From: Joanna Bolton
To: Conlon, Bernie (IHRD)
Cc: Devlin, Denise; Ross, Leanne
Subject: BELFAST TRUST RESPONSE
Date: 01 September 2016 13:10:38

Dear Bernie,

I have received the Belfast Trust response to the recent information request made by the Inquiry. I am in the process of formatting same. It's a fairly large document with various attachments so I am sending it in five separate emails.

Kind Regards,

Joanna

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PLEASE ENSURE DLS CASE REF IS QUOTED ON ALL CORRESPONDENCE TO THIS OFFICE

Questions Belfast Health & Social Care Trust

No	Context	Question
1	*"Belfast Trust 'Policy and Procedure for the Management of Complaints and Compliments' (2010)".* *The Concern which I wish to look at ... is that this policy, at least on paper, provides for very little input on the part of a patient or family into the complaint beyond making the complaint in the first place.* **Transcript 11th November 2013 p.6 L.1-6 AVMA/PCC**	**i.** Please provide a copy of the current policy.
Q1 answer	i. Policy and Procedure for the Management of Complaints and Compliments (TP44/10) attached. Some examples from the policy: P11 Lay Persons A Lay Person is an independent person that does not act as an advocate, conciliator or investigator. Neither do they act on behalf of the complainant or complained about. Their involvement is to help bring about resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Their involvement must be agreed by both the Trust and the Complainant. P12 Independent Expert The use of an Independent Expert in the resolution of a complaint may be requested by the complainant or the Trust. Input will not be required in every complaint but will be considered according to the nature and complexity of the complaint and any attempts at resolution. Involvement of an Independent Expert may be considered beneficial where the complaint cannot be resolved locally; indicates a risk to public or patient/client safety; could give rise to serious breakdown in relationships, threaten public confidence in services or damage reputation; to give an independent perspective on clinical issues. P22 Complaints and SAI interface The complainant will be advised and kept informed throughout the [SAI] process by the Complaints manager. It is important that all aspects of the complaint are answered and that the final outcome of the investigation is shared with the complainant. If the complainant remains unhappy with the process or aspects of the complaint remain unanswered, the complainant can re-engage with the complaints process.	

No	Context	Question
	P24 Appendix 7 Investigation and Resolution It may be more appropriate, depending on the complexity of the complaint, that a meeting would be offered to the family to discuss the outcome of the investigation. This decision would be agreed by the Complaints Manager and Service Directorate Manager. P25 In line with the DHSSPS guidance, complaints must be investigated and the person making the complaint issued with a written response, signed by the relevant Director, on behalf of the Chief Executive, within 20 working days where possible. If for any reason this is not possible the complainant will be advised of the delay, the reason for it and when they are likely to receive a full reply. P 29 Flowchart summarising the process for staff to follow when dealing with Complaints • Listen to the Complainant • Record the issues accurately • Agree a plan of action with the complainant and document • Inform relevant staff (including Line manager) • Carry out actions and feedback to complainant and document • If Complainant is happy with the outcome – record on Complaints record form which can be found on the Intranet site P 35 Conciliation Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to gain 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 such as; ☐where staff or practitioners feel the relationship with the complainant is difficult; ☐when trust has broken down between the Trust and both parties feel it would assist in the resolution of the complaint; ☐where it is important, e.g. because of on-going care issues, to maintain the relationship between the complainant and the Trust; ☐when there are misunderstandings with the relatives during the treatment and care of the patient/client. 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 others point of view and ask questions. Conciliation may be requested by the complainant or the Trust.	

No	Context	Question
	There are also repeated references to assistance and support provided to complainants throughout policy but 2 key parts are as follows; Page 8 At all stages within the complaints process assistance from the Complaints Manager will be provided; independent advice and support for complainants is also available from the Patient Client Council and other independent specialist advocacy services. Page 35 Advocacy & Conciliation The Trust will 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.  See Document 401-001x BHSCT_Complaints and Compliments Polic	
2	Policy and Procedure for the Management of Complaints and Compliments April 2010. Chairman: *Review date was April 2013 – it is currently under review"* **Transcript 11th November 2013 p.7 L.10-11 AVMA/PCC**	**i.** When was the review completed? **ii.** Please provide a copy
Q2 answer	i. This policy was approved in February 2014. It is currently undergoing further review including significant consultation with stakeholders, a revised version is expected to be approved by Trust policy Committee in October 2016. ii. See policy TP44/10 (attached in Q1).	

No	Context	Question
3	*"A complaint cannot properly be investigated in any way by somebody who's provided the care to the patient in question".* **Transcript 11th November 2013 p.66**	**i.** To what extent does this still happen during the 'local resolution' phase?
Q3 answer	**Complaints - Investigation – see P52 current Policy Sept 2013** In the interests of addressing patient concerns efficiently and effectively, every effort is made to explore and resolve complaints at ward / department level at the time the complaint is raised. This is usually led by the nurse or consultant in charge of the ward that day. This individual would not be the subject of the complaint. Page 18 of the policy outlines that some complainants may prefer to make their complaint to someone within the Trust 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. The outcome of discussions will be recorded in the medical notes. Should this not be possible, the issues raised in each complaint are formally investigated as part of the formal Complaints procedure. A Lead Investigator who has not been directly involved in the delivery of treatment or care to the patient will be identified by the Service Area to co-ordinate the investigation process. Such investigations typically require relevant individuals to be interviewed and/or provide statements. Individuals named in a formal complaint should be interviewed by any one of the following: - • Line manager / Senior Manager with the appropriate level of seniority • An independent person with appropriate level of seniority • A relevant Medical, Clinical, Nursing or Professional person with the appropriate level of understanding and Seniority. • Senior Manager Complaints and Legal Services / Complaints Manager where appropriate. • Governance Manager where appropriate Where it is not possible for an interview to take place, the individual named in the complaint will be asked to respond in writing. This response along with the relevant patient/client notes must always be peer reviewed by an appropriate person with the appropriate level of skills and understanding of the speciality. This peer review must be clearly documented and sent as part of the investigation.	

No	Context	Question
4	**Transcript 11 November p 74 L 17-19** Chairman: *"Is there any way in Northern Ireland ... of measuring the outcome of complaints ... or has any thought been given to developing such a system".* **Transcript 11th November 2013 p.74 L.17-19 AVMA/PCC**	**i.** Are the outcomes of complaints measured by the Trust now?
Q4 answer	Examples of how the Trust currently measures complaints outcomes include: • Complainant Satisfaction Survey • Audit of revisited / reopened complaints • Presentation of data to Trust Complaints Review Group on Quarterly basis • Accountability/performance processes within Service Areas • Ongoing monitoring of Ombudsman Cases including review of complaints management processes and resultant proposals for shared learning • Annual meetings with Ombudsman • Shared learning procedure incorporating learning from complaints • Complaint reports are themed for learning opportunities with focus on the most common themes such as attitude, behaviour and communication.	
5	**The BH&SCT refers to the** *"discussion/sharing of the final report with the family"*. **348-002**	**i.** Is their provision for sharing a 'draft report' or providing an 'update on the investigation' where the process of achieving a final report is protracted?
Q5 answer	With regard to SAIs, families are advised that the report describes the findings, conclusions and recommendations of the investigation team. The purpose of the investigation and report is to find out what happened and identify opportunities for learning. That is, the report is the investigation team's opinions based on the evidence that is presented to them. Families are invited to meet with the investigation team during the investigation to share their experiences and talk about areas that they would like further clarity on.	

No	Context	Question
	Once the report is concluded, it is shared with families and a meeting to discuss its findings with the family is arranged. Should the family feel that the report does not fully answer the questions they have, a further review of events may occur. Any new findings will be included as an addendum to the original report. At the start of the investigation, families are advised of their main point of contact during the investigation process. This could be a member of staff from the Risk and Governance Department, the Governance Manager in the Directorate, a Co-director or the chair of the investigation panel. This individual will keep in contact with the family to provide an update on progress with the investigation and will be available to be contacted by the family if required. With regard to complaints, the majority are relatively “straightforward” to investigate and respond to as they frequently relate to waiting times for an appointment, a procedure or the attitude or behaviour of an individual member of staff at a specific period in time. More complex complaints are investigated in a similar way to serious adverse incidents. The appropriateness of seeking an opinion from a clinician external to the Belfast Trust is considered on a case by case basis. Families are advised in writing that an investigation in to their complaint is taking place and they will be contacted by the investigating team. The main point of contact in these circumstances is a member of staff from the Complaints Department.  SHWH Complaints Flowchart.pdf See Document 401-001y	

No	Context	Question
6	RQIA Review of Advocacy Services for Children and Adults in Northern Ireland (January 2016), which states: *"The provision of advocacy services continues [since the Department's 'Developing Advocacy Services: Policy Guide for Commissioners'] to be predominantly for mental health, learning disability and children's service. There have been some developments for other programmes of care"*. (page20)	**i.** In what circumstances and how many times have advocacy services been offered in past 3 years?
Q6 answer	There have not been any cases in the past three years when advocacy services has been offered for a Serious Adverse Incident review. However, the Patient Client Council and members of the legal profession have supported patients and their families during the complaints process. In addition, in the past, VOYPIC (Voice of Young People in Care) has supported young people attending RBHSC. Relevant Advocacy services are offered to **all** complainants via the initial response letters issued by the Trust upon receipt of every complaint: See copy of "You have made a Complaint" leaflet attached. This leaflet is included with all complaint acknowledgement letters issued by the Trust (see relevant extract below). "*Please find enclosed a leaflet which explains the Complaints Procedure, this also includes contact details for the Patient and Client Council who offer independent support for complainants if required"* The Trust's Complaints web site also provides a list of advocacy services for patients / clients. The Trust Complaints Policy details a range of Internal/ External Support/ Contacts e.g. NIPSO, PCC, RQIA and provides information regarding the role of these organisations and the nature of support provided to complainants. This information is readily available to all Trust staff to enable them to signpost patients / clients appropriately.  You have Made a Complaint Leaflet.pdf See Document 401-001z	

7	**Chairman** "*in what sort of scenario are lay reviewers engaged to assist?"* **Transcript 12th November 2013 p.17 L.10-14 Trust Evidence**	**i.** In what circumstances and how many times have lay reviewers been used in past 3 years?
Q7 answer	**SAI's** A lay person has been used in SAI reviews on 2 occasions in the last 3 years. A layperson chaired an SAI review panel in 2016. This was a review of a social work case that had been subject to a PSNI investigation. The HSCB stipulated that the Chair of the SAI Review panel was independent to the Trust. A member of the HSCB pool of lay people used for complaints and SAIs was utilised. A layperson was on the panel of a SAI regarding a research incident in 2014. The individual was a member of a Research Committee in another organisation and had subject knowledge. **Complaints** The Trust Complaints Policy states (Page 24) that "consideration should be given to the use of an independent Lay Person (list available from the HSCB) or obtaining an Independent Expert opinion in complex cases to help resolve the complaint. Advice should be sought from the Complaints Manager / Senior Complaints Manger where necessary". Statistics are not currently recorded to monitor the use of lay reviewers within the Trust, however lay reviewers are used at Stage 1 and Stage 2 of all Children Order Complaints. The Policy also directs (Page 26) that "If the complainant remains dissatisfied with the complaint response …they can contact the Complaints Department. and consideration will then be given to "revisit" the complaint for further local resolution. This may include advocacy, conciliation or the use of lay persons".	
8	*BHSCT SAI Procedure April 2014 – "The Co-Director responsible for the SAI* ***should ensure*** *the appropriate level of involvement of ... family ... throughout the investigation including discussion/* ***sharing of the final report*** *with the ... family ... and this* ***should be agreed*** *with the investigation team at the outset".* **348-002**	**i.** In what circumstances would you not involve the family? **ii.** If the family are not involved would they still be informed that a SAI investigation was underway? **iii.** Are the decisions not to inform a family recorded and monitored?

Q8 answer	Trust Overview i. For every SAI the "Checklist for Engagement / Communication with Service User / Family / Carer following a Serious Adverse Incident" must be completed and returned to the Health and Social Care Board. Please find checklist attached. This checklist monitors that families / carer / service users are informed that the incident is being reviewed as an SAI and if the Final Report of the SAI review has been shared with the family. The rationale for not notifying the family / carer / service user of the SAI is stipulated as: • No contact or Next of Kin details or Unable to contact • Not applicable as this SAI is not 'patient/service user' related • Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user • Case involved suspected or actual abuse by family • Case identified as a result of review exercise • Case is environmental or infrastructure related with no harm to patient/service user The Trust adheres to this regional policy. Completion of the checklist is monitored by a central corporate team within the Trust and also by the HSCB. The Trust has a leaflet, please find enclosed, which is given to all families / carer / service user once a SAI is reported. This leaflet includes a contact person in the Trust who family / carer / service users can contact to express concerns or to learn how they can contribute to the investigation. ii. As above, a family would be informed that a SAI review is underway unless one of the criteria was applicable. iii. The decision not to inform a family that a SAI review is being undertaken is recorded for every SAI in the checklist. This is monitored within the Trust by Corporate Governance and also externally by the HSCB.  1311 - Serious adverse incidents lea See Document 401-001aa RBHSC Specific We are not aware of a situation where a family would not be involved in the investigation of a level 2 SAI. From October 2014 until February 2016, all child deaths that occurred in a health care setting were notified to the HSCB using an SAI template. Most of these deaths were anticipated and followed a period of palliative care for conditions such as cancer or for children with complex health and care needs.

	Level 1 SAIs were subject to a Significant Event Audit (SEA) conducted by the multidisciplinary team that cared for the child. Families would generally be advised that the care of their child would be reviewed as part of standard procedures. This review would be discussed with families when they met with the clinical team a period of time after the child's death. Rarely would families of children who were expected to die be advised that the care would be reported under SAI procedures as staff felt that describing an expected child death as a serious adverse incident would cause further and unnecessary distress to families. Where a death is unexpected, these are reported as a level 2 SAI. Families are informed that an investigation would take place in keeping with the process described in answer to question 5.	
9	Draft BHSCT Serious Adverse Incident (SAI) Procedures – April 2014 **348-002a**	**i.** Please provide a copy of final version?
Q9 answer	i. BHSCT Serious Adverse Incident (SAI) Procedure enclosed. This procedure was approved in August 2016. The previous version is also enclosed for information.  BHSCT SAI Procedure.pdf See Document 401-001ab  Belfast Trust SAI Policy.pdf See Document 401-001ac	

10	**Donaldson Report** *4.6, p.38: "The system is too often falling down to level two [open but poor communication] because:* • *Staff who communicate with patients and families during the Serious Adverse Incident investigation process have variable communication skills ... Little formal effort has been made to train staff to manage these difficult interactions well.* • *Patients and families are often not offered the opportunity to meet with those who they would like to – the staff directly involved in the incident. Instead they tend to meet with managers and with clinicians who were not involved.* • *There are frequently delays in the process of investigating a Serious Adverse Incident.* *Patients and families are too often sent letters filled with technical jargon and legalese*	**i.** Is training currently being made available to help staff develop the communication skills to "manage these difficult interactions well"? **ii.** What is the current procedure in relation to the family being able to meet (if they wish to) with those directly involved in their children's care?
Q10 answer	i. <u>Allied Health Professionals</u> This is a training need which has been identified and prioritised by the AHP Education Commissioning Group for AHP staff dealing with situations such as these for 16-17. A programme titled: Dealing with Difficult Situations: The Power of Empathetic Communication, has been sourced and it is anticipated that at least 1 cohort will be delivered this year with a small number of places available per Trust. There are already plans to prioritise this training for further cohorts to be delivered in 17-18. <u>Doctors</u> NIMDTA Communication skills training as part of any of their mandatory programme of Generic Skills workshops for Foundation year 2 trainees. <u>Nursing</u> Communication is an underpinning theme of all pre- registration nursing programmes . A range of education products are accessed as part on ongoing CPD for nursing staff to further enhance effective communication skills and 'manage difficult interactions well'. following registration . These include Communication Effectively, Managing Critical Conversations, Managing Critical Conversation and Root cause Analysis Training is also available for nursing staff required to undertake investigations. All registered nurses are required to undertake 2 supervision sessions/year and all are encouraged to reflect on events or experiences in their professional practice. More recently, registered nurses are required to revalidate with the NMC and this process requires each	

	nurse to prepare five written reflective accounts. Much like supervision, these accounts are required to be related to events or experiences in the nurse's professional practice. These events or experiences may include those related to managing difficult interactions with patients and families. The accounts form part of the conversation with the person responsible for confirming that the nurse has met the revalidation requirements. In addition to training, there are a range of Trust policies for nursing staff to refer to, such as 'Being Open Policy – saying sorry when things go wrong'. <u>Overarching Trust (all staff)</u> The Trust has a "Being Open Policy – saying sorry when things go wrong". "Being open" is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident. The Trust also has a Being Open eLearning training package which is accessible for all staff. This eLearning training has been promoted to all medical staff within the Trust and to the other HSC Trusts via the Medical Directors Forum and is due to be made available across the region.  Being Open Policy – Saying sorry when th See Document 401-001ad ii. <u>RBHSC</u> Generally, families will meet with members of the clinical team when they are ready to discuss the events surrounding their child's death. Often, the clinicians who have been directly involved in the care of child who has died unexpectedly will meet with the family. This decision is taken on a case by case basis and is often dependent on the wishes of the family.	
11	**Joint Guidance from GMC and NMC (15 June 2015)*:*** *"Your organisation should support you to report adverse incidents and near misses routinely. If you do not feel supported to report, and in particular if you are discouraged or prevented from reporting, you should raise a concern in line with our guidance."*	**i.** In light of concerns that there is lack of support for doctors and nurses who want to report adverse incidents and near misses. What steps are being taken to provide that support?

Q11 answer	Trust Overview The Belfast Trust Being Open policy expresses a commitment to provide open and honest communication between healthcare staff and service users when there has been harm. The Policy views promoting a culture of openness as vital to improving patient safety and the quality of healthcare. The Trust view is that a culture of openness is one where healthcare: • staff are open about incidents they have been involved in. • staff and organisations are accountable for their actions. • staff feel able to talk to their colleagues and superiors about any incident • organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned. • staff are treated fairly and are supported when an incident happens. This requirement is reinforced through training and Directorate forums and is supported by a 'Being Open' e-learning training package which has been shared regionally. In addition the Adverse Incident Policy is clear that staff are obliged to report incidents and near misses and can do so without fear of blame or punitive action. An adverse incident is defined in regional policy as: "Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation / Special Agency or commissioned service". Adverse events are to be viewed as learning opportunities and the Trust has a number of initiatives to support this agenda. These include: Safety Message of the Week – sharing learning outcomes from incidents, SAIs, complaints and Mortality and Morbidity reviews. Please find example enclosed.  1. SMOTW - Keep Prescriptions Legible ! See Document 401-001ae Safety Matters newsletter – published quarterly outlining lessons learnt and safety messages. Please find example enclosed.  Safety Matters Newsletter Issue 6 F\ See Document 401-001af Trust Shared Learning event, "Learning not Blaming" – organised for September 2016.

Safetember initiative – branding September as “Safetember”. A number of events Trust wide to energise staff to increase their focus on safety and quality and promote quality improvement. Safetember took place in 2015 and planning is underway for 2016.

The Trust has a schedule of Leadership Walkrounds which are part of the Trust Safety and Quality Improvement agenda. Please see attached paper. The Leadership Walkrounds are led by Directors and offer staff the opportunity to raise issues and discuss incidents.

A6. 2015_12_07_LW_SQ

See Document 401-001ag

Nursing

All that is listed above is relevant to all staff, including nursing staff. Training is available on incident reporting and DATIX provides opportunities for nursing staff (and everyone) to report incidents at any time. With regard to raising concerns / whistleblowing:

1. The NMC Code requires registered nurses to raise concerns immediately if you believe that a person is vulnerable or at risk and needs extra support and protection; and, cooperate with all investigations and audits.
2. In addition to their line manager, nursing staff can escalate concerns to senior nurses working in each Directorate as well as in Central Nursing.
3. Each Directorate has regular professional forums, and there is a Trust wide forum bi-annually.
4. There are regular leadership walkrounds focused primarily on safety and quality.
5. Nursing staff are key members on a range of meetings and forum focused on safety and quality.
6. DHSSPS learning letters are forwarded to University Nursing Heads of School where they are and disseminated through individual University process to Course leads for action. Relevant learning is integrated into relevant modules with public reports included in reflective discussion.
7.

Upon commencing post, nurses receive a central induction, a local induction and then have a minimum of two weeks of supervised practice. Each Directorate has an Associate Director of Nursing who is a member of the Senior Nursing and Midwifery Team. This offers a line of accountability to raise concerns or to seek support.

Doctors

The GMC provides clear guidance to Doctors in relation to raising concerns; http://www.gmc-uk.org/about/index.asp.

The BHSCT has issued guidance on raising concerns in the context of appraisal for Doctors and Dentists. This guidance was circulated to all Medical / Dental Consultants, Associate Specialists and Specialty Doctors. Doctors can express a concern at any time via their Clinical Director or up the reporting line to the Associate Medical Directors and to the Medical Director. Support is available to all staff at any time from

	Staff Care and from Occupational Health. Medical induction for Trainee Doctors takes place in RBHSC twice a year and is facilitated by the BHSCT Paediatric Specialty Tutor. The induction programme includes an overview of the governance structure in RBHSC and all staff are encouraged to report incidents via the electronic reporting system, Datix. This section of the induction programme is delivered by either the RBHSC Clinical Lead for Quality Effectiveness and Audit, the RBHSC Quality Co- ordinator or one of the RBHSC Assistant Service Managers. All trainee medical staff are encouraged to attend RBHSC Audit / M&M and it is emphasised that this is a very important educational opportunity for all staff. Permanent medical staff in the Children's Hospital are now as part of a wider roll out across the Trust being allocated two weeks upon starting to undertake mandatory training, orientation and shadowing as part of their induction. This is protected time free from service delivery. There are a number of professional fora in which staff can raise concerns and discuss incidents. These include: • Weekly CHIP meeting to review incidents. • Multi-disciplinary Governance meeting. • Listening Events with nursing staff, Occupational Health and HR in attendance to support staff. • RJMS are currently piloting a weekly patient safety and governance meeting to discuss incidents, SAIs, complaints amongst other issues.

12	*"In the Children's Hospital, all deaths are now reviewed irrespective of whether there have been any concern about the quality of care. These meetings are recorded and a culture of openness and candour is being actively encouraged."* **Transcript 12th November 2013 p.9 L.9-13 BHSCT Evidence**	**i.** Where is this done and how is the result measured and assessed?
Q12 answer	Each month, protected time equivalent to afternoon or morning sessions is given to audit and mortality and morbidity (M&M) meetings. In RBHSC, as well as audit, at this time, child death cases are presented by the consultant who was responsible for the child's care to a multidisciplinary audience of staff from the hospital. Discussions highlight any additional learning and whether this should be shared further and with whom. Since February 2016, all deaths occurring in RBHSC have been added to the MMRS database and are subsequently discussed at an M&M meeting. The child death report is included in the agenda for the quarterly RBHSC governance meeting. Any ongoing concerns due to adverse incident or complaint regarding care are highlighted at this meeting and actions identified if required. Staff from RBHSC participate in the regional HSC Safety Forum which facilitates a number of quality improvement collaboratives across the region. One of these is the regional paediatric quality improvement collaborative. Staff from RBHSC participate in this collaborative and in so doing are able to share their QI initiatives with other paediatric units regionally. In addition, RBHSC staff have an opportunity to learn about QI initiatives in these other paediatric units. The safety forum has also had a regional work shop on learning from SAI / SEAs. RBHSC has participated in this event in order to share any learning regionally through this event. The BHSCT and the Safety Forum have funded a number of staff from BHSCT to attend the Scottish Patient Safety Programme Fellowship. Two members of RBHSC medical staff have completed this fellowship and are now supporting QI initiatives both within RBHSC and within the wider BHSCT. Last year the Trust launched the Safety Quality Belfast Training Programme which aims to train staff in Quality Improvement methodology to enable continuous quality improvement of services. Staff from all Directorates of the Trust were trained. This programme is helping to embed the ethos of Belfast Trust as an open, transparent organisation with a learning culture. Feedback from this training has been extremely positive and the number of places available in year two has tripled to 150. The Trust aims to have 1000 staff trained in Quality Improvement within 5	

	years.	
13	"*I suppose I expected that some planning would take place into the formation of a protocol, but what I know happened was that it had been tried -- that is a police officer taking statements -- but it didn't seem to work."* **Transcript 26th June 2013 p.88 L.24 Coroners Evidence** **Chairman***: "There was a point at which the coroner had raised the possibility that the statements should no longer be forwarded to him through the hospital, as had been the practice. In fact, he had suggested, but effectively he let it drop, that it should be the police who take the statements. I presume that is not happening?"* **Transcript 12th November 2013 p.56 L.15-24 BHSCT**	**i.** Who currently takes statements for Inquests?
Q13 answer	<u>Dealing with this question in the context of the transcripts mentioned for question 13.</u> Currently, Coroner statement requests from staff working in the Belfast HSCT come directly from the Coroner's Office to one administrative officer working in Bostock House, Royal Victoria Hospital. This officer works solely on matters relating to the Coroner. These requests for statements can come with detailed questions and topics that need to be covered within the statements.	

	The administrative officer then begins a process of finding the whereabouts of the relevant staff; many have moved elsewhere in the Province, UK, Ireland and abroad. This process can be prolonged and requires background expertise of medical practice and networks to trace individuals. Staff are then asked to provide a statement within a specific time scale and in a specific format (attached).  Statement Form.dotx See Document 401-001ah The statements are always drafted by the witness. They usually need access to the patient's clinical notes to provide the necessary detail for their report and accessing these notes by the administrative officer, in itself, requires medical knowledge to gain access. The witness may use the services of their Medical Defence organisation to view their draft statement before sending it to the Bostock office for forwarding to the Coroner. A witness might ask (if they wish) this office to review their statement. However, they often just send a signed statement to the office for direct forwarding to the Coroner's Office. If the witness wishes this office to review a draft, it is checked by the administrative officer, by an Assistant Medical Director (dedicated to Coroner affairs) and sometimes by the Legal Service Manager, for errors of omission, grammar, spelling and matters such as incorrect dates. This process has been agreed by the Coroner's Office. This process requires medical knowledge to check for spelling mistakes of medical terms. They are also checked to affirm that they answer the specific requirements as set out in the statement request from the Coroner (see above). The draft with suggested amendments is returned to the witness for them to amend, if they so wish and to sign. Upon return, it is forwarded directly to the Coroner's Office. On a very rare occasion, a statement may offer criticism of another healthcare worker or the organisation. The Assistant Medical Director in those circumstances will first of all ask that all the facts are laid down. If the witness has an opinion that an error has been made and criticism is due, they are asked to provide evidence and the factual basis for their opinion. Those criticised would then be offered the right to answer, in the form of offering a statement for forwarding to the Coroner, who will hear the arguments. Also, in these circumstances, the Medical Defence organisations and the Trust's solicitors are asked to view statements and advise. The final statement is always that of the witness and they always have the final say in its contents. They are NOT drafted by the hospital or agents of the hospital.

14	"*We have learned from the events of this inquiry and are updating our arrangements to ensure a proper separation of coronial and medico legal functions".* **Transcript 12th November 2013 p.10 L.16-18 BHSCT Evidence**	**i.** What "updated" arrangements are currently in place?
Q14 answer	For some time, one administrative officer working in Bostock House, Royal Victoria Hospital has dealt with all matters arising in the Belfast Trust concerning the Coroner's Office. She has no other duties. There is one administrative officer dealing with legacy Coroner matters affecting the Belfast City Hospital. She does not deal with new cases and this post will soon be amalgamated with the Bostock team to complete the separation trust wide. Since June 2015, an Assistant Medical Director was appointed to the Belfast Trust who deals solely with matters relating to the Coroner. He does not deal with any other litigation material. Another consultant has been appointed as Assistant Medical Director for clinical negligence.	
15	**Department's position paper to the Inquiry (333-304):** "*Teaching about the requirement to refer death to the Coroner, and how to complete a MCCD has been a long standing part of the undergraduate training for medical students at Queen's University."* *"In 2005 a review of induction processes for junior doctors recommended that first day induction should include Coroner's issues. In recent years a presentation on death certification and referral to the Coroner has been included in the induction for foundation doctors, and they are also required to complete an e-learning module. Knowledge of death certification and referral to the Coroner is also included in the foundation curriculum."*	**i.** What continued professional development is doctors receiving on this, particularly at consultant-level? **ii.** If death certification and referral to the Coroner is not being audited, how is doctors' training monitored in this area? **iii.** In what way are student doctors and nurses learning in their training lessons which have been learnt from unexpected deaths in hospitals and from Coroners Inquests? Please give specific examples.
Q15 answer	i. Training for, a. reasons to refer to the Coroner; and b. how to complete a MCCD, are provided to, a. Medical students, as part of their training prior to examinations, b. Foundation Year students as FY0 work experience, and	

c. Postgraduate students,

in the form of,

a. training packages,
b. presentations and
c. PowerPoint presentations.

For Postgraduate doctors these occur at Induction events held on a Regional basis every August for Foundation Year doctors FY1 and also at local Trust induction events held every August and February for all postgraduate doctors.

Regarding Consultant staff, there is a Trust policy "*Guidance on actions to be taken after a patient's death in hospital.*" It includes instructions regarding reasons to refer to the Coroner and how to complete a MCCD. This is available on the Trust Intranet and is available to all staff to use at any time.

There is new work in progress, where newly appointed permanent medical staff will undertake a formal 2 week Induction course before taking up their clinical role. This course will include training on items which are part of the Mandatory Training Matrix including one on Death Certification. The Mandatory Training Matrix will become a functional element of Consultant Appraisal.

ii. Death certification is included as a mandatory module on the regional Training Tracker e-learning for doctors training working throughout Northern Ireland. The module is valid for five years. In the Belfast Trust, doctors completion of this module is monitored twice a year at changeover (August and February) If a doctor has not completed their mandatory modules they and their educational supervisor are emailed and asked to complete. Any outstanding non-compliance is then escalated to the relevant Specialty Tutor.

iii. The following information was provided to Queens University for the purpose of informing medical students:

Safety Matters newsletter
Medsafe newsletter
SAI Learning x 2
Complaint Learning x 1
PHA review paper re SAIs involving misidentification of patients


401-001ai
MedSafe issue 8final.pdf


401-001aj
Item 5.1.1 Shared Learning re SAI 14 14


401-001ak
Item 5.1.2 re SAI 14 159.pdf


401-001al
Item 5.3.1 re ASPC CAMHS.pdf


401-001am
Item 7.1 PHA HSCB Thematic Review of S

<table>
<tr><td></td><td colspan="2">The Trust has offered to provide this information on an on-going basis.

Nursing students in their 3rd year at QUB are taught by Trust Bereavement Coordinators, via a workshop, how to manage death in various circumstances including sudden death.</td></tr>
<tr><td>16</td><td>Department Position Paper (333-303): A pilot scheme has also been developed within the Belfast HSC Trust to review all deaths that occur in their hospitals and discussions are ongoing on implementing this process across Northern Ireland. Essentially the process will record, review, monitor and analyse all hospital deaths.</td><td>i. What was the outcome of the pilot scheme?

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In parallel with this IT development throughout 2013, a Trust-wide system of 46 peer review clinical mortality and morbidity (M&M) teams was established with a responsibility to review all their patient deaths at M&M meetings.

Since May 2013, the M&MR system was rolled out to all 4 BHSCT hospitals. It is currently used to record details of the MCCD and then the details of a clinical M&M peer review of the circumstances surrounding the death of patients.

The M&MRs has,
• been tested and piloted;
• completed;
• rolled out across 4 hospitals in Belfast;
• collected details entered onto the Medical Certificate of Cause of Death or given to the Coroner.
• reviewed (and corrected if necessary) these details by Consultant Staff.
• peer reviewed deaths at a Mortality and Morbidity Meeting.
• recorded discussions, learning lessons and action plans.
• used this information for Consultant appraisal.
• generated strong clinical engagement;
• supported clinical governance; and
• supported appraisal and revalidation.

Further development of the system stopped pending the regional system (see below).</td></tr>
</table>

	ii.	The success of the BHSCT roll-out attracted interest from the Chief Medical Officer and the 4 Medical Directors of the other Heath & Care Trusts in NI. The functions of the Belfast Trust M&MR system have now been used to develop the Regional M&MR system (RM&MRs). It is now being developed as part of the Northern Ireland Electronic Care Record. This will be rolled out across NI as part of the implementation of death certification reforms by the end of March 2017.

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17	**CMO Annual Report for 2015 (published 18 May 2016) p38:** *"It is anticipated that the RM&MRs will begin a phased roll-out in August 2016, with the system being fully functional in all Trusts by March 2017."* Also: "e*ffective use of the RM&MRS will help front line staff, working together on a multi-disciplinary basis, to identify learning which will improve the quality of care they can provide and to share this learning with others. It will also provide means for additional scrutiny of the death certification process ... the main benefits for improving quality of care derive from the opportunity for health and care professionals to learn from any cases where the quality of care could have been better and to promulgate learning."*	**i.** Please provide any documents available explaining the full procedure for the implementation of the RM & MRs? **ii.** What training will staff be provided with for these RM & MRs reviews? **iii.** Will the consultant reviewing the death be the consultant involved in the care? **iv.** Will the M&M Review Meetings be minuted?
Q17 answer	i. The RM&MRs has been developed by and is the property of the DoH. ii. The RM&MRs has been developed by the DoH and a complete answer to this question should be obtained from them. The amount of training for the implementation of the RM&MR system will be reduced for the BHSCT because it has been using a very similar system since 2013 and has already organised the setting up of 46 M&M teams. A detailed 'guidance' document has been produced by the DoH with input from all 5 Trusts. Funding has been provided for an Implementation Facilitator to help with training. iii. The RM&MRs has been developed by the DoH and a complete answer to this question should be obtained from them. The Consultant involved in providing care to patients who have died will obviously take part in reviewing their death. Both to provide information and also to be part of the learning process, if there is any learning to be had. The M&M review process is one where a whole team of staff peer review the circumstances surrounding the death including any learning lessons and actions that need to be taken to prevent any repeats of any errors. This can include referring the death for further review by involving the incident reporting system (SAI). The Consultant involved would not in this case be on the investigating team. iv. The RM&MRs has been developed by the DoH and a complete answer to this question should be obtained from them. Yes.	

16 (2)	**Chairman:** *"she [Staff Nurse McRandal] then said: "It is still not normal to measure urine output on the Allen Ward, but it is on other wards" ... Can you help with that?"* **Brenda Creaney***: "Yes. That is a matter of concern ... Subsequent to the evidence given last year, it became apparent to us that our policy wasn't explicit enough in that regard ... we have revised the policy"* **Transcript 12th November 2013 p.50 L.9 et seq BHSCT Evidence**	**i.** What is the revised policy? **ii.** When did the revised policy come into effect? **iii.** How is compliance with the revised policy being monitored and evaluated? **iv.** What procedures does BH&SCT currently have in place to identify any similar non-compliance through 'ambiguity'/'lack of clarity'?
Q16 (2) answer	i. Copy revised policy attached.  See Document 401-001x Policy for recording fluid prescription and ii. The revised policy came into effect in February 2015. iii. Since September 2013, a weekly audit - *Paediatric IV Fluid Audit and Improvement Tool* (PIVFAIT) has been undertaken in all inpatient wards in RBHSC. The purpose of the audit is to challenge practice in real time to ensure the safe administration of IV fluids to children in our care. The audit is as follows: • Ward based • Weekly audit by Ward staff • Patient identification • Patient weight • Daily fluid calculation guidance • Electrolyte monitoring • Glucose monitoring • Cumulative input and output totalling and Fluid balance • 12 hour reassessment The audit has evolved following extensive trialling both locally and regionally and we are currently using version 10 of the tool which will be superceded by version 13 in September 2016. It has recently been presented to CMO Medical Leaders	

Forum for regional implementation. The audit monitors multidisciplinary compliance and is presented monthly at the Clinical Directors' meeting, Sisters' meetings and is circulated widely within RBHSC to all clinical teams. This audit is also discussed and reviewed monthly at the Directorate patient safety meeting.

Attached is the audit data from September 2015 - June 2016.

401-001ao

CMO MLF PIVFAIT 07_03_2016.pptx

401-001ap

FBC Audit breakdown June 201

401-001aq

PIVFAIT Audit tool V0 13.xlsm

401-001ar

Paediatric FP&B chart - Overall month

All staff have training every three years as outlined in the BHSCT Policy.

Hyponatraemia training is a key element of induction for both medical and nursing staff.

At the end of year to March 2016 are 90% of nurses had up to date training, with all training in the process of being updated for 2016. This is monitored and reviewed monthly by the Assistant Service Managers (ASM) and Quarterly by the Associate Director of Nursing (ADON) and ASMs at accountability review to ensure compliance.

iv. A review date is specified within each policy, and in addition policies may be modified at any time in response to issues identified in the audit process as discussed in iii) or learning identified through other routes. Policies are a standing item at the IV Fluid and Electrolyte Group which meets every two months.
The Standards and Guidelines Committee meets every other month as does the Policy committee. Both of these group scrutinise policies under review and will challenge seek clarity if the content is not clear.

17 (2)	**Colm Donaghy** *"In relation to serious adverse incidents ... We have recently strengthened our corporate arrangements by establishing a learning from experience steering group chaired ... by the deputy chief executive"* *"We have the HSCB Procedure for the Reporting and follow up of Serious Adverse Incidents (Oct 2013)".* **Transcript 12th November 2013 p.11 L.2-9 BHSCT Evidence**	**i.** Please provide the current version of 2013 Health & Social Care Board procedure for reporting and following up serious adverse incidents. **ii.** What are the 'strengthened corporate arrangements' referred to? **iii.** Does the 'learning from experience steering group' issue reports and/or make recommendations? **iv.** If so to whom? **v.** What benefits has it brought and how are they measured and assessed?
Q17(2) answer	i. Regional SAI Policy enclosed. Please note elements of this Policy have subsequently changed regarding the removal of the criteria to report all child deaths from 1st February 2016. Some of the appendices were subsequently updated. The HSCB notified Trusts via email but the policy in its entirety was not updated and re-issued. ii. The Learning from Experience Group is chaired by the Deputy Chief Executive and meets every two months. This group oversees all learning that is being shared within the Trust. The Learning from Experience Group reports to the Assurance Group and through to Assurance Committee and Trust Board within the Assurance Framework. iii. The Learning from Experience Group approves learning to be shared from SAI reviews, complaints, mortality and morbidity review meetings, litigation cases and case management reviews. The Learning from Experience Group provides an update report quarterly to Assurance Group. iv. Learning can be shared Trust wide or within specific specialty areas as appropriate. v. The terms of reference and an example of a Shared Learning Template are enclosed. The aim of sharing learning is to inform staff of learning outcomes following an adverse event in the provision of care to our patients. Where possible system processes and issues are addressed to prevent the incident reoccurring and in the least the sharing of learning will make Trust staff aware of an incident and how it occurred. The Trust also has a Sharing Learning Policy to support these processes. Attached. Where applicable learning is	

	submitted to the Public Health Agency for consideration to be shared across the region.  Item 5.1.3 Shared Learning re SAI 16 01 401-001as  Policy for sharing learning Apr 16.pdf 401-001at  HSCB Procedure for the reporting and foll 401-001au	
18	**Colm Donaghy** *"... there have been one or two instances that have arisen where we believe applying the serious adverse incident process could potentially cause further hurt or trauma"* p.33, L.17-20 **12th November 2013** *"... we're in discussion with the Health & Social Care Board for example around those sorts of areas and there may be another way".* **Transcript 12th November 2013 p.34 L.5-7 BHSCT Evidence**	**i.** What was the result of those discussions in terms of 'another way'?
Q18 answer	Child deaths were removed from the SAI criteria form 1st February 2016. There is a new regional process for reporting child deaths to the Public Health Agency. A form is issued to the Public Health Agency within 12 weeks of the death of the child. Since February 2016, all Trusts in Northern Ireland have implemented a Child Death Notification process. This enables Trusts to report all child deaths to HSCB without the need to use the Serious Adverse Incident (SAI) process. Following notification, the child's case is recorded on the Trust M&MRS database and put forward for discussion at the next available M&M meeting as described in response to question 12. Attached is the flow chart describing the process for child death notifications in RBHSC.  HSS MD 1 2016 Process for Reporting Unexpected deaths continue to be reported in line with the Serious Adverse Incident policy. All the necessary details are included within HSS(MD) 1/2016 (attached above).	

19	*"... our SAI board ... brings together all of the SAIs within the organisation – and other incidents as well – and looks to see if there's any trend or any issues that we need to learn from"* *"Annual Report for BH&SCT (2014/2015) sets out an 'Assurance Sub-Committee Structure' (p.80), starting with the Board and going on to an 'Assurance Group', on to a 'Learning from Experience Steering Group' and finally to an SAI Group."* **Transcript 12th November 2013 p.38 L.15-19 BHSCT Evidence**	**i.** How does the 4 tier structure operate in practice and over what time frame does it consider incidents?
Q19 answer	i. Please see attached Board Assurance Framework structure diagram for an outline of the reporting arrangements for SAI Group – Learning from Experience Group – Assurance Group – and Assurance Committee which has delegated authority from Trust Board. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled. This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation. SAI Group meets monthly but incidents and SAIs are managed on a daily basis by the Corporate Governance team in conjunction with Directorates. Learning from Experience Group meets every two months to review and share learning from SAIs, complaints, mortality and morbidity review meetings, litigation cases and case management reviews. A formal report on both Incidents and SAIs is approved quarterly at Assurance Committee. Trust Board meets monthly and has Emerging Issues as a standard agenda item which is an opportunity to consider any urgent issues concerning SAIs. When an incident occurs if there is immediate learning to be shared to ensure service delivery is safe and not compromised, this is done so by the Directorate.  401-001aw Item 5.2 Board Assurance Framewor	
20	**Chairman's letter to BH&SCT (27.03.14) – re June 2013 'Learning Report' (348-001):** *"it does not address a more fundamental and worrying*	**i.** How is the Trust addressing this given it makes the largest number of SAI reports and has the premier Children's

	point, namely, whether there is any consistency in identifying and categorising adverse incidents".	Hospital?
Q20 answer	The Trust has an Adverse Incident policy and associated procedures established the SAI procedure in included in these documents. The policy includes a regionally agreed risk matrix which has been adopted by all Trusts in the region and HSCB. The matrix supports a consistent approach to grading of incidents and is also used for grading complaints and claims. The Incident policy and procedures are widely available on our Hub and form the basis for our internal incident training, this supports a consistent approach to identifying and categorising adverse incidents. The BHSCT uses 3 tier coding structure called CCS (Common Classification System) which is built into the Datix software and is standard across all Datix users world-wide. All Trusts in the region and HSCB used this software. Tier 1 of the coding structure is the 'Category' and these consist of broad domains of incidents, tier 2 is 'Subcategory' which are subordinate domains and tier 3 is 'Detail' and provides further breakdown. Within Belfast the Corporate Governance admin team code each incident using these 3 tiers. These staff are trained and have established quality assurance procedures for all Trust incidents and will routinely query with the Service Directorates any incident which appears to meet SAI reporting criteria. In 2014 The Department of Health commissioned a review into a Regional Learning System. The Trust fully engaged in the review and provided detailed information in relation to the coding and classification system, policies and procedures and views of staff. This information was subsequently reflected in the final report along with findings from other Trusts. The recommendations were brought to the Regional Governance Leads Group in Dec 2015 by Colleagues from PHA/HSCB, with a specific request from the Department to consider what could be progressed at no cost. The Group, comprising of Governance leads from each Health & Social Care Trust together with HSCB /PHA representatives have collectively considered and reported Department representatives in July 2016 which recommendations would have associated costs to progress, those with no cost and whether work to address each was possible within a short, medium or long timeframe. There are several recommendations which will lead to improved consistency in identification and categorisation of Adverse Incidents across the region. It is anticipated that the following recommendations can be progressed in the short term (approximately 6 months) at no significant extra cost and there is agreement in principal these will be progressed during 2016/2017 year. i. Review the definition of an adverse Incident ii. Review and agree datasets, including codes and classification within services and then regionally to ensure consistency of reporting (Trust/HSCB/PHA) iii. Develop and agree regional adverse Incident Guidelines & procedures across the HSC (Trust/HSCB/PHA) A number of additional recommendations in this report could also support improved consistency however each would have an associated cost, for which funding has not yet been identified.	

	Whilst the proposal to progress the no cost recommendations is not yet formalised (July16) BHSCT is fully engaged and supportive of this. In relation to SAIs and specifically those involving children, if a Serious Adverse Incident is identified it will be reported in line with substantive procedures. If BHSCT believe an incident to have occurred outwith BHSCT the other organisation will be informed and an interface notification is submitted to HSCB in line with substantive procedure. BHSCT will support any review as required and Trusts communicate closely in relation to incidents that interface across Trust Boundaries. Following review of the SAI process from February 2016 child deaths are only reported via this route if the incident meets the revised definition and criteria. The current HSCB reporting form includes a requirement to record the CCS code. HSCB will have an overview of CCS codes provided regionally for SAIs.	
21	*BH&SCT reports* **(348-002)** *that the "4 week timeframe for investigation ... is insufficient to involve family in the review at such a difficult and traumatic time"*.	**i.** How this being managed by the Trust?
Q21 answer	i. Each child's case is considered on an individual basis. Typically, where an expected death occurs, families will be contacted approximately six weeks after the child has died to invite the family to meet with members of the clinical team to discuss the circumstances of the child's death. This also gives families an opportunity to clarify any points they may have and ask questions of the clinical team. With an unexpected death, again, cases are considered on an individual basis. As described in response to question 5, the investigating team offer families the opportunity to meet with them. Depending on the family, this meeting could occur within weeks. However, there has been a case where a family felt unable to meet with the team until after the first anniversary of their child's death. Timescales for the completion of investigations and reports is monitored by the Directorate Governance Manager, Service Co-director, Trust Risk and Governance Department which reports to the SAI review group and through to the Trust Assurance Committee. Regular updates on progress and reasons for any delay in providing a final report are also provided to HSCB	
22	*RQIA's report of December 2014 of SAIs refers draft guidance "currently at the final stages of consultation" for HSC organisations on "engagement with*	**i.** *What a*ction has been taken by the Trust regarding engagement with families?

	patients, clients and families as part of the SAI process" (para.2.2, pgs.3-4)	
Q22 answer	As per Engagement Checklist – the Trust adheres to regional policy and monitors the completion of the checklist and also any case where families / carers / service users have not been advised a SAI has been reported.	
23	HSCB: A Guide for Health and Social Care Staff – Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident (January 2015), provides guidance on apologies (p.9, 3.3)and on the involvement and services of the Patient Client Council (Appendix 2, p.27)	**i.** How is the implementation and effectiveness of this guidance being monitored?
Q23 answer	This guide from the HSCB has been adopted into Trust policy and practice. The guide was discussed at SAI Group on 24th February 2015 and it was agreed that the Trust SAI leaflet should be amended to reflect content. The leaflet contained in the HSCB guide has been adopted into a Trust leaflet which is routinely provided to all families following an SAI, please see attached at question 8. The Trust Being Open Policy covers how Trust staff should say sorry when things go wrong.	