more succinct than the Level 2 report.

In the Level 1 report, there is no 'findings' section but instead, a section titled 'why it happened'. This title is erroneous. It implies that 'why' is determinable and automatically infers that the incident was preventable. It does not promote a balanced, constructive, analytical process.

In the Level 2 reports, there was a 'findings' section, but this was not structured. There were no uniform subheadings to guide a report author about what they should be recording. For example:

- Evidence that shows that expected standards of care were delivered as intended.
- Evidence of deviations from the expected standards of care.

Some reports made statements of policy and procedural compliance but did not say what these were and did not present an evidence base for the reported levels of compliance.

Some review reports stated their findings in relation to human factors, such as team elements, education and training. However, in the majority of instances the Expert Review could not link these findings to a systematic analysis of these areas of concerns in keeping with the approach of the National patient Safety Agency.[9] This indicates that the review panel, the author of the SAI review report and those signing off the reports did not fully understand how to effectively implement a human factors approach.

Some reports reviewed by the Expert Review Team did outline deviations in the care and management of the patient but did not make clear the significance or seriousness of these in relation to the patient outcome. As stated above, rarely was this accompanied by any structured or evidence-based explanation regarding how and why these deviations occurred. As a result, there was a lack of outcome-focused recommendations within the reports reviewed.

In stating the above, the Expert Review Team is not inferring that staff who undertook the reviews or wrote the reports were failing to deliver what was required of them, rather, the lack of structure and quality of the reports is a consequence of:

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- A lack of investment in those tasked with leading the reviews in terms of their knowledge, skill base and time required to do the job adequately.
- A report structure that is not fit for purpose (Level 1 and Level 2 templates).
- A lack of effective quality assurance of reports at senior management levels across HSC Trusts.
- A lack of empowerment in HSC Trusts to adopt a more comprehensive approach and a better style of report, based on the principles outlined in regional policy and guidance.
- A lack of an effective quality assurance process within each HSC organisation and at a regional level. There appears to be no reliable process through which reports are peer reviewed to ensure delivery of an acceptable standard of review, including outcome-focused recommendations. Nor are they quality assured with a view to ensuring that there is a standard of report writing suitable for sharing with patients and their families.

Expert Review Team findings in relation to specific indicators of a robust SAI review

These are the findings from the Expert Review Team's structured assessment of the 66 review reports.

Indicator 1: The methods, tools and techniques used by the review panel are clearly stated and appropriate to the incident under examination

The following list describes what was found to be commonly recorded in terms of the methodology and approach to reviewing SAIs:

- The patient's notes were reviewed.
- A tabular timeline established.
- Relevant staff were interviewed.
- Family was invited to participate in the review.

The above elements are not sufficient to be considered a methodology, nor do they provide clarity regarding the approach taken by the relevant review panel. As previously articulated in this report, the primary reason for this is a lack of understanding about what constitutes a fair and reasonable review, with a regional approach that is too limiting and not embracing a tool-kit method.

Indicator 2: The evidence upon which findings and conclusions are based has a clear triangulated evidence-base

None of the reports reviewed satisfied the Expert Review Team that there was a triangulated, and thus validated, evidence-base for what was written in the findings section of the reports. This represents an unacceptable situation. A credible review aims to establish what happened, how it happened and why it happened.

An SAI Review Panel Chair understands the importance of triangulating and validating information and understands the dangers of not delivering this standard of practice. The SAI reports reviewed demonstrated a region-wide lack of adherence to

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defendable review practice. This is mostly due to a lack of training, an unclear competency framework and insufficient professional supervision.

Indicator 3: An appropriate range of subject advisers have been engaged in the process

Regarding the independence and appropriateness of subject advisers, in 93% of reports this was either unclear or absent. Regarding relevant experience of subject advisers, this was unclear in 45% of the reports reviewed. The lack of clarity was in part influenced by the design of the regional report template which did not require precision in the recording of this information.

Indicator 4: The key elements of processes and procedures relevant to the effective care and management of the patient's condition are recorded

This was missing from almost all reports reviewed. It is not a current requirement of the regional report template, and its absence underlines the lack of appreciation about what is necessary for a structured and credible review.

Each report should give a clear account of:

1) What happened.
2) Where policy/process/procedural expectations were delivered as expected.
3) Where there was deviation from policy/process/procedural expectations and an explanation for such deviations.

Although there was a clear account of what happened, few reports provided an analysis that enabled the reader to know where expectations were delivered, where they were not, and where the design of the process for care delivery and management was incomplete.

This is a significant shortcoming in the SAI protocol which does not require systems based analysis as part of its approach to conducting SAI reviews or within its regional report template.

Reports of reviews must determine:

- What was expected.
- Where the evidence supports that the standard of care was delivered as expected.
- Where the evidence shows deviation from what was expected.
- Where the evidence shows there was a pre-existing deficiency in the design of care and treatment requirements and associated systems and processes.

Where deviation from policy, process or procedural expectations is identified, there is an explanation of any or all of the following:

- Whether the deviations were reasonable and justifiable based on the presentation of the patient, their clinical needs at the time and the unfolding situation.

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- Whether the deviations were not reasonable and therefore not justifiable.

Where deviations in care standards and the care and treatment delivered were identified, there was little evidence regarding the reasonableness of such deviations. It is accepted across all domains of clinical practice that sometimes it is necessary to do things differently than what is outlined in policy and procedure. Clinical professionals are trained to apply their clinical skills and to have a clear reason why a different approach in any given situation is right for the patient under their care. It is possible to make a correct decision at the time care is delivered to alter the normal plan and for this to be later contemplated as a contributor to an incident that occurred later. The rights and wrongs of these decisions must be carefully contemplated, alongside the application of principles such as the substitution test (that is, what would a similarly qualified group of professionals, providing care under the same/similar set of circumstances, reasonably have done). There was no evidence from the reports reviewed that these core principles have been applied.

The situation is uncomplicated if the review panel and the care team agree that an unjustifiable deviation occurred. The problem arises when there is a difference of opinion between the care team and the SAI review panel. In all such instances, the SAI review panel must apply the substitution test.

There was no indication in any of the reports reviewed as to whether the care teams had agreed or disagreed with the findings and conclusions of the SAI review panel.

Many report authors and SAI review panels tried to draw conclusions regarding contributory factors and causal factors. However, there was a lack of robustness in the evidence-base on which such important conclusions were being made. In some cases, where a finding of causality had been made, it was clear from the content of the report and the Expert Review Team's clinical knowledge that the conclusion of causality would not stand up to independent scrutiny. It is the lack of a robust evidence base for such conclusions that contributes to the widely-held view, supported by some members of staff during focus groups, that a culture of blame pervades reviews.

Regarding the human factors and systems-based analysis, report authors and the review panels clearly tried to undertake this analysis and present its outputs in the review report. However, based on most of the reports assessed by the Expert Review Team, there is a lack of understanding about how this needs to be approached, and how the findings need to be structured and presented. The design of the regional report template will have further compounded this.

Indicator 5: Recommendations to address the most significant influencing factors to the identified contributory and causal factors

The quantitative assessment of the 66 SAI reports reviewed by the Expert Review Team revealed:

- There was a lack of clarity about whether the report made recommendations. This was found in 14 (21%) of the SAI reports.

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- Recommendations were only made in 26 (39%) of the SAI reports, but what they were trying to achieve was unclear.
- In terms of whether there was a correlation between the incident, the report content, and the recommendations, in 30 (45%) of the SAI reports this was clear, in 32 (48%) it was unclear, and in 4 (6%) it was difficult to make a judgement about this.
- In terms of the appropriateness of recommendations, in 22 (33%) of the SAI reports the recommendations seemed reasonable, but in 40 (61%) they did not. In 4 reports (6%) it was difficult to make a judgement about this.
- Regarding any correlation between recommendations and the subsequent action plan, this was clear in 29 (44%) of SAI reports while in 36 (55%) it was not. In 1 report (2%) it was difficult to make a judgement about this.

In no report was there evidence that a structured approach was taken to the formulation of recommendations. The regional guidance on SAIs does not describe any requirements for this and neither do the regional report templates.

An example of a structured approach to recommendations is:

- Clear identification of the intended recipient of the recommendation.
- A clear statement of what is required.
- A clear statement about what the recommendation should deliver.
- A clear statement of what risk the recommendation is meant to contain.
- A clear statement of the scope of the recommendation (local, regional).

Indicator 6: Regarding the non-technical aspects of SAI reports

SAI review reports should adhere to the following non-technical requirements:

- Clarity about the questions posed by the family and the answers to these questions.
- A good standard of writing, with the correct use of grammar, punctuation, and syntax, with no abbreviations, unless already in common usage within the population of Northern Ireland.
- A readable report, written in non-technical language.

Each of the reports was assessed in relation to these factors. Regarding the level of family engagement and understanding, it is the Expert Review Team's perspective that most SAI review reports did not deliver any evidence, or at least convincing evidence, of compliance with candour.

The standard of writing was variable as was the use and non-use of technical language.

Regarding the degree of satisfaction a patient and family might have with the report presented, the lay members of the Expert Review Team considered that they would be satisfied with 16 (24)% of SAI reports reviewed. They considered that they would not be satisfied with (23) 35% of the SAI reports and were unable to determine an opinion of their satisfaction with the remaining 27 (41%).

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Regarding the inclusion of evidence that patient and/or family questions had been asked and responded to during the SAI review process, there was evidence in 15 (23%) of SAI reports reviewed that this had happened. In 44 (66%) of SAI reports, there was no such evidence, while in 7 (11%) of SAI reports it was unclear.

Regarding readability and comprehension of SAI review reports, the lay members of the Expert Review Panel considered most reports 89 of 132[3], (67%) as easy to read in terms of structure and flow, but this dropped to 26 of 66 (39%) in terms of ease of comprehension of report contents.

Wider Consideration from Structured Assessment of 66 SAIs

On consideration of the implications of the overall findings of the structured assessment of the 66 SAI review reports, the Expert Review Team considered the necessary steps to ensure SAI reviews and their reports are of good quality, readable, respond to family questions and provide evidence an acceptable standard of review.

They agreed on a number of general issues that need to be addressed regarding the procedure and its implementation, if the overall standard and credibility of the SAI report, which sets out the findings, conclusions and recommendations of the significant adverse incident review process, are to improve. These include:

- A regional framework that makes clear what the approach to learning from unexpected and unintended harm is intended to deliver; that is, what are its measurable markers of success.
- A regional approach to SAI reviews that delivers recognised international good practice in the science of review.
- A reasonable amount of time to conduct an effective review and include the patient and family in the process in an empathetic, meaningful, and respectful way.
- A single, new report template and regional style guide that enables a consistent approach to SAI reviews across the region but is flexible enough to allow SAI review report writers to remove and add sections to the template.

There is no single activity that will achieve the above. The Expert Review Team wish to make clear that re-writing the regional standards will not achieve the standard of practice that harmed patients and their families are rightfully demanding of this specialist field across the HSC. This is a standard of practice that is comparable to other industries where the activity of reviewing and learning from unexpected harming incidents deliver the core components necessary for an evidence-based review, undertaken by investigators who are skilled for the job, so the right lessons are learned and the right safety improvements are implemented.

[3] The denominator in this indicator is 132 as there was not consensus. 132 reviews were undertaken 2 of each 66 reports. One by each lay reviewer.

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It is the Expert Review Team's assertion that there must be a comprehensive recalibration of the approach to the requirement for, and delivery of, SAI reviews across Northern Ireland.
A new approach must achieve:

- Greater flexibility in an approach that focuses on the opportunity for learning and safety improvement.
- A lower number of in-depth reviews. Where early assessment indicates that this depth of review is necessary, there should then be capability and capacity in the system to do this well.
- A process by which individuals and/or organisations who want the opportunity to deliver 'Investigating Well' training to HSC staff, are asked to undertake an assessment process so that it can be determined that they have the right knowledge and skills to deliver such training. This would preferably then lead to a regional register of preferred providers from which individual HSC Trusts can source training.
- A register of individuals and organisations who are authorised and have been assessed as competent to lead the review of unexpected harm events that meet the threshold for an in-depth fully independent review - for example, mental health homicide, removal of a body part in error, in-patient suicide.

Northern Ireland is in the envious position of having only six HSC Trusts. This provides an opportunity to reset the compass in a way that is not possible in regions with larger populations. Achieving this reset and designing a fit-for-purpose approach to reviewing and learning from SAIs will require unified and cooperative work across all involved organisations. Furthermore, it will require frontline senior clinicians to be prepared to provide straightforward, peer-to-peer assessment, reflection and feedback to colleagues in neighbouring Trusts about the care and treatment provided to patients when the outcome constitutes unexpected and unintended healthcare harm. This is a core element of professionalism and clinicians of all disciplines need to meet this challenge head-on. It should not be the case that trusted independent clinical opinion has always to be sought from outside of Northern Ireland.

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5.0 Conclusion

The work undertaken for this review has, alongside other related projects, determined that the SAI procedure and its implementation across Northern Ireland is not working as intended.

It frequently fails to:

- Answer patient and family questions.
- Determine where safety breaches have occurred.
- Achieve a systemic understanding of those safety breaches.
- Design recommendations and action plans to reduce the opportunity for the same or similar safety breaches in future.

Patients and their families are not fully enabled to engage with the process as partners and their questions are not always sought. They do not always receive open, honest and straightforward answers to their questions. The witness testimonies of patients and families are not routinely collected and, when they are, they are not treated as they should be; that is, as evidence in the same way staff testimonies are treated. The current situation is not tenable and must change.

Frontline staff, who come to work to help and support patients to achieve the best quality of health they can, consider the current process to be blame-orientated and not learning-orientated. It does not embrace the basic principles of a credible review process, a reasonable expectation of fair treatment, or the right to know of any criticism that is to be made and its relevant evidence-base. Staff are most frequently engaged as passive recipients to the process, which is not a good platform for learning and positive change.

The SAI review reports largely do not evidence a defendable approach to the review and identification of learning arising from unexpected patient harm. There are several contributory factors, including:

- Staff asked to lead the reviews are mostly asked to do this on top of pre-existing work commitments, including frontline patient care duties.
- The level of training provided to staff that are tasked with leading SAI reviews is insufficient and is not informed by regionally agreed competencies or a core patient safety training strategy or curriculum.
- The regional timescales allowed for undertaking a complex review, including meaningful engagement with a patient and their family, are unrealistic and lead to a bureaucratic process.
- The regional report templates are not designed to support the delivery of a quality, evidence-based report.

It is worth noting that since this review was commissioned, a number of Public Inquiries, patient recall and lookback exercises have been initiated in Northern Ireland. The Expert Review Team considers that such lengthy inquiries and large-scale pieces of work could be avoided by a robust system for deriving and implementing learning from SAIs. Ineffective systems and processes for review

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and identification of learning emerging from SAIs, not only damage public confidence and trust in the SAI process, but also adversely impact on the trust of patients, their families and the public in the healthcare system as a whole.

There is now an important opportunity to achieve better for patients, for staff and for Health and Social Care services across the region. It is patently evident that continuing as we have been is not an option. The Expert Review Team has made five recommendations that, if implemented, should transform the current approach to learning from and preventing recurrence of harm within Health and Social Care in Northern Ireland. The RQIA look forward to working in partnership with DoH, PHA, HSC Trusts, patients, families and carers to deliver on a new and improved regional system for optimising the learning from adverse incidents which occur in Health and Social Care services and ensuring every opportunity is seized to improve the safety of Health and Social Care services.

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6.0 Recommendations

The following recommendations are intended to deliver a new regional policy for reporting, investigating and learning from adverse events.

Recommendation 1:

The Department of Health should work collaboratively with patient and carer representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.

Recommendation 2:

Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.

Critical success factors

Appendix D provides an example of the critical success factors the Department of Health may wish to use to commence the work of redesigning the region's approach to learning from SAIs.

An example of a critical success factor and its core objectives:

- Families and patients are supported as active partners in the review process as much as they wish to be involved, including the involvement of an appointed advocate.
- Patients/families experience a compassionate and empathetic approach, which includes the method and frequency of contact throughout the review process.
- The voice of the patient and family is heard, their testimony is captured and they have the same status as any professional contributing information to the review process.
- The patient and family have a named source of support outside of the review panel. The role of this individual is clearly defined, including their authority to act in the best interest of the family.
- Questions asked by the patient and family are responded to fully, with honesty and integrity.
- The patient and family are encouraged to contribute to and influence the terms of reference for incidents identified as requiring in-depth.
- Patients/families are taken through the interim findings of the review and they are provided with enough time to enable them to read, comment on and influence the content of the final report.

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How individual HSC organisations deliver these objectives is for them to determine. However, what must be required from all HSC organisations is evidence of achievement and an equal opportunity to be involved. This must be validated by patients and families who have experienced unexpected healthcare harm of a nature that warrants a dedicated review.

The Expert Review Team recommends that a co-production model, involving frontline staff, patients and their families, be adopted regionally to shape any way forward.

Implementing this recommendation will achieve:

Meaningful involvement of patients and families as partners in the SAI review process. This should incorporate a restorative process delivered within a culture of learning and improvement. The incident of harm and its resulting impact is one which the patient and their family must manage and live with. Therefore, it is essential that the patient and their family are at the centre of the review process if their trust in the Health and Social Care service concerned is to be retained.

This recommendation should address the risk of:

Further loss of public confidence in the systems of learning from healthcare harm and, importantly, risk of unnecessary harm to patients/families.

Recommendation 3:

The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.

What is required:

RQIA has found throughout its inspection and review work, widespread practice, where adverse outcome for the patient often drives the requirement for a Level 2 or Level 3 review. This practice must change. Not all unexpected harm, irreversible harm, and unexpected deaths are attributed to mistakes in the care or treatment provided.

Clear guidance is necessary which includes the implementation of a system of early, structured case assessment, taking place within one to two weeks of the incident occurring. This will deliver a greater degree of clarity regarding the degree of variance from expected care and treatment standards, and, on this basis, a proportionate decision can be made regarding the subsequent level of review required.

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The Expert Review Team suggests:

- In all cases where there is concern that an identified variance may have contributed to the outcome for the patient, an in-depth examination of those variances is required.
- Where a serious breach in the expected standards of safe care is identified, an in-depth examination is warranted – even if the variance itself is not considered to have contributed to the patient's outcome.
- Where the incident represents issues known to have been previously examined individually, that consideration is given to conducting a structured, in-depth, whole system review rather than repeating another individual incident review which, by its nature, is unlikely to include systems-based learning and improvement.

In all the above suggestions, it is expected that there will be involvement and engagement with the harmed patient and their family.

Other considerations that should be incorporated into a decision-making process:

- It should be considered whether a further Level 2 or Level 3 review will achieve more learning than has already been achieved by a previous review.
- It should be considered whether a safety improvement plan, regarding issues relevant to this SAI, is already underway. If yes, then the value of an individual incident review should be determined. Consideration must be given to incorporating this case into the pre-existing safety improvement project.

Implementing this recommendation will achieve an approach that:

- Is proportionate.
- Makes appropriate use of public funds.
- Allows review panels to focus in-depth reviews on those cases where there is the greatest opportunity for learning and improvement.
- Enables the relevant clinical teams and service managers to retain ownership of incidents that do not reach the threshold for a level 2 or 3 review. This ensures recognition of the skill, competence and integrity of staff that are entrusted with the delivery of safe patient care.

In summation, this recommendation should address the risk of perpetuating a situation where the volume of level 2 reviews required exceeds the capacity and capability to deliver to a credible standard. The resulting proportionality will also support measurable improvements in safety and quality. This will also serve to address the risk of prolonging the dissatisfaction with the process that has been expressed by patients, their families, and frontline staff.

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Recommendation 4:

The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by 'just culture' principles and a clear evidence-based framework that delivers measurable and sustainable improvements.

Recommendation 5:

The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.

What is required:

There are several issues that must be addressed if the overall standard of how serious incidents are reviewed and learnt from is to improve. These include:

- A regional framework that makes clear the key factors for success[4], against which each Trust/DoH (SPPG) is performance managed.
- A regional approach that delivers international good practice in the science of review. The development of a standard operating procedure that focuses on the practice of investigating rather than performance targets would support this.
- A process that embraces a just and fair culture where staff are supported through a constructive learning process and not scapegoated should deficiencies in systems or processes be found.
- A quality assurance system that makes explicit the accountability of senior managers within each Trust/DoH (SPPG) organisation, alongside a mechanism for holding them to account for SAIs signed-off as acceptable.
- A regional training curriculum, competency framework, certification or accreditation process and mentorship programme.
- Investigators of SAIs must demonstrate that they have the competencies to do so and have completed a programme of training in line with regional curriculum requirements.
- Educators/trainers and mentors must demonstrate that they have the right knowledge and competencies. Furthermore, they must complete an assessment process in order to be included on a region-wide approved provider register. Only providers on this register can provide review training to Trusts/DoH (SPPG).
- A fair and reasonable amount of time to conduct a credible review must be provided. This must include time to engage and involve the family/patient in an empathetic, meaningful and respectful way.
- A single new report template and regional style guide must be designed. This must facilitate a consistent approach to report formulation and presentation, with enough flexibility to allow a report writer to adapt it to meet the needs of the review conducted.

[4] That is the critical success factors and the core objectives for each success factor are agreed, and adopted by all Trusts and HSCB.

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A new approach must achieve:

- Greater flexibility in approach, that focuses on the opportunity for learning and safety improvement.
- A lower number of in-depth RCA reviews. However, where early assessment indicates that this depth of review is necessary, there must then be the capability and capacity in the system to do this well.

Implementing this recommendation will achieve:

An approach to learning from harm that HSC staff and the public can have confidence in, in terms of:

- Learning lessons.
- Measurable safety improvement.
- Transparency.
- Alignment with the core principles and hallmarks of a robust review process.
- Restoration and reconciliation.

This recommendation should address the risk of:

A system of learning that is overwhelmed by too many reviews, few of which lead to measurable improvements in safety or learning of any significance. This will enable the HSC Trusts to develop a flexible and innovative approach to learning from harm; one which engages the patient and their family in the process and mitigates the risk of perpetual mistrust.

There is no single activity that will achieve the above recommendations. There must be a comprehensive recalibration of the approach to the requirement for, and delivery of, SAI reviews across the region.

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Appendix A: SAIs by Category and by HSC Organisation

	SAI Level	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NIAS	Primary Care	Total
Maternity related	Level 1	2	5	3	0	4	0	0	14
	Level 2	0	0	1	1	0	0	0	2
Sepsis	Level 1	1	0	2	0	0	0	0	3
	Level 2	0	0	0	1	0	0	0	1
Choking	Level 1	0	0	1	0	0	0	0	1
	Level 2		1	0	0	0	0	0	1
Never Event	Level 1	1	0	3	0	1	0	0	5
Reference to Private Hospital/Nursing Home	Level 1	1	1	0	0	1	1	0	4
Person with a learning disability who died from a treatable condition	Level 1	0	0	0	0	0	0	0	0
Primary Care	Level 1	0	0	0	0	0	0	4	4
Reference to a person with a learning disability in Residential Care	Level 2	0	0	0	1	0	0	0	1
Other Level 1 SAIs	Level 1	0	0	1	0	0	3	0	4
Other Level 2 SAIs	Level 2	5	3	2	11	4	0	0	25
Other Level 3 SAIs	Level 3	1	0	0	0	0	0	0	1
Total SAIs reports to be assessed		**11**	**10**	**13**	**14**	**10**	**4**	**4**	**66**

Source: Information provided by HSCB and HSC Trusts. Categories suggested by DoH

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Appendix B: Other Organisations that were offered the Opportunity to Input Into this Review

Organisation
Medicines & Healthcare products Regulatory Agency (MHRA)
Northern Ireland Adverse Incident Centre (NIAIC)
Health and Safety Executive Northern Ireland (HSENI)
Police Service for Northern Ireland (PSNI)
Safeguarding Board for Northern Ireland (SBNI)
Northern Ireland Adult Safeguarding Partnership (NIASP)
Information Commissioner Office (ICO)
British Medical Association (BMA)
General Medical Council (GMC)
General Dental Council (GDC)
Northern Ireland Medical and Dental Training Agency (NIMDTA)
Pharmaceutical Society Northern Ireland (PSNI)
Northern Ireland Social Care Council (NISCC)
Royal College of Nursing (RCN)
Nursing and Midwifery Council (NMC)
Health Care Professional Council (HCPC)
Northern Local Medical Committee (NLMC)
Eastern Local Medical Committee (ELMC)
Southern Local Medical Committee (SLMC)
Western Local Medical Committee (WLMC)
UNISON
Unite the Union
Northern Ireland Public Sector Alliance (NIPSA)

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Appendix C: Improvements Suggested by Staff

During the engagement process, staff were asked to share any suggestions they felt would improve the SAI review process or patient and family engagement. Staff suggestions were used to formulate the following suggested improvements.

Suggested improvements to the SAI process

Classification of incidents

- The identification of incidents requiring an in-depth review must be driven by a structured assessment, which identifies:
    - a significant learning opportunity
    - the presence of significant care lapses, or care concerns
    - the depth and range of family questions

  Eliminating the determination for an in-depth review based on incident type and/or patient outcome alone can minimise the number of reviews with little impact on improving safety.
- Incidents involving suicide should not automatically be classified within the SAI process.

Timescales for Conducting SAI reviews

- Overwhelmingly, HSC staff consider that the timescales for conducting SAI reviews need to allow greater flexibility and take account of the complexity and the needs of the patient and family.
- A structured timescale approach that outlines the importance of capturing factual accounts and situational context within the first 48 hours post-incident, and early capture of information from families followed by a realistic period to allow an initial assessment of the information before determining what subsequent review is required, along with its depth and approach.

Terms of Reference

- The terms of reference for SAI reviews should be specific to the incident and referred to as key lines of enquiry to reflect a more learning-based approach.
- Terms of reference must include patient and family questions, where the patient and family have questions.
- The practice of pre-determined terms of reference that are used for all SAIs should desist as it provides no meaningful structure for the review process.

Staff Involvement

- Staff said that to achieve a ‘just culture’ and optimal learning they needed to be more involved in the process, specifically:
    - Their team leaders need to be involved in decisions over what to review, at what depth, and why

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- Involved staff need an early invitation to capture a full account of what had happened and the situational context of the day, shift, or relevant period
- There needs to be a shift away from only reviewing documents to engaging involved staff in conversation about what had happened
- More group learning approaches could be utilised, such as after-action review
- Providing feedback on a high quality draft of the review report, that their comments are listened to and taken account of by the review panel
- In formulating recommendations
- In contributing to the design of action plans
- In participating in a post review learning event.

Communication with Staff

- Staff involved in an incident should receive notification that an SAI has been requested and be provided with a copy of the agreed terms of reference or key lines of enquiry, as well as information about who is conducting the review.
- Staff involved in an SAI ought to expect their team leader to receive update reports regarding the progress of the review so that the whole team is informed about this.
- Several staff thought a website or shared area should be established to keep those staff involved in an incident up to date on the progress of the SAI review while maintaining confidentiality.

SAI Review

- Currently, the SAI process is perceived as a negative review that does not support a 'just culture'. It must be mandated that the aspects of care that met or exceeded care standards, as well as those aspects that could have been improved, are reported on. This includes interventions that may have mitigated the impact of the incident.

SAI Review Panel

- Where it is identified that there were, or may have been significant care lapses, staff considered a dedicated SAI review panel from outside the Trust was required. This includes the lead reviewer and the subject advisors/field experts. Staff considered that such a team needed to be appointed by an external agency such as the HSCB/PHA.
- There should be a set of competencies, skills and knowledge required of the chair of an SAI review panel/lead reviewer, and the subject advisors/field experts asked to work with this individual.

Independence

Staff recognised that achieving complete independence was not feasible. However, they considered that:

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- The lead reviewer/chair should not come from the service involved in the incident.
- Mentorship should be available for lead reviewers/chairs to support them in maintaining objectivity and impartiality.
- Ideally, a non-clinician with the right investigatory skills and competencies should chair the SAI review panels.
- A lay person or trained family advocate should be included in the SAI review panels. This would support meeting family needs and writing a report that is understandable by a non-technician.
- Optimal use of interventions such as web-conferencing and remote web-based interviews could be utilised to support involvement of independent technicians without the excessive cost often associated with this.

Staff Support

- Staff involved in an incident must be given protected time to prepare and attend interviews or meetings during the SAI review.
- Staff involved in an incident must be given the opportunity for pastoral/psychological support to deal with traumatic incidents.
- A rapid team debrief post incident must become normal practice.
- All SAI teams must include an administrator to support its smooth delivery and to ensure that the time of frontline, professionally qualified staff is used appropriately.
- Corporate teams responsible for patient safety must have the necessary competencies required to provide support and mentorship to SAI leads/chairs.
- Staff asked to lead SAIs must have received a minimum of two days training, plus mentorship and coaching support so that they can lead the process competently.
- Staff required to conduct the initial reviews of incidents before a decision is made to progress to SAIs need to know how to conduct a structured review, and what information is required to do this competently.

Advocacy

- Northern Ireland needs to engage with patient advocacy organisations to develop a system where lay people can become accredited advocates for families following patient safety incidents.
- Publicly funded independent advocacy should be available for patients/families that require this and where there are concerns about the adequacy of care and/or treatment offered.

Recommendations

- Staff need protected time to participate/lead in Quality Improvement Action plans emerging from SAI reviews.
- Multidisciplinary staff should be brought together to help develop outcome-focused recommendations. This should not be the sole domain of the SAI review panel.

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- Recommendations from SAI reviews should be benchmarked against core criteria, and the teams and services involved in the incident must be invited to comment on the appropriateness of the recommendations made.
- When contemplating whether a recommendation is or is not accepted and how it is treated, due consideration must be given to pre-existing safety and quality improvement projects already underway or planned.
- Recommendations from SAI reviews need to be outcome-focused and drive action plans that deliver measurable and sustainable improvements in the quality and safety of care.

Learning

- There must be more formal processes for disseminating learning from SAI reviews. The Oxford Model developed in the 1990's and successfully utilised by Mersey Care NHS Trust is an example of this.
- Each Trust must be required to demonstrate not only what it has learnt but how it has improved. This will drive disseminated learning.
- RQIA and other regional bodies must show how the learning within individual Trusts is captured and used for learning across Northern Ireland.

SAI Review Reports

- Feedback from all key staff involved should be considered in the finalisation of an SAI review report. This assures factual accuracy and greater engagement by frontline professionals.
- A meeting with all staff associated with the incident, and who provided information to the SAI review panel, should be conducted to enable findings, conclusions and recommendations to be discussed and agreed.
- The SAI review report template should be revised to include a section that allows greater articulation of patient and family engagement.

Action Plans

- How action plans are developed must be in line with good practice, rather than copying and pasting recommendations into an action plan template. This does not deliver sustainable or measurable change.

General

- The practice of retrospective recordkeeping in the 72 hours post incident needs to be enabled. Where this is not possible for whatever reason, accounts of involvement must be collected.
- SAI reviews should focus less on assigning blame and scapegoating, and instead embrace the principles of a ‘just culture’ and justifiable accountability.
- The SAI process should be reviewed to examine how best to review future incidents in a more proportionate way.

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Suggested improvements for patient and family engagement

Information for Patients/Families

- Patients/families should be better informed of the SAI review process. For example, there could be better quality information leaflets available, or a video or podcast explaining the process on the DoH or RQIA's website.
- The SAI process must be explained to patients/families before the process commences so they can have realistic expectations.

Communication with Patients/Families

- There must be clear standards of how a patient and family should be communicated with during the SAI process, with patients/families asked for formal feedback at the end of the process via a questionnaire or online survey tool. This should also accommodate requests for anonymity.
- The terms of reference/key lines of enquiry must be shared with patients/families prior to an SAI review commencing, and these must include the patient and family questions alongside technical clinical/process-based questions.

Patient and Family Engagement

- Trusts must demonstrate their commitment to the SAI process and to the patients/families affected by SAIs by ensuring senior management are actively involved in communications with families. This is particularly important at the start and end of the process.
- Staff must receive training from experienced advocates and families who have experienced the SAI review process so they know how to achieve and maintain positive engagement with a family.

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Appendix D: Examples of Critical Success Factors

The factors listed below are examples of critical success factors (CSF), previously developed by an HSC organisation in the UK and provided to this review by Maria Dineen, member of the Expert Review Team. This list is not intended to serve as a definitive list; rather, its purpose is to provide an initial starting point for a wider conversation about what the critical success factors could look like in Northern Ireland.

Critical Success Factor 1:

We consistently value and engage meaningfully with patients and their families through the entire review (including complaints) process.

The core objectives for this CSF are proposed as:

- Patients/families experience a compassionate and empathetic approach.
- The voice of the patient and family is heard.
- The patient and family are well informed throughout the process.
- Questions asked are responded to with honesty and integrity.
- Patients/families are provided with the opportunity to contribute to and /or influence the terms of reference for incidents identified as requiring in-depth review.
- Patients/families are taken through the draft review report, and provided enough time to enable them to read, comment on and influence the content of the final report.

Critical Success Factor 2:

We consistently value and engage meaningfully with staff throughout the entire review (including complaints) process

The core objectives for this CSF are proposed as:

- Staff experiences a compassionate and empathetic approach.
- The voice of the staff involved in an incident is heard. This includes their experience of 'the day', and the 'context' in which the incident occurred.
- Staff involved are well informed throughout the review process.
- Staff are treated fairly and equitably, in line with NHS Improvements Just Culture Guidance.
- Staff involved in the incident, and other key staff informants to the review, are facilitated in reading the draft report and providing feedback on it relating to factual accuracy, tone and style.
- Staff involved in the incident and service(s) in which the incident occurred are actively engaged in designing the action plan to deliver measurable and meaningful improvement.

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Critical Success Factor 3:

We will consistently show that measurable improvements in standards, safety and quality occurs, is sustained, and known about by staff.

The core objectives for this CSF are proposed as:

- There is a corporate action planning/lessons learnt group that acts as a repository for those issues identified in one division, but which have wider implications for other services / divisions within the Trust. A central approach will ensure these issues are assessed and addressed corporately.
- Within each division the safety governance group, lessons learnt and recommendations arising from reviews are a standing agenda item.
- Recommendations are targeted towards i) the local team ii) the local service/division and iii) corporate wide. Further they are mostly addressing systems improvement and not individual practice.
- There is an action planning method/approach that facilitates engagement of staff involved in service delivery and sets out clearly the range of activities required to deliver the intent of the recommendation.
- All action plans include how success is to be measured and at what frequency to assure sustainability.
- Recommendations are formulated to make clear their intent (i.e. what needs to be achieved if they are accepted and implemented).
- Staff are aware of the improvements implemented in their service and division as a consequence of reviews conducted, and more widely across the organisation.

Critical Success Factor 4:

Incidents will be reviewed proportionately i.e.: right level, right depth, and right breadth of review according to the volume and magnitude of errors (if any).

The core objectives for this CSF are proposed as:

- The Trust has an achievable and defined method/process through which harming incidents that meet the threshold for Duty of Candour (i.e. moderate harm and above) are assessed to determine the depth of review required and with what degree of independence.
- The Trust has a clear categorisation system for incidents that meet the threshold for Duty of Candour (and above) so that there is clarity between those that occurred despite good care, and those that were caused by mistakes in care delivery. (E.g. Category A means care and treatment was appropriate, and category D means there were several lapses in care and treatment that may have contributed to the outcome).
- The Trust assigns the review of cases where there may have been a contribution to the harm because of mistake to a case reviewer who has the right competencies to lead and deliver a more complex review.

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- Terms of reference for reviews are bespoke and make clear the relevant technical questions that must be asked and answered, alongside any family questions that have been posed.
- The Trust has a review framework, and approach, that allows a range of methods and tools to be employed to meet the discrete requirements of each review.
- The Trust has in place a process to enable early preservation of information including memory capture, so that the assessment of incidents and any subsequent review is well informed and can be explored to the right depth and breadth.

Critical Success Factor 5:

Reviews are conducted using appropriate methods and tools, and in line with good project management principles, assuring delivery within an agreed and realistic timescale.

The core objectives for this CSF are proposed as:

- The Trust will have enough staff trained to undertake the case screening element of the review journey within 10 working days of incident occurrence.
- The Trust will have enough staff trained to a higher level of knowledge and competency to delivery those reviews that are categorised C or D (i.e. care/ management a bit 'hit or miss' or serious lapses are identified).
- The Trust will commit to a stepped review process including clear boundaries for the review arising from carefully formulated terms of reference that make clear the necessary technical questions as well as including family questions.
- Staff asked to act in a case screening or lead reviewer/case reviewer capacity will have the necessary adjustments made to their pre-existing diary commitments so that they have a fair amount of dedicated time to deliver the review project.
- Specialist advisors will be allocated to the appointed case reviewer in a timely manner so that avoidable delays do not occur.
- The Trust will ensure for all category C and D reviews that there is reasonable administrative support provided to the case investigator so that working practices are as efficient as possible. (Category C and D - i.e. care/ management a bit 'hit or miss' or serious lapses are identified).

Critical Success Factor 6:

Review reports are consistently produced and meet the following standards:

- Well written.
- Understandable by a non-technician.
- Reasoned (i.e. evidence and not opinion orientated).
- Clear findings, conclusions and recommendations.
- Answer all family questions where it is possible to do so.
- Accessible.
- Validated.

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The core objectives for this CSF are proposed as:

- The Trust has a practical approach to proof reading reports that includes insights from:
    - a technical advisor
    - a lay person
    - someone who has good grammar, and spelling
    - someone who is good at formatting documents, using 'smart report' technology.

- The Trust has a well-designed report template that includes:
    - acknowledgements
    - contents list
    - an executive summary
    - introduction (case over view and context of care, as well as outcome and reasons for the review)
    - a family section
    - a findings section (what was delivered to a reasonable standard, what could have been improved, any significant or serious lapses in care standards.)
    - what has changed / improved since the incident
    - what additional lessons learnt arose from this review
    - conclusions
    - recommendations
    - appendices

- Both the patient / family and the staff involved are provided with the opportunity to read and comment on the report when in good draft format. Their comments are listened to and incorporated into the final report document as far as it is possible to do so. Where it is not, they are advised of this and why not.
- Review reports are written empathetically and compassionately.
- Review reports are written in plain language so they understandable by all readers.
- Staff required to write review reports have a mentor who can support the development of their writing and presentation skills.

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The Regulation and Quality Improvement Authority

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Southern Health and Social Care Trust

Quality Care - for you, with you

Policy for the Management of HSC Complaints 2019

Lead Policy Author & Job Title:	Lindsey Liggett Complaints Officer
Directorate responsible for document:	Medical
Issue Date:	28 January 2019
Review Date:	31 January 2022

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Policy Checklist

Policy name:	Policy for the Management of Complaints
Lead Policy Author & Job Title:	**Lindsey Liggett Complaints Officer with input from Directorate Clinical and Social Care Governance Teams and the AD of Clinical and Social Care Governance**
Director responsible for Policy:	Dr Maria O'Kane
Directorate responsible for Policy:	Medical
Equality Screened by:	Click here to enter text.
Trade Union consultation?	Yes ☐ No ☐
Policy Implementation Plan included?	Yes ☐ No ☐
Date approved by Policy Scrutiny Committee:	28 January 2019
Date approved by SMT:	Click here to enter a date.
Policy circulated to:	Clinical and Social Care Governance Teams
Policy uploaded to:	Sharepoint and Trust Website

Version Control

Version:	**V0_1**
Supersedes:	1. Policy for the Management of Complaints, November 2010 2. Working Draft Policy for the Management of Complaints 2013 3. Working Draft Policy for the Management of Complaints June 2018 Description of Amendments(s)/Previous Policy or Version: Reviewed and updated in-line with changes to the Governance structures within the Trust and to ensure continuing compliance with regional complaints procedures.

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Eg Version 1_0	Click here to enter text	Click here to enter a date.	Click here to enter text
Eg Version 2_0	Click here to enter text	Click here to enter a date.	Click here to enter text

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Contents

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Introduction

1.0 The Southern Health and Social Care Trust Complaints Policy is based on *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*, which was published by the DHSSPSNI on 1st April 2009 (and updated June 2011 and June 2013, April 2019). The policy also reflects the ongoing regional work with HSC to ensure best practice in the management of complaints.

1.1 A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the *Children (NI) Order 1995 Representation and Complaint Procedure*.

1.3 This Guidance should be read in conjunction with the Department of Health Guidance in Relation to the HSC Complaints Procedure April 2019. Relevant documents will be available on the Trusts Internet and Intranet sites.

Purpose and Aims

2.1 The Trust is committed to developing a culture of responsible openness and constructive criticism, and to encouraging all service users to contribute views on all aspects of the Trust's activities. It has introduced this policy to enable service users to raise any concerns they may have at an early stage and in the right way.

2.2 The aim of this policy is to:

- Inform staff of the Trust's processes for complaints handling; and
- Provide service users, patients and clients with the information they require to make a complaint.

Objectives of this Policy

3.1

- **Policy openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **Responsiveness** – providing an appropriate and proportionate response;
- **Fairness and independence** – emphasising early resolution in order to minimise strain and distress for all;
- **Learning and improvement**– ensuring complaints are viewed as a positive opportunity to learn and to improve services.

Statement

4.1 The Southern Health and Social Care Trust (hereafter referred to as the "Trust") believes

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that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of service user feedback in improving service provision for patients and the public through listening, learning and improving.

Scope of Policy

5.1 This Policy is applicable to all services provided by the Trust with the following exception for which alternative procedures are already in place: *Children (NI) Order 1995 Representation and Complaints Procedure*.

Responsibilities

6.1 Chief Executive:

- has overall accountability/responsibility for complaints management within the Trust;
- overall responsibility to ensure that all service user feedback is integrated into Trust Clinical and Social Care Governance and Risk Management arrangements.

6.2 Medical Director is responsible for:

- taking a strategic viewpoint on behalf of the Trust in relation to complaints;
- delegating the responsibility for managing the requirements of this Guidance to the Assistant Director of Clinical and Social Care Governance;
- maintaining an overview of the issues raised through service user feedback and providing assurance that appropriate organisational learning has taken place and that action is taken, when appropriate.

6.3 Assistant Director of Clinical and Social Care Governance is responsible for;

- ensuring that the complaints process is managed in accordance with all relevant guidelines, legislation and standards and for ensuring that processes are in place to identify and disseminate learning on a Trust wide/regional basis;
- working with the Trust's operational, executive and corporate governance leads and support leads on the ongoing development of systems and procedures to monitor and improve safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries;
- providing recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action;
- ensuring that a 'Lessons Learned' strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads.

6.4 Directors and Assistant Directors are responsible for:

- ensuring managers and staff within their area of responsibility are aware of and

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comply with the requirements of this Guidance and Procedure;

- the proper management of appropriate, effective and timely responses to complaints received in relation to the services they manage;
- ensuring learning and service improvement occurs and is shared across the Trust;
- ensuring the management of service user feedback is integrated into Directorate/ Division governance arrangements;
- staff being appropriately trained in receiving and responding to complaints;
- utilising the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans.
- designating a deputy to deal with complaints or enquires in his/her absence.

It is the role of the Assistant Director, where concerns are raised in a complaint about clinical/ social treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

6.5 Governance Co-ordinators are responsible for:

- leading their Directorate Governance Team in ensuring that each level of Directorate staff have access to timely, high quality and appropriate information in relation to complaints, and that within each service team this information is being acted upon appropriately in order to mitigate risk, improve quality of care and patient/client safety;
- ensuring that the complaints process is conducted in accordance with Regional and Trust complaints procedures;
- co-ordinating via the Directorate Governance Team the timely and appropriate responses to complaints on behalf of the Directorate;
- providing the Directorate and the organisation corporately with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses to individual complaints.

6.6 The Directorate Governance Team are responsible for:

- managing all service user feedback received within their respective Directorates;
- maintaining a comprehensive IT system (Datix) of all complaints received;
- obtaining consent where required in the case of third party complaints or enquiries;
- taking account of any corroborative evidence available relating to the complaint;
- providing support and advice to staff investigating/responding to complaints;
- contacting service users and/or their representatives, when appropriate; and
- identify training needs of staff and ensuring that appropriate programmes are organised in conjunction with line managers;
- providing information as requested by the Northern Ireland Commissioner for Complaints (the Ombudsman);
- acknowledging complaints received by their office within two working days

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6.7 Line Managers are responsible for:

- seeking informal resolution of complaints raised at service level within identified timescales, if possible, as a rapid response and personal contact often results in effective complaints resolution;
- ensuring that the Trust's Complaints Guidance and Procedure is included in the induction of their staff, and that staff are trained and empowered to deal with complaints as they arise;
- supporting, advising and assisting staff to resolve the issues giving rise to the complaint or enquiry, when possible; ensuring all formal complaint letters received by staff are forwarded immediately to the Service User Feedback Team;
- contributing to the investigation of complaints and enquiries and making sure statements and reports address all of the issues raised;
- ensuring that statements / reports are returned to the Complaints Department within the required timescales;
- ensuring informal complaints are recorded on the Trust's Point of Service Delivery Form/ Datix and retained on file with a copy forwarded immediately to the Service User Feedback Team;
- introducing service improvements and making sure that all relevant information is disseminated throughout the service/team; and
- ensuring completion of the online form for recording of compliments and the return for gifts received.

6.8 All Trust staff are responsible for:

- attempting to resolve complaints, as they arise, in an informal, sensitive and confidential manner; and record on Trust's Point of Service Delivery Form/ Datix.
- ensuring that the Trust's complaints posters and leaflets are available and accessible to service users to encourage all types of user feedback (see Sharepoint for complaints leaflet in a variety of languages);
- referring the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seeking advice from their Directorate Governance team on how to proceed;
- keeping their line manager updated on complaints and enquiries they are currently dealing with and outcomes including improvements made;
- contributing to the investigation of complaints and enquiries within the service/team and returning statements, reports and other information, within requested timescales; and
- ensuring when they receive a written compliment it is shared with their manager and colleagues and reported using the online form for recording compliments.
- ensuring completion of the monthly return for Gifts received.

6.9 Service User Feedback Team are responsible for:

- providing a first contact for service users regarding compliments, enquiries, comments and complaints;
- screening service user contacts and determining if these are enquiries or

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complaints;

- facilitating in either resolution of the enquiry or complaint, or aiding the complainant in their use of the Trust's formal complaints procedure by directing the complaint to the relevant Directorate Governance Team;
- Acknowledging complaints received by their office within two working days. (Chief Executives office acknowledges enquiries/ complaints received into their office);
- providing the same support and consideration for those enquiries and complaints from third parties, such as MLAs and the Minister's office;
- advising complainants about the support available from the Patient Client Council
- providing complaints and service user feedback related analyses and reports to services and Committees within the Governance Accountability Framework;
- providing information as requested by the Northern Ireland Commissioner for Complaints (the Ombudsman);
- delivering of Corporate Complaints and User Views awareness training;
- maintaining complaints and user view information and resources for service users; and
- maintaining up to date information and resources for Trust staff.

Legislative Compliance, Relevant Policies, Procedures and Guidance

7.1 The Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009 requires HSC organisations to make arrangements in accordance with the provisions of the directions for the handling and consideration of complaints. The Regional Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning conform to this legislative framework. Trust staff must also take cognisance of relevant professional standards and guidance to their own profession.

7.2 The Regulation and Quality Improvement Authority (RQIA) is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews. RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

Equality & Human Rights Considerations

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

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

8.3 Similarly, this Guidance has been considered under the terms of the Human Rights Act

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1998, and was deemed compatible with the European Convention Rights contained in the Act.

This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

Sources of Advice & Further Information

9.1 Line Managers should be contacted in the first instance, in relation to any specific queries on Policy content. Line Managers should then escalate queries which they are unable to address, via their operational processes and onwards to Corporate Governance as required.

9.2 This document is available on request in alternative formats which include large print, audio disc and in other languages to meet the needs of those who are not fluent in English. These formats can be requested from the Service User Feedback Team. P*lease refer to* ***Appendix 1*** *for contact details*.

9.3 *We Value Your Views* leaflets, which provide service users/clients with an overview of the Trust's complaints procedures and contact details, are available from the Trust Sharepoint site in large print and other languages. (http://sharepoint/gov/corp/Complaints/Forms/AllItems.aspx)

The Southern Health and Social Care Trust follow the Regional Guidance in Relation to the HSC Procedure April 2019.

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Appendix 1 - Useful Contacts

Southern Trust Contacts	
Service User Feedback Team	**Southern Health and Social Care Trust,** **Beechfield House,** **Craigavon Area Hospital,** **Portadown,** **BT63 5QQ** **Telephone: (028) 3756 4600** **Email:complaints@southerntrust.hscni.net**
Acute Services Clinical & Social Care Governance Office	**Telephone:** Personal Information redacted by the USI
Children & Young People's Services Clinical & Social Care Governance Office	**Telephone:** Personal Information redacted by the USI
Mental Health & Disability Directorate Clinical & Social Care Governance Office	**Telephone:** Personal Information redacted by the USI
Older People & Primary Care Directorate Clinical & Social Care Governance Office	**Telephone:** Personal Information redacted by the USI
Inspire Workplaces	**Inspire Central** **Office Lombard House** **10-20 Lombard Street** **Belfast** **BT1 1RD** **Telephone: 0800 389 5362 (Helpline)** **028 90 32 8474 (Central Office)** **Website:** Personal Information redacted by the USI
Northern Ireland Commissioner for	**The Ombudsman,**

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Complaints (the Ombudsman)	**Freepost BEL 1478,** **Belfast,** **BT1 6BR** **Telephone: 0800 34 34 24** **Email:ombudsman@ni-ombudsman.org.uk** **Website: www.ni-ombudsman.org.uk**
The Regulation & Quality Improvement Authority (RQIA)	**The Regulation & Improvement Authority,** **9th Floor Riverside Tower,** **5 Lanyon Place,** **Belfast,** **BT1 3BT** **Telephone: (028) 9051 7500** **Fax: (028) 9051 7501** **Email: info@rqia.org.uk** **Website: www.rqia.org.uk**
Patient and Client Council	**Quaker Buildings** **High Street** **Lurgan** **BT66 8BB** **Telephone: 0800 917 0222** **Email: info.pcc@hscni.net** **Website:** **www.patientclientcouncil@hscni.net**
Human Rights Advocate	**Disability Action's Centre on Human Rights** **Disability Action** **Portside Business Park** **189 Airport Road West** **Belfast** **BT3 9ED** **Telephone: (028) 9029 7880** **Textphone: (028) 902907882** **Email: humanrights@disabilityaction.org**

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Voice of Young People In Care	**Flat 12, Mount Zion House Edward Street** **Lurgan** **BT66 6DB** **Telephone:** (028) 3831 3380 **Website:** www.voypic.org
Legal and Investigations Team **Northern Ireland Commissioner for Children and Young People**	**Equality House** **7-9 Shaftesbury Square** **Belfast** **BT2 7DP** **Telephone: (028) 9031 1616 (Monday – Friday: 9:00am to 5:00pm)** **Email: listening2u@niccy.org** **Website: www.niccy.org**
Age NI	**3 Lower Crescent** **Belfast** **BT7 1NR** **Telephone: 0808 808 7575 (8:00am to 7:00pm, 7 days a week)** **Email: advice@ageni.org** **Website: www.ageni.org/advice**
Complaints about Family Practitioner Services **(family doctors, dentists, pharmacists, opticians)**	
HSC Board **Complaints Manager**	**Southern LCG,** **Tower Hill,** **Armagh,** **BT61 9DR** **Email: Complaints.hscb@hscni.net**

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Appendix 2
Complaints *Process*

Complaint is raised by or on behalf of a service user at the point of service delivery

Member of staff who first learns of complaint should respond immediately & directly in an attempt to resolve the matter informally, speedily & appropriately.

IS THE MATTER **RESOLVED**?

YES

If a member of staff has resolved a complaint 'at point of service delivery' they should complete and return all sections on the *Complaints at Point of Source Delivery form.*

NO

Formal Complaints Process

If the person remains dissatisfied, they should be offered a copy of the Trust's 'We Value Your Views' leaflet and advised that they may wish to contact the Service User Feedback team to make a formal complaint

This is also the starting point for anyone who approaches the Service User Feedback team directly with their complaint.

The Service User Feedback team will screen all service user contacts and determine if these are enquiries or complaints. The office will also facilitate early resolution of the enquiry or complaint, if possible.

Service User Feedback Team, Southern Health & Social Care Trust, Beechfield House, Craigavon Area Hospital, Portadown, BT63 5QQ

Telephone: 028 375 64600
Email: complaints@southerntrust.hscni.net

Working DAY 1: Complaint is sent to the relevant Governance Co-ordinator's office.

Working DAY 2: Governance Co-ordinator's office to send **ACKNOWLEDGEMENT** of the complaint to the complainant.

INVESTIGATION

Working DAY 20: Director will issue a **RESPONSE** to the complainant.

Complainant Satisfied?

YES

Complaint file is closed.

NO

Assistant Director to consider the following measures: ***Further written response*** to outstanding issues; ***meeting with the complaint***; enhanced local resolution ***investigation by a second team***; c***onciliation***; use of ***Lay people to assist***; or the use of ***independent experts***.

Complainant Satisfied?

NO

Where the Trust has exhausted all options available to it and there is no resolution to a complaint the complainant is advised of the procedures for contacting the ***Ombudsman's office.***

YES

Complaint file is closed.

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

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Revised April 2019

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added	01 April 2019

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Directions	Details	Date Effective
	in regard to SAIs.	
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	01 April 2019
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No	01 April 2019

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Directions	Details	Date Effective
	investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The **Main Directions** were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where	01 April 2019

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Directions	Details	Date Effective
	paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint. • Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers **(Amendment)** Directions (Northern Ireland) 2013	The **HSC Board Directions** were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: • Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and • Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 **2013 N0. 12**
Health and Social Care Complaints Procedure Directions **(Amendment)** (Northern Ireland) 2009	The **Main Directions** were amended for the first time at: • Paragraph 2	02 September 2013 **2013 N0. 11**

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Directions	Details	Date Effective
	(Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as **BSO Directions**	26 July 2010
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The Directions were introduced. Known as **PHA Directions**	26 July 2010
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family	The Directions were introduced. Known as **HSC Board Directions**	01 April 2009

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Directions	Details	Date Effective
Health Services Practitioners and Pilot Scheme Providers		
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as **Main Directions**	01 April 2009

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BACKGROUND

The HSC Complaints Procedure*, 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'* was developed and published in 2009*.* It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

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The key principles remain unchanged however this document follows a review and refresh of the HSC Complaints Procedure in order to bring it up to date for 2019. Any changes or improvements in complaints handling across the HSC are set out in detail. The document has been renamed the '*Guidance in relation to the Health and Social Care Complaints Procedure' or 'HSC Complaints Procedure'* for short. Updates include the:

- details on the new government department name introduced under the Departments Northern Ireland Act 2016[1];
- details of the role of the Northern Ireland Public Services Ombudsman (NIPSO) known as 'the Ombudsman' further to changes introduced under the Public Services Ombudsman Act (Northern Ireland) 2016[2];
- removal of the restriction on providing electronic responses to complainants;
- removal of the ability for HSC staff to complain to the Ombudsman about the way they have been dealt with under the Complaints Guidance;
- clarity on the role and remit of the honest broker in complaints handling;
- updated information on complaints about Independent Sector Providers (ISPs); and
- process for dealing with complaints and serious adverse incidents that are subject to legal proceedings.

This single tier process aims to provide:

- a strengthened, more robust, local resolution stage;
- an enhanced role for commissioners in monitoring, performance management and learning;
- improved arrangements for driving forward quality improvements across the HSC; and
- improved arrangements for the delivery of responses to complainants.

[1] Departments Northern Ireland Act 2016: http://www.legislation.gov.uk/nia/2016/5/section/1/enacted
[2] Public Services Ombudsman Act (Northern Ireland) 2016: http://www.legislation.gov.uk/nia/2016/4/enacted

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The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well-defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;
- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process. The eight specific standards of HSC are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

More details on each of the standards are provided in Annex 1 of this document.

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It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

This revised guidance in relation to the HSC Complaints Procedure is effective from 01 April 2019. It will be known as *'Guidance in relation to the Health and Social Care Complaints Procedure'*.

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SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2019 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Board, HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

1.2 The HSC Complaints Procedure continues to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10

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working days within FPS settings). The expectations of service users should be managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right and be signposted to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the HSC Complaints Procedure.

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

- **openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **responsiveness** – providing an appropriate and proportionate response;
- **fairness and independence** – emphasising early resolution in order to minimise strain and distress for all; and
- **learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

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1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

1.10 The HSC Complaints Procedure deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- HSC Board
  - commissioning and purchasing decisions (for individuals)
- HSC Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- Business services organisation (BSO)
  - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

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1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[3] as an alternative to making an application to the courts.

[3] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

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What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[4] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board
- requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR)
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[5]

[4] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[5] Public Interest Disclosure (Northern Ireland) Order 1998

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1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

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1.18 The Chief Executive (or designated senior person[6]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annex 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the HSC Board

1.21 Complaints about the HSC Board's commissioning decisions regarding purchasing of services may be made by, on or on behalf of any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities. Where general concerns about commissioning issues are raised with the HSC Board a full explanation of the HSC Board's policy should be provided. These issues should not, however, be dealt with under the HSC Complaints Procedure.

[6] A designated Senior Person should be a Director (or Nominee)

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Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[7] and requests for access to health or social care records under the General Data Protection Regulation (GDPR)[8].

Independent Inquiries and Criminal Investigations

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 15. The HSC Board and HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[9].

[7] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[8] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr
[9] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents

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Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[10]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[11]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[12]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

[10] Adult Safeguarding Operational Procedures: http://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Adult-Safeguarding-Operational-Procedures.pdf
[11] Protocol for Joint Investigation of Adult Safeguarding Cases: http://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Protocol-for-joint-investigation-of-adult-safeguarding-cases.pdf
[12] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

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Coroners Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroners investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroners investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

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Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) investigation. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI investigation is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI investigation. However, only those aspects of the complaint not falling within the scope of the SAI investigation will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the investigation is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

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SECTION 2 – MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

Promoting access

2.2 Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annex 1 refers). Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available, for example, through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the HSC Complaints Procedure and other less formal avenues in an effort to address barriers to access.

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

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Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

- individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- individual is incapable (for example, rendered unconscious due to an accident; judgement impaired as a result of a learning disability, mental illness, brain injury or serious communication problems);
- subject of the complaint is deceased; and
- delay in the provision of consent may result in a delay in the resolution of the complaint.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[13].

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/client. The HSC organisation must consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

[13] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

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Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the General Data Protection Regulations (GDPR) which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information* [14]published January 2012.

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigators, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only

[14] DoH Code of Practice: https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

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information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable 'need to know' in connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

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2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint "on the spot" or pass it to the Complaints Manager. It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[15]. (See Flowchart page 50)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure which forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

[15] Section 75 of the Northern Ireland Act 1998
https://www.legislation.gov.uk/ukpga/1998/47/section/75

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2.17 Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaints Manager if he/she does not feel able to approach immediate staff (see flowchart page 51).

2.18 Where requested, the HSC Board will act impartially as "honest broker" to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the HSC Board should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the HSC Board or the offer of conciliation services where they are appropriate. The HSC Board's Complaints Manager should seek with the complainant's agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The HSC Board's Complaints Manager is also available to Practice/Practitioner staff for support and advice.

2.19 The HSC Board has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The HSC Board will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

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Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[16] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;
- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 52) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

[16] Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

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2.26 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults' procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.27 HSC Trusts must assure themselves that regulated establishments and agencies that deliver care on their behalf are effective and responsive in complaints handling. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.28 Copies of all correspondence relating to regulated sector complaints should be retained. The RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

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Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 53).

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2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 53).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;

- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and

- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

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2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

2.41 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annex 1 refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available (Annex 7 refers).

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What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.45 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.46 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

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SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate (Annex 1 refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and learning from complaints should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or

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fallen below standard the organisation has the opportunity to improve and avoid a recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DOH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[17] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

[17] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

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3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;
- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[18] to assist staff requiring professional indemnity[19];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and

[18] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[19] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

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- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.10 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.11 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.12 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge; and
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

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Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annex 1 refers).

3.15 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local

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resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This is particularly so for complaints that have been resolved "on the spot" and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.18 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within **3 working days** in line with legislative requirements (see Legal Framework at Annex 2). The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person's health or well-being.

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

3.21 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.22 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.23 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify any other organisations involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.24 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate (Annex 1 refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;
- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

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Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

3.30 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; and
- conciliators.

3.31 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The HSC Board will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

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Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[20] will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.34 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.35 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

[20] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

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Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

3.37 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.38 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC

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organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annex 1 refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures**.**

3.42 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

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3.43 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints (including those FPS complaints lodged with the HSC Board), the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.44 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter;
- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

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Concluding Local Resolution

3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[21]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

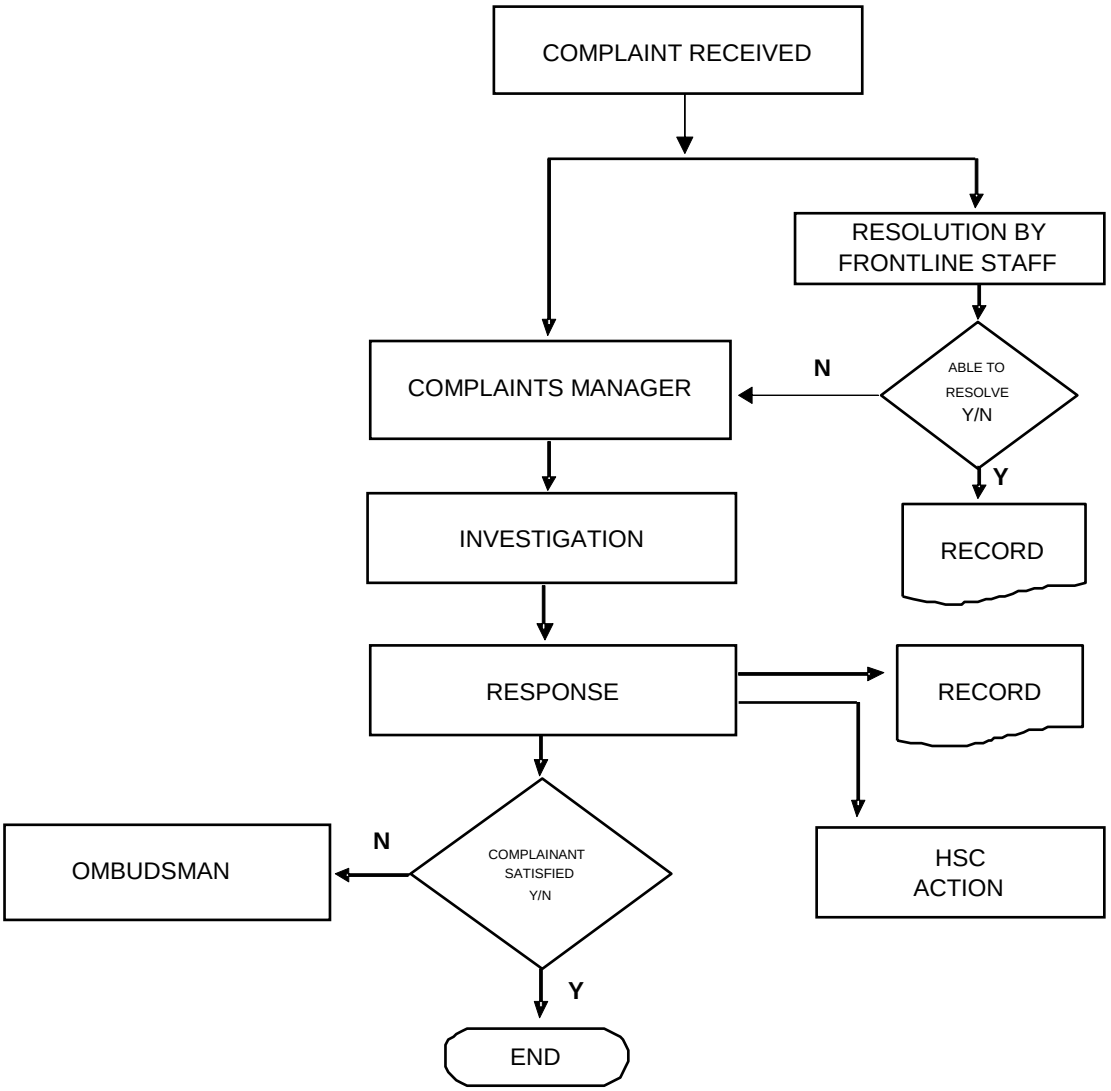
3.46 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

[21]Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

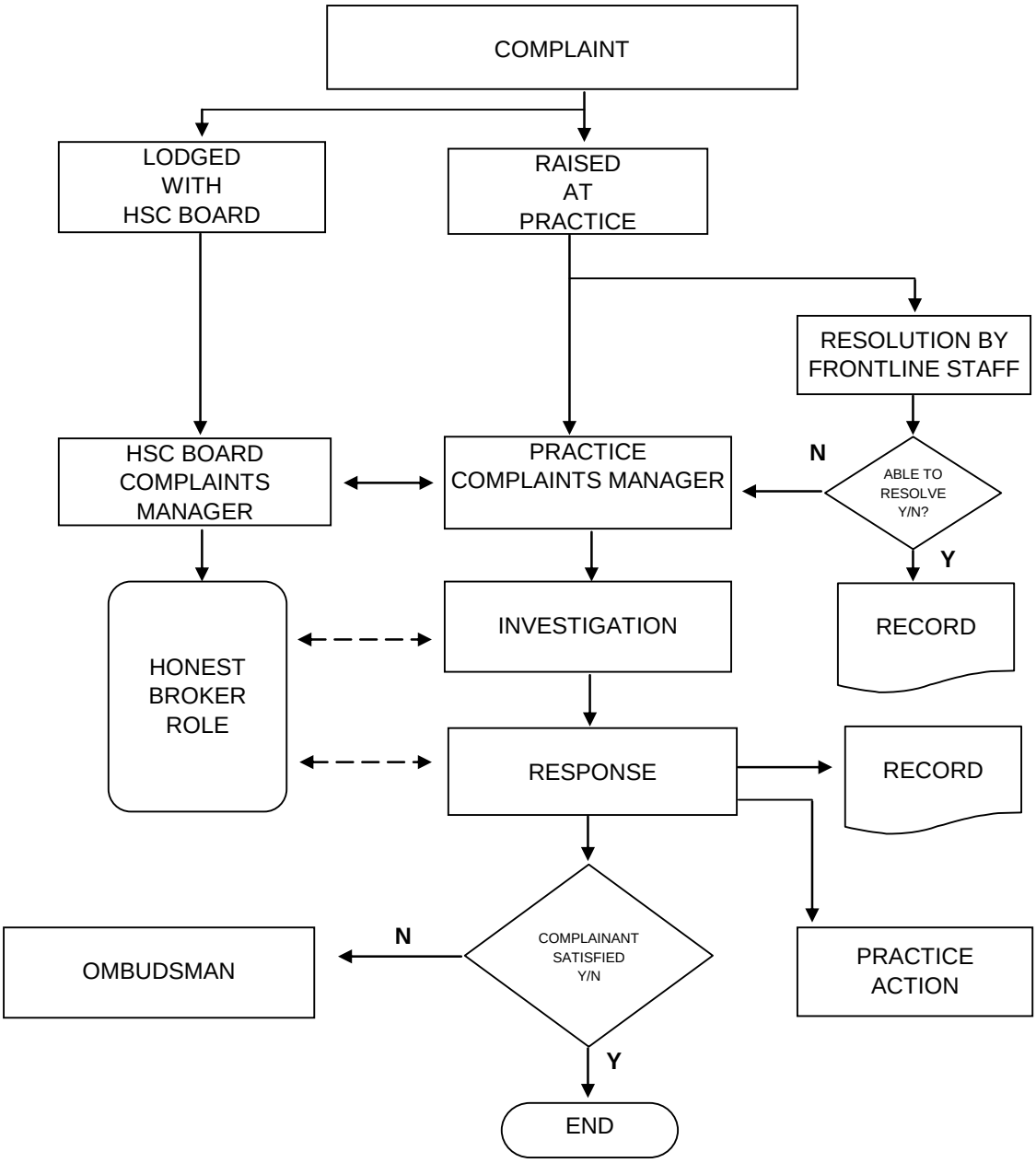
Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



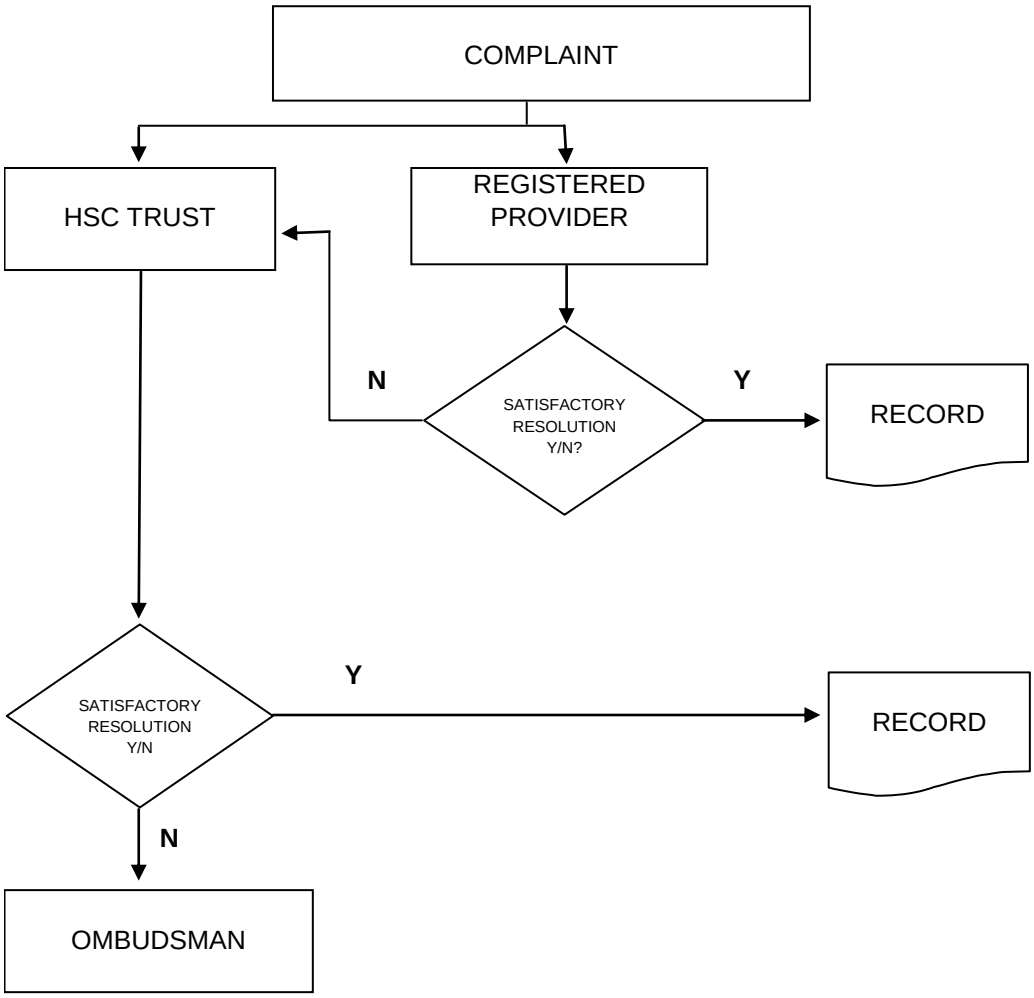
Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



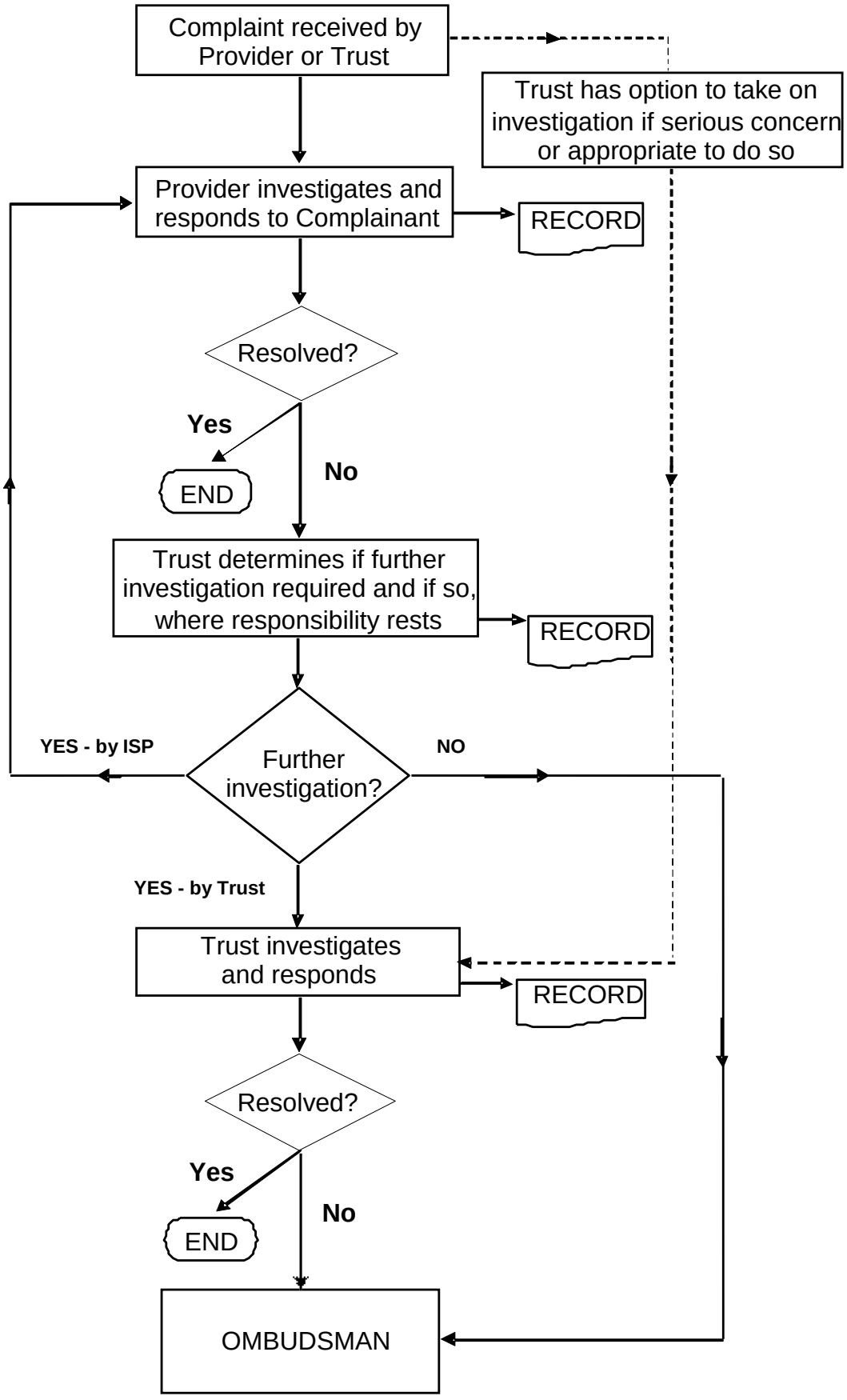
Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC)



Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days (20 working days if lodged with HSC Board)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation's response

*** A working day is any weekday (Monday to Friday) which is not a local or public holiday.**

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements.

4.3 The *Standards for Complaints Handling* (Annex 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally. HSC organisations should also involve service users and staff to improve the quality of services and effectiveness of complaints handling arrangements locally

4.4 The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

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The HSC Board

4.5 The HSC Board must maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The HSC Board must provide the Department with quarterly complaints statistics in relation to all FPS and, where appropriate, out-of-hours services.

4.7 The HSC Board must produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the HSC Board acted as "honest broker". Copies should be sent to the PCC, the RQIA, the Ombudsman and the DOH. Reports must not breach patient/ client confidentiality.

HSC Trusts

4.8 All HSC Trusts including the Northern Ireland Ambulance Service (NIAS) must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the HSC Board with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

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4.10 HSC Trusts must also produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the HSC Board, PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Board and HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 The HSC Board's quarterly reports to their management board should include a breakdown of complaints received in relation to **all** Family Practitioner Services and, where appropriate, out-of-hours services.

4.13 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.14 Family Practitioner Services must provide the HSC Board with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

4.15 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the HSC Board.

4.16 The HSC Board must record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.17 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC, HSC Board and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.18 All regulated establishments and agencies are required if requested to provide the RQIA with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

Department of Health (DoH)

4.19 The DoH will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

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Learning

4.20 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[22].

4.21 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. All HSC organisations, the RQIA and Ombudsman must share the intelligence gained through complaints.

4.22 The HSC Board must have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[22] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SECTION 5 - ROLES AND RESPONSIBILITIES

HSC Board

5.1 The HSC Board is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annex1 refers).

5.2 The HSC Board must maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The HSC Board must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The HSC Board must have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The HSC Board will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DoH Medicines Regulatory Group (MRG).

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Patient and Client Council (PCC)

5.6 The PCC is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

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5.7 If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- help in accessing medical/social services records.

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: www.patientclientcouncil@hscni.net or Freephone 0800 917 0222

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

WHO CAN HELP ME RAISE MY COMPLAINT?

You can get practical help to raise your complaint from the Patient and Client Council (PCC).

You can contact a PCC Officer at:

Phone: 0800 917 0222
Email: complaints.pcc@hscni.net

For more information, visit PCC's website:
www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

- Give you information on how to complain and who to complain to
- Help you write letters of complaint
- Make telephone calls for you about your complaint
- Go with you to meetings about your complaint and make sure your concerns are responded to
- Work with health and social care organisations to improve services as a result of your complaint

WHAT CAN I DO IF I AM NOT SATISFIED WITH THE TRUST'S RESPONSE?

If you are not happy with the trust's response to your complaint, you can contact the Northern Ireland Public Service Ombudsman (NIPSO) at:

Phone: 0800 343 424
Email: nipso@nipso.org.uk
For more information, visit NIPSO's website:
www.nipso.org.uk

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled. These are the standards to which HSC organisations are expected to operate for complaints handling:

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and
8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

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STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DOH guidance on responding to unreasonable or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

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STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and
8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;

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STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations must consider alternative methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

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STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness; and
6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

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STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and
7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

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ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
- Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013)
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010).

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The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI)2007;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;

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ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 76377181 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 71676000 www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	**Professional Standards Authority for Health and Social Care (the Authority)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: 020 73898030 http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 028 95362600 www.niscc.info

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ANNEX 4: HSC PRISON HEALTHCARE

1. From 1 April 2008 responsibility for HSC prison healthcare was transferred to the DOH. From that date the DOH delegated responsibility for commissioning those health and social services to the Eastern Health and Social Services Board (EHSSB). From 1 April 2009 this responsibility transferred to the HSC Board. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care or treatment or about issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

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ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[23] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.
(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –
(a) that the complaints handling procedure is exhausted, and
(b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.
(3) A notice under subsection (2) must –
(a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and
(b) provide details of how to contact the Ombudsman.

[23] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

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2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:

www.nipso.org.uk

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ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DOH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DOH informed on matters concerning the provision, availability and quality of services.

4. The RQIA may be contacted at:

   9th Floor, Riverside Tower
   Lanyon Place
   Belfast
   BT1 3BT
   Tel: 028 90 517500

   http://www.rqia.org.uk/

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ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

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ANNEX 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the Practice/ Practitioner/HSC organisation/HSC Board and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Practice/Practitioner/HSC organisation/HSC Board; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 13 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve

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difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/HSC Board. In FPS complaints it may be suggested by the HSC Board.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the HSC Board Complaints Manager for advice.

7. Where a request for a conciliator is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the HSC Board Complaints Manager will advise the FPS Practice/Practitioner. In some cases the HSC Board may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or HSC Board (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and

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- explaining what happens when conciliation ends.

10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the HSC Board of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or HSC Board (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

Appointment of conciliators

12. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The HSC Board will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

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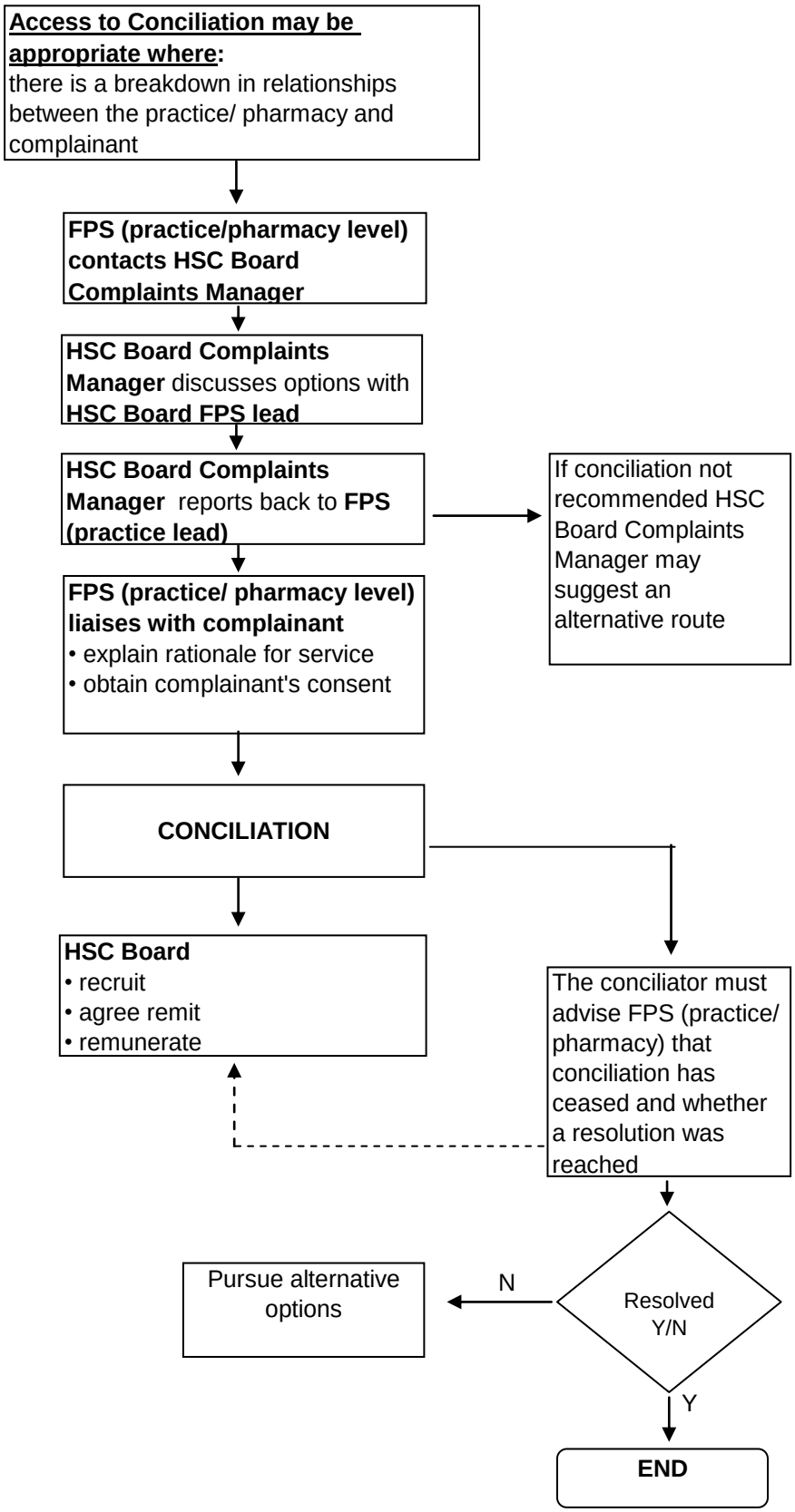
Conciliation – FPS Access



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ANNEX 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the Practice/Practitioner/ HSC organisation. In FPS complaints it can also be suggested by the HSC Board. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation; and
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practice/Practitioner should approach the HSC Board Complaints Manager for advice.

3. Where a request for an Independent Expert is received the HSC Board Complaints Manager **may** wish to liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/HSC Board must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

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5. The HSC organisation or HSC Board may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/HSC Board should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/HSCB (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the HSC Board (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation

Appointment of Independent Experts

9. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local

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Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The HSC Board will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

12. A flowchart outlining the process for FPS is shown overleaf.

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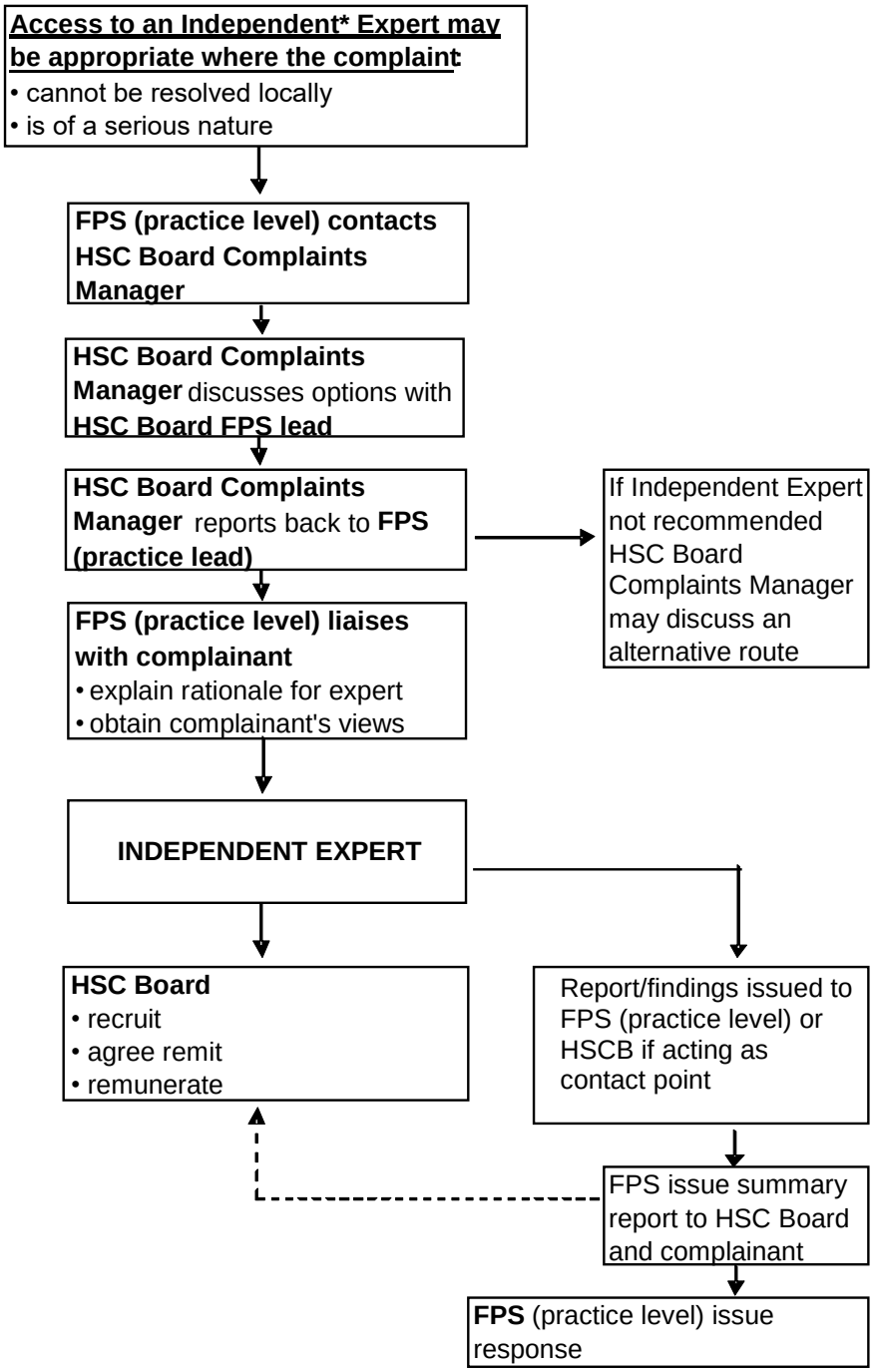
Independent Experts - FPS Access



* Definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

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ANNEX 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annex 13 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships; and
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practice/Practitioner should approach the HSC Board Complaints Manager for advice.

6. Where a request for a lay person is received the HSC Board Complaints Manager **may** liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board **may** consider an alternative to a lay person.

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Agreement and consent

7. The FPS Practice/ Practitioner/ HSC Organisation/HSC Board must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the Practice/Practitioner/HSC Organisation/HSC Board should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The layperson's findings/ report will be forwarded to the Practice/Practitioner/HSC Organisation/HSC Board. The full report will be made available by the Practice/ Practitioner/HSC Organisation/HSC Board (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/HSC Board.

Appointment of lay persons

11. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

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Monitoring

12. The HSC Board will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

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ANNEX 11: HONEST BROKER ROLE

1. "Honest broker" is the term used to describe the role of the HSC Board Complaints Manager in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the HSC Board to act in this role at any point in the complaints process. It is expected that the HSC Board will not carry out the investigation but it is also expected that the HSC Board will add value to the process by providing support and advice to FPS.

2. It is not an alternative to local resolution. Neither is it an opportunity for the HSC Board to take over an investigation. Rather it is about facilitating communications and building relationships between the Practice/Practitioner and the complainant or reaching positions of understanding. The honest broker will act as an intermediary and is available to both, the complainant or Practice/Practitioner staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the Practice/Practitioner;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between/with both parties together or separately.

3. Paragraphs 2.16 to 2.21 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the HSC Board. Where the complainant contacts the HSC Board the Complaints Manager will explain the options available to resolve the complaint:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the HSC Board can act as honest broker between the complainant and the Practice/Practitioner.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of complaints. FPS will be asked for their agreement should the complainant prefer the HSC Board's involvement.

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5. Where the HSC Board Complaints Manager has been asked to act as honest broker he/she will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[24]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

6. Whichever process is used it is important to note that the Practice/Practitioner are responsible for the investigation and the response. The HSC Board Complaints Manager, however, must ensure that:

- a written response is provided by the Practice/Practitioner to the complainant and any other person subject to the complaint (whether this is direct from the Practice/Practitioner or from the HSC Board after receiving a report from the Practice/Practitioner ;
- the response is of sufficient quality and addresses the complainant's concerns;
- the written response is provided within target timescales and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the HSC Board Complaints Manager for further advice and support.

[24] For 'honest broker' this is 20 working days from receipt of the complaint: for FPS, this is 10 working days from receipt of the complaint.

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ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[25]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**
AND/OR
b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

[25] 'Adult Safeguarding – Prevention and Protection in Partnership' (July 2015) (https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents), p10

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4. An '**adult in need of protection**' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

5. In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

6. The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Reportable offences and allegations of abuse

7. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk then the regional *'Adult Safeguarding Operational Procedures' (September 2016)* and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases' (August 2016)* should be activated (see paragraph 1.26).

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ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[26] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

4. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the HSC organisation or unreasonable behaviour towards HSC staff to be unacceptable. It is these actions that HSC organisations aim to manage under this policy.

[26] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

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Aggressive or abusive behaviour

5. HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC position in relation to attacks on the workforce. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

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9. Examples of actions grouped under this heading include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; and
- repeatedly changing the substance of a complaint or raising unrelated concerns.

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a

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complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

15. When the HSC organisation is looking at a complaint, it will need to ask the individual who has complained to work with them. This can include agreeing with the HSC organisation the complaint it will look at; providing it with further information, evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

16. Sometimes, an individual repeatedly refuses to cooperate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it is unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

17. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in a termination of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

18. HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

19. HSC staff will end telephone calls if they consider the caller aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that their behaviour is unacceptable and end the call if the behaviour persists. In extreme situations, the HSC organisation will tell the

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complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

20. The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

21. Where a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

22. Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

23. In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

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24. The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decisions about unreasonable behaviour

25. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

27. It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

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28. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They must advise the complainant in writing[27] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

29. The HSC organisation records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above, may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complainants with restricted contact arrangements on a regular basis.

[27] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

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ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[28] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:
   - any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
   - matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
   - those personal social services to children provided under the Adoption Order (NI) 1987[29].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[30].

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Board and HSC Trusts should familiarise themselves with these requirements.

[28] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[29] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[30] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

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CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

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1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

↓

2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

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3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))

If **<u>YES</u>** to **ANY** of above → **Progress via Children Order Procedure**

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

<u>NB</u>: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 <u>and</u> 2 <u>and</u> 3 MUST all be YES.

Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

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Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

Complaint	"an expression of dissatisfaction that requires a response"
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH[31]	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the HSC Board's role in FPS complaints
HSC Board	Health and Social Care Board
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes the HSC Board, HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

[31] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

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	Northern Ireland Blood Transfusion Service
NIBTS	Northern Ireland Public Services Ombudsman (NIPSO, known as 'the Ombudsman')
NIPSO	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
Out of-Hours services	
	Patient and Client Council
PCC	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal
Pilot Scheme	dental services provided by an HSC Trust in this case)
	is a complaints procedure established by the pilot scheme
Pilot Scheme Complaints Procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Practice based complaints procedure	person carrying on or managing the establishment or agency
Registered Provider	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and
RQIA	quality of health and social care services provision by independent and statutory bodies in Northern Ireland
	for example, residential care homes, nursing homes, children's homes, nursing agencies, independent clinics/hospitals, etc. registered with
Registered Establishments and Agencies	
	and regulated by the RQIA

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Regulated Sector	refers to registered establishments and agencies
Senior Person	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust
Service User	means a patient, client, resident, carer, visitor or any other person accessing HSC services
Special Agency	For example the NI Blood Transfusion Service (NIBTS)

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

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2022

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REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Updated to reflect the closure of the Health and Social Care (HSC) Board and migration of functions to Strategic Planning and Performance Group (SPPG), DoH.	01 April 2022
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the third time at: CURRENTLY WITH DSO	Xx xxxxx 2022
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The HSC Board Directions were revoked. CURRENTLY WITH DSO	Xx xxxxxx 2022
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The PHA Directions were amended for the second time at: CURRENTLY WITH DSO	Xx xxxx 2022

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Directions	Details	Date Effective
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The BSO Directions were amended for the second time at: CURRENTLY WITH DSO	Xx xxxx 2022
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 **2019 No. 4**
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and	01 April 2019 **2019 No. 3**

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Directions	Details	Date Effective
	• Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b)	01 April 2019 **2019 No. 2**

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Directions	Details	Date Effective
	substitute(b) The HSC Board Complaints Manager acts impartially as “honest broker” to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The **Main Directions** were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as “honest broker” to the complainant and Practice/Practitioner in the resolution of the complaint.	01 April 2019 **2019 No. 1**

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Directions	Details	Date Effective
	• Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers **(Amendment)** Directions (Northern Ireland) 2013	The **HSC Board Directions** were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: • Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and • Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 **2013 No. 12**
Health and Social Care Complaints Procedure Directions **(Amendment)** (Northern Ireland) 2009	The **Main Directions** were amended for the first time at: • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	02 September 2013 **2013 No. 11**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as **BSO Directions**	26 July 2010
Directions to the Regional Agency for Public Health	The Directions were introduced. Known as **PHA Directions**	26 July 2010

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Directions	Details	Date Effective
and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints		
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions were introduced. Known as **HSC Board Directions**	01 April 2009
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as **Main Directions**	01 April 2009

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BACKGROUND

The HSC Complaints Procedure*, 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'* was developed and published in 2009*.* It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

On the 1st April 2019 revised guidance was introduced and incorporated a number of legislative changes. The document was renamed, '*Guidance in relation to the Health and Social Care Complaints Procedure' or 'HSC Complaints Procedure'* for short.

The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well-defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;

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- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process. The eight specific standards of HSC are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

More details on each of the standards are provided in Annex 1 of this document.

It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

Update – 01 April 2022

As a result of the migration of the HSC Board to the Department of Health this guidance has been amended to reflect the transfer of the HSC Board functions in respect of HSC Complaints to the Strategic Planning and Performance Group (SPPG) in the Department.

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SPPG will on behalf of the Department of Health assume the roles and responsibilities previously undertaken by the HSC Board. This updated guidance is effective from 01 April 2022.

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SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2022 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

1.2 The HSC Complaints Procedure continues to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings). The expectations of service users should be

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managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right and be signposted to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the HSC Complaints Procedure.

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

- **openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **responsiveness** – providing an appropriate and proportionate response;
- **fairness and independence** – emphasising early resolution in order to minimise strain and distress for all; and
- **learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

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- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

1.10 The HSC Complaints Procedure deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- HSC Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- Business services organisation (BSO)
  - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[1] as an alternative to making an application to the courts.

[1] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

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What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[2] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by DoH
- requests for information under Freedom of Information or access to records under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[3]

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints

[2] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[3] Public Interest Disclosure (Northern Ireland) Order 1998

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Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint <u>not</u> covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

1.18 The Chief Executive (or designated senior person[4]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

[4] A designated Senior Person should be a Director (or Nominee)

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in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annex 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the DoH

1.21 Complaints about commissioning and the purchasing of services can be made generally; or by, or on behalf of, any individual personally affected by a commissioning decision taken by the department, and will be dealt with under the DoH Complaints Procedure.

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[5] and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)[6] and Data Protection Act 2018.

[5] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[6] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

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Independent Inquiries and Criminal Investigations

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 14. The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[7].

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[8]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[9]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[10]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

[7] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[8] Adult Safeguarding Operational Procedures: Adult Safeguarding (hscni.net)
[9] Protocol for Joint Investigation of Adult Safeguarding Cases: DRAFT (hscni.net)
[10] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

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not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

Coroners Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroner's investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroner's investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

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1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) review. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI review is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI review. However, only those aspects of the complaint not falling within the scope of the SAI review will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the review is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing[11]. All HSC organisations should have their own separate procedures in place.

[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-whistleblowing.PDF

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SECTION 2 – MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

Promoting access

2.2 Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annex 1 refers). Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available, for example, through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the HSC Complaints Procedure and other less formal avenues in an effort to address barriers to access.

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
  - someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

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Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

- individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- individual is incapable (for example, rendered unconscious due to an accident; judgement impaired as a result of a learning disability, mental illness, brain injury or serious communication problems);
- subject of the complaint is deceased; and
- delay in the provision of consent may result in a delay in the resolution of the complaint.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[12].

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/client. The HSC organisation must consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

[12] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

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Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information* [13]published January 2012.

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigators, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable 'need to know' in

[13] DoH Code of Practice:
https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

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connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint “on the spot” or pass it to the Complaints Manager.

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It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[14]. (See Flowchart page 45)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure which forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team[15], if he/she does not feel able to approach immediate staff (see flowchart page 46).

[14] Section 75 of the Northern Ireland Act 1998 https://www.legislation.gov.uk/ukpga/1998/47/section/75
[15] SPPG Complaints Team acting on behalf of the DoH.

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2.18 Where requested, the SPPG Complaints Team will act impartially as "honest broker" to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the SPPG Complaints Team should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the SPPG Complaints Team or the offer of conciliation services where they are appropriate. The SPPG Complaints Team should seek with the complainant's agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The SPPG Complaints Team is also available to Practice/Practitioner staff for support and advice.

2.19 The SPPG Complaints Team has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The SPPG Complaints Team will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[16] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;

[16] Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

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- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 47) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

2.26 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults' procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered

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providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.27 HSC Trusts must assure themselves that regulated establishments and agencies that deliver care on their behalf are effective and responsive in complaints handling. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.28 Copies of all correspondence relating to regulated sector complaints should be retained. The RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated

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officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 48).

2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 48).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;
- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and
- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

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2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

2.41 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

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Supporting complainants and staff

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annex 1 refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available (Annex 7 refers).

What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.45 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.46 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety

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and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

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SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate (Annex 1 refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and learning from complaints should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a

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recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[17] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;

[17] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

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- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[18] to assist staff requiring professional indemnity[19];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should

[18] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[19] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

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assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.10 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.11 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.12 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge; and
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function

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effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annex 1 refers).

3.15 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This

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is particularly so for complaints that have been resolved “on the spot” and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.18 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within **3 working days** in line with legislative requirements (see Legal Framework at Annex 2). The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person’s health or well-being.

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

3.21 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

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3.22 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.23 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify any other organisations involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.24 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the DoH or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the Departmental or the HSC Complaints Procedure.

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate (Annex 1 refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;

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- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those

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responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

3.30 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; and
- conciliators.

3.31 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The SPPG Complaints Team on behalf of DoH will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[20] will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual

[20] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

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accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.34 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.35 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

3.37 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

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Physical Injury

3.38 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annex 1 refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures

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3.42 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.43 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.44 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter;
- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

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Concluding Local Resolution

3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[21]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

3.46 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

[21]Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

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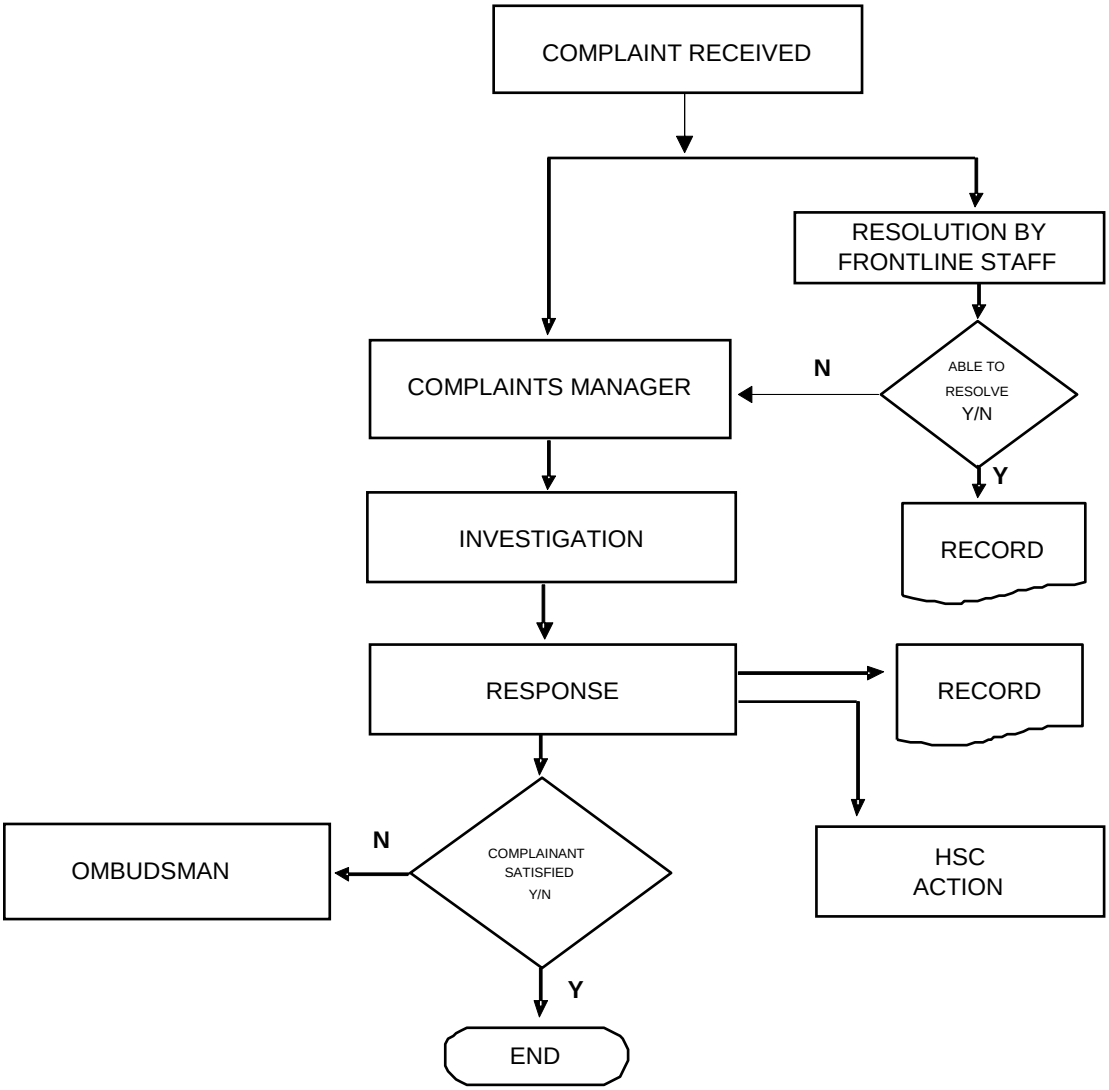
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



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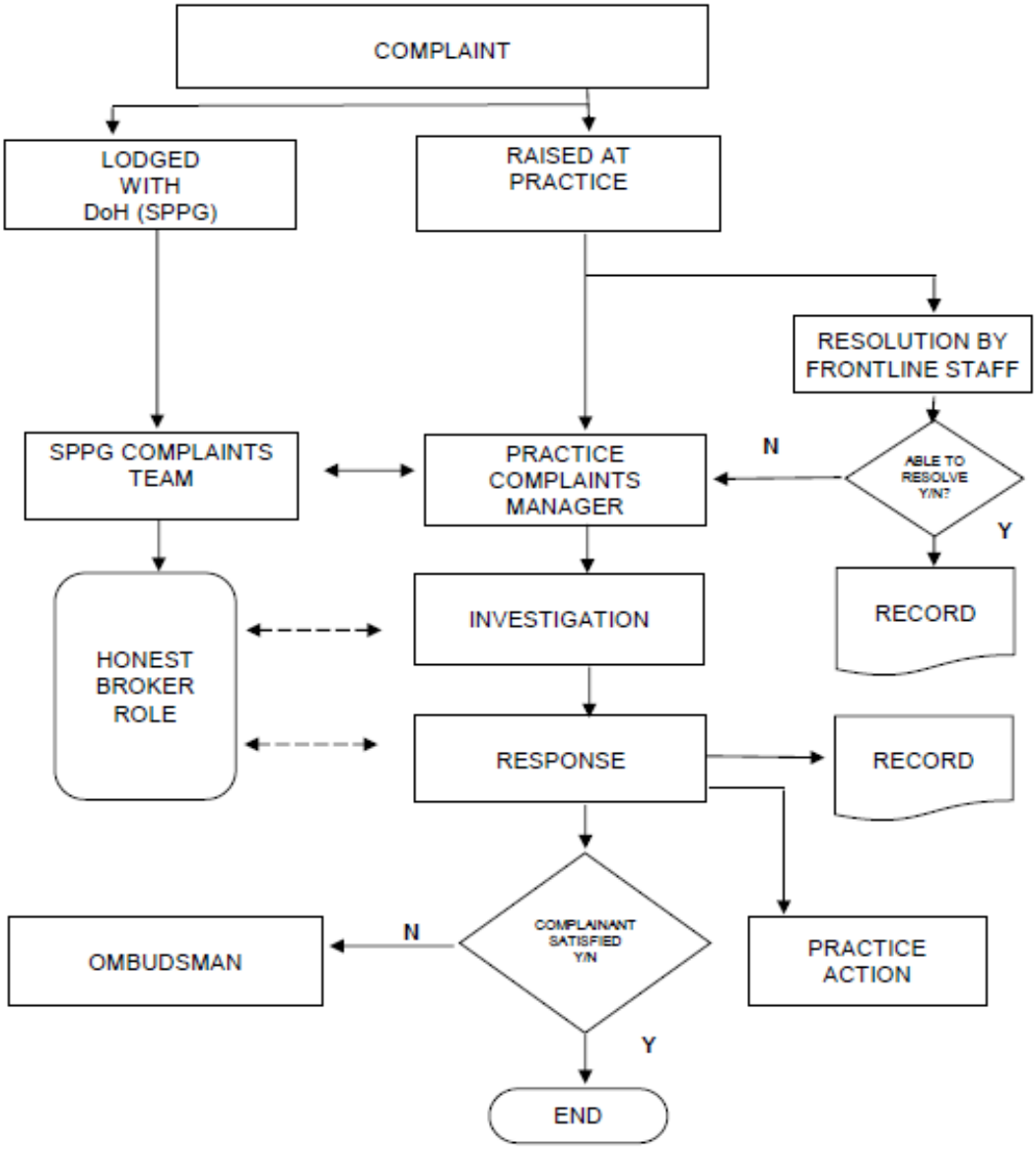
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



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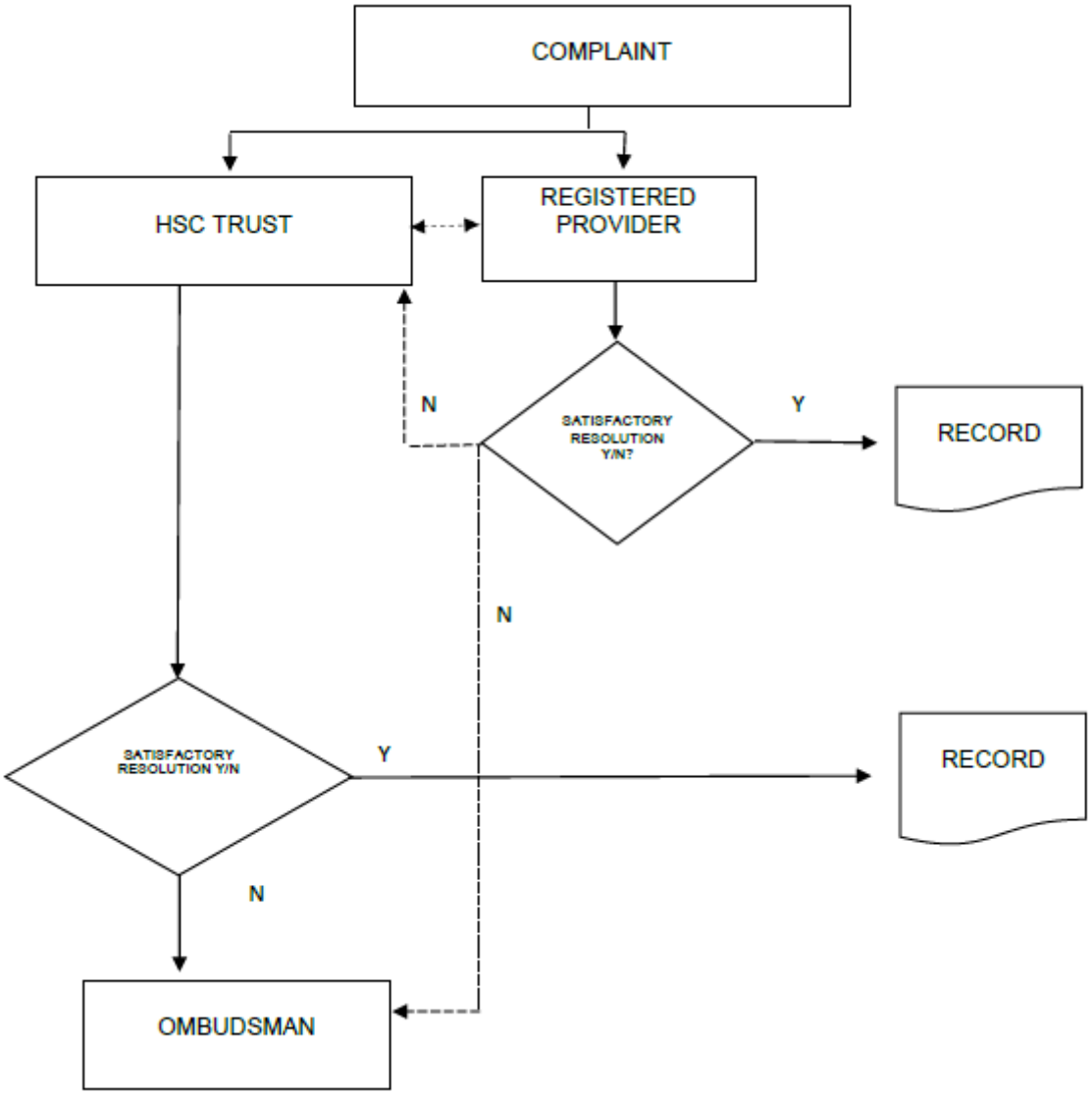
REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC - Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.)



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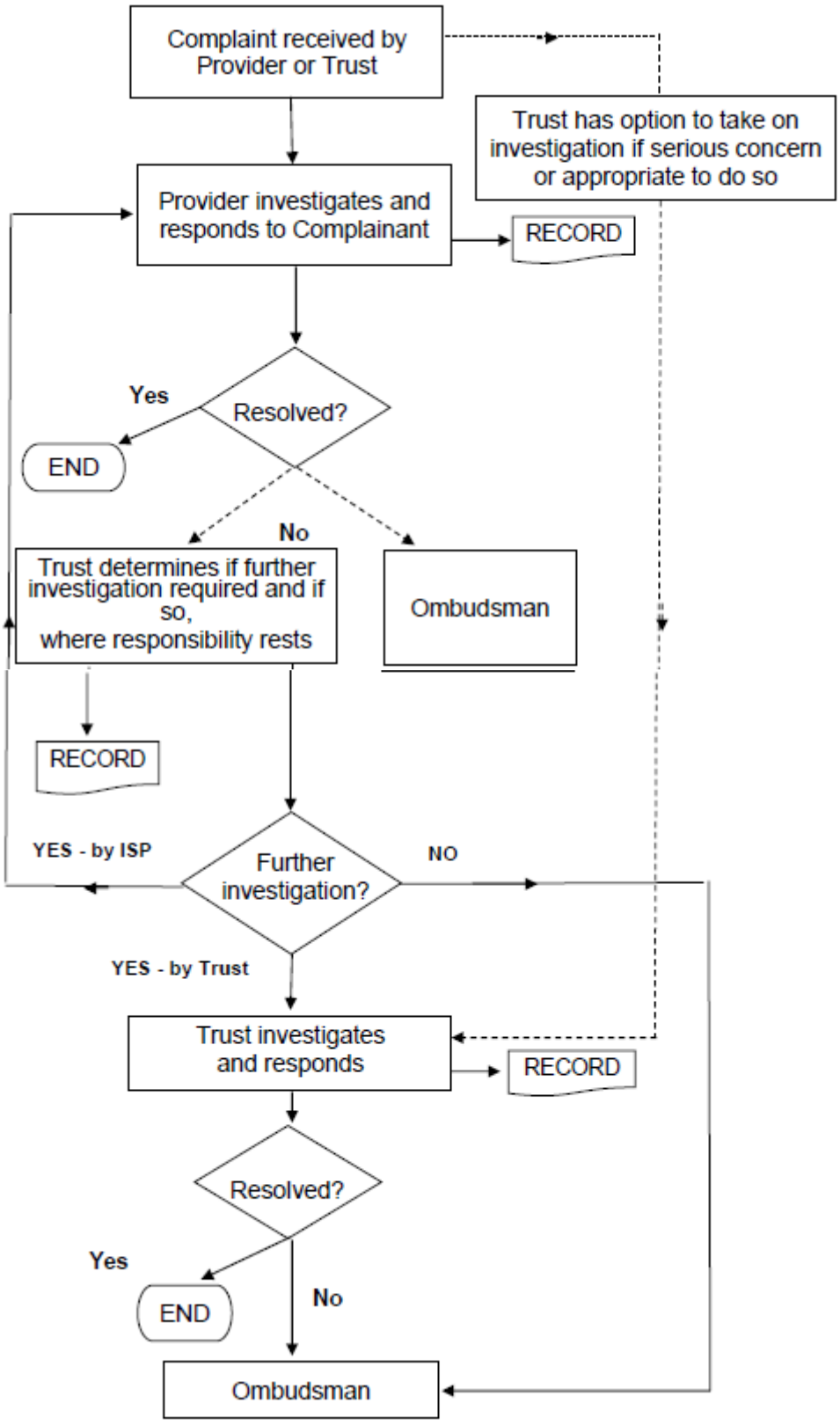
INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



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SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days (20 working days if lodged with the SPPG Complaints Team)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation's response

*** A working day is any weekday (Monday to Friday) which is not a local or public holiday.**

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SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements.

4.3 The *Standards for Complaints Handling* (Annex 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally. HSC organisations should also involve service users and staff to improve the quality of services and effectiveness of complaints handling arrangements locally

4.4 The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

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DoH

4.5 The SPPG Complaints Team on behalf of DoH will maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The SPPG Complaints Team will produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the SPPG Complaints Team acted as "honest broker". Copies should be sent to the PCC, the RQIA and the Ombudsman. Reports must not breach patient/ client confidentiality.

4.7 The DoH will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

HSC Trusts

4.8 All HSC Trusts must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the DoH with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

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4.10 HSC Trusts must also produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.13 Family Practitioner Services must provide the SPPG Complaints Team with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.14 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the SPPG Complaints Team.

4.15 The SPPG Complaints Team will record and monitor the outcome of all FPS complaints lodged with them.

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Other HSC organisations

4.16 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.17 All regulated establishments and agencies are required if requested to provide the RQIA with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[22].

4.19 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. All HSC organisations, the RQIA and Ombudsman must share the intelligence gained through complaints.

4.20 The SPPG Complaints Team on behalf of the DoH will have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[22] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf

Received from Chris Walmsley on 25/10/22. Annotated by the Urology Services Inquiry.

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

5.1 The SPPG on behalf of DoH is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annex1 refers).

5.2 The SPPG Complaints Team will maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The SPPG Complaints Team must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The SPPG Complaints Team on behalf of the DoH will have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The SPPG Complaints Team will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DoH Medicines Regulatory Group (MRG).

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HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Patient and Client Council (PCC)

5.6 The PCC is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

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5.7 If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- help in accessing medical/social services records.

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: www.patientclientcouncil@hscni.net or Freephone 0800 917 0222

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WHO CAN HELP ME RAISE MY COMPLAINT?

You can get practical help to raise your complaint from the Patient and Client Council (PCC).

You can contact a PCC Officer at:

Phone: 0800 917 0222
Email: complaints.pcc@hscni.net

For more information, visit PCC's website:
www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

- Give you information on how to complain and who to complain to
- Help you write letters of complaint
- Make telephone calls for you about your complaint
- Go with you to meetings about your complaint and make sure your concerns are responded to
- Work with health and social care organisations to improve services as a result of your complaint

WHAT CAN I DO IF I AM NOT SATISFIED WITH THE TRUST'S RESPONSE?

If you are not happy with the trust's response to your complaint, you can contact the Northern Ireland Public Service Ombudsman (NIPSO) at:

Phone: 0800 343 424
Email: nipso@nipso.org.uk
For more information, visit NIPSO's website:
www.nipso.org.uk

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ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled. These are the standards to which HSC organisations are expected to operate for complaints handling:

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STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and
8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

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STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

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STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

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STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DoH guidance on responding to unreasonable or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

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STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria:

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and
8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;

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STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations must consider alternative methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

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STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness; and
6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

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STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and
7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

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ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
  Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
  Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013)
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010).

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The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003:

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI)2007;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;

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ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 76377181 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 71676000 www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	**Professional Standards Authority for Health and Social Care (the Authority)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: 020 73898030 http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 028 95362600 www.niscc.info

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ANNEX 4: HSC PRISON HEALTHCARE

1. HSC prison healthcare is commissioned by the DoH. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care, treatment or issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

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ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[23] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.
(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –
(a) that the complaints handling procedure is exhausted, and
(b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.
(3) A notice under subsection (2) must –
(a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and
(b) provide details of how to contact the Ombudsman.

[23] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

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2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:
www.nipso.org.uk

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ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DoH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DoH informed on matters concerning the provision, availability and quality of services.

4. The RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: 028 90 517500

http://www.rqia.org.uk/

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ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

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ANNEX 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the Practice/ Practitioner/HSC organisation/SPPG on behalf of the DoH and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 13 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

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5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH. In FPS complaints it may be suggested by the SPPG Complaints Team.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the SPPG Complaints Team for advice.

7. Where a request for a conciliator is received the SPPG Complaints Team will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the SPPG Complaints Team will advise the FPS Practice/Practitioner. In some cases the SPPG Complaints Team may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or SPPG Complaints Team (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and
- explaining what happens when conciliation ends.

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10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the SPPG Complaints Team of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or the SPPG Complaints Team (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

Appointment of conciliators

12. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The SPPG Complaints Team will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

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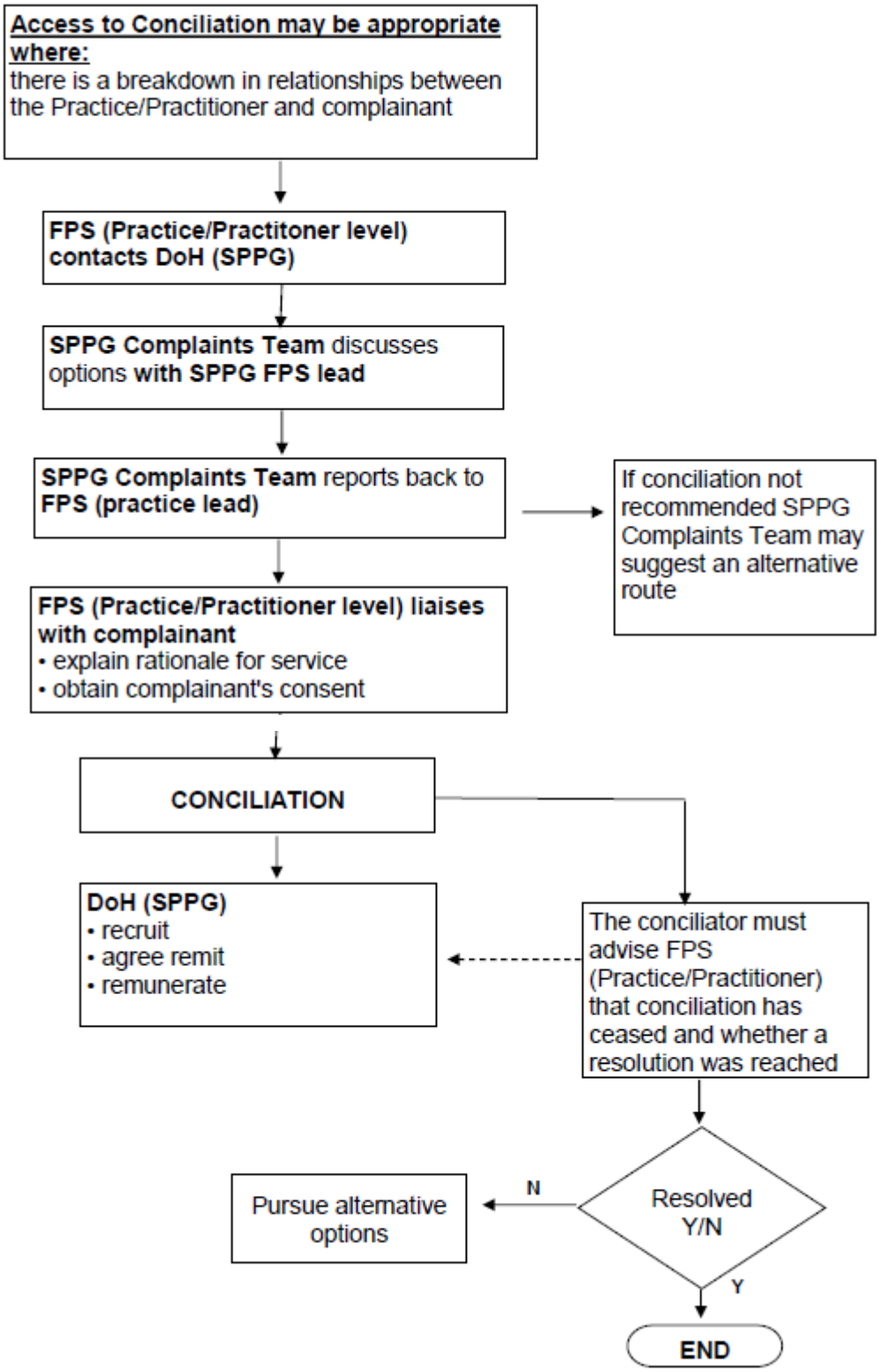
Conciliation – FPS



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ANNEX 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the Practice/Practitioner/ HSC organisation. In FPS complaints it can also be suggested by the SPPG Complaints Team on behalf of the DoH. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation; and
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

3. Where a request for an Independent Expert is received the SPPG Complaints Team **may** wish to liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

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5. The HSC organisation or SPPG Complaints Team may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/SPPG Complaints Team (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the SPPG Complaints Team (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation.

Appointment of Independent Experts

9. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

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Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

12. A flowchart outlining the process for FPS is shown overleaf.

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