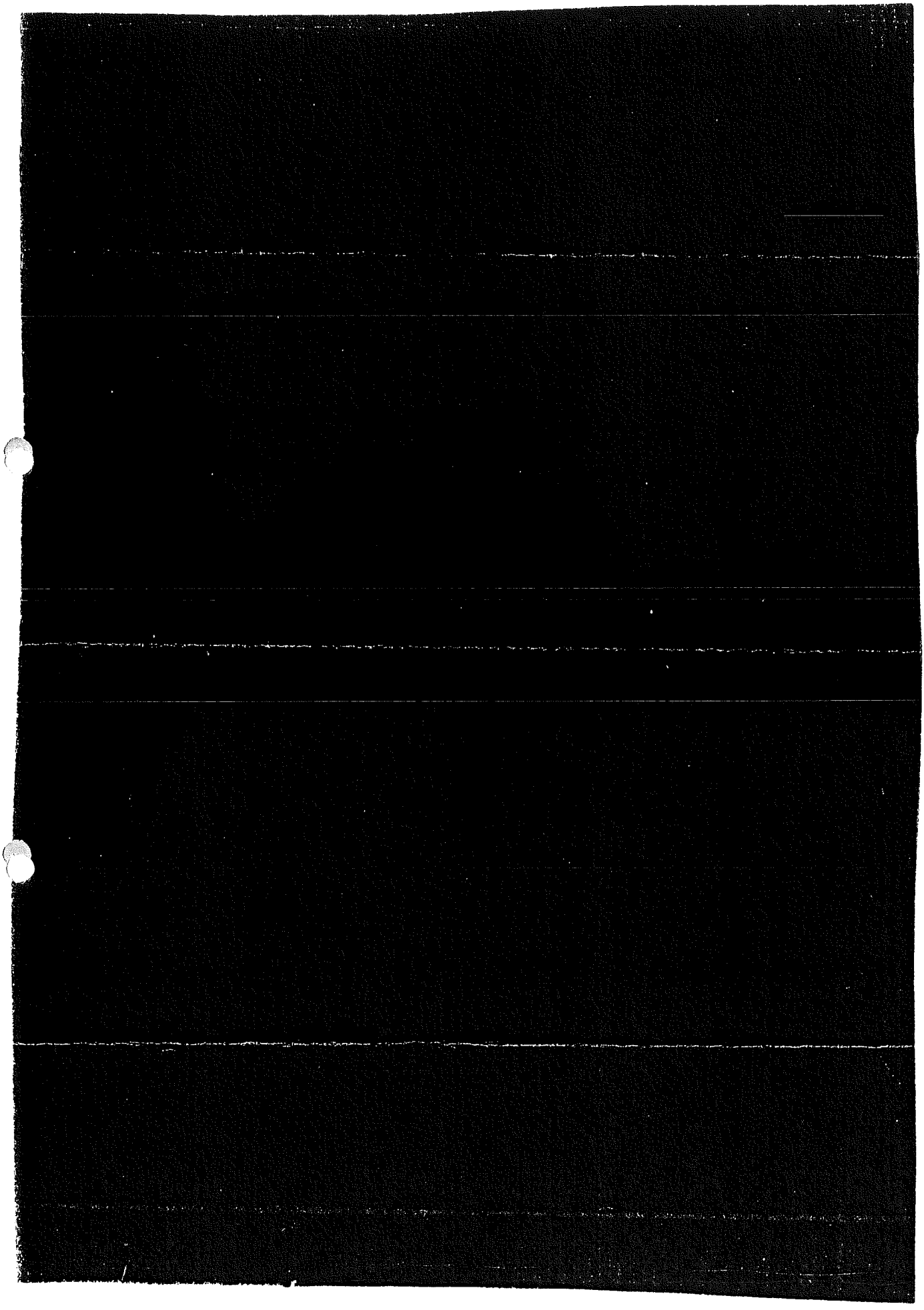

[redacted]

- Lessons of LC case have not been learned in terms of management of clinical incidents;

[redacted]

Why Us?

Trust accountable to Department for Service Delivery. Board accountable for commissioning safe high quality services and securing services for people of Western Area.

Governance – patients are at risk and we feel a responsibility to intervene/act if quality of service is not being provided.

Implications of sending letter

- Focus on importance of issue and priority to assess risk and put in place plan to manage this.
- Alerts Department and puts pressure on them to act.
- Impact on Chief Executive of Trust and staff – could be positive from some staff's perspective if concerned re: quality of service – could be negative for others and, in particular, for Hugh who may feel undermined.

- Puts the Trust under the spotlight again.
- May damage relationships between Trust/Board – depends on how it is managed.
- Puts patients first and may avert further clinical incident.
- May result in a rationalisation of, eg critical care and emergency services, on one site – this could be perceived in a negative way in Omagh.