2.022

Belfast Health and Social Care Trust

Reference No: SG 17/12

Mortality and Morbidity policy – learning through recording, reviewing, monitoring & analysing deaths.				
Author(s)	Dr JR Johnston Co-Chair, Standards and Guidelines Committee			
Ownership:	Dr AB Stevens, Medical Director			
Approval by:	Standards and Guidelines Committee		**Approval date:**	S+G 17/5/12 PC 21/5/12
Operational Date:	April 2012		**Next Review:**	April 2015
Version No.	V1	**Supercedes**	Legacy policies	
Links to other policies	Guidance on actions to be taken after a patient's death			

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

There are many different methods available for studying adverse events and hazards that arise within a healthcare system and each has its strengths and limitations. Their primary aim is to reduce the incidence of these incidents through learning from past experience.

A study of mortality and morbidity (M&M) is one of the oldest quality assurance approaches in health care. It has become increasingly important for trusts to demonstrate that they are systematically and continuously reviewing patient outcomes and especially mortality and morbidity.

Scrutiny of mortality rates and concerns about patient safety have intensified with the extensive coverage of investigations into NHS hospital failures e.g. Francis report - Mid-Staffordshire NHS Foundation Trust, 2010. The Health Care Commission (now Care Quality Commission), in its review of the Mid Staffordshire Trust, found that the Trust did not know about key issues in mortality and was not able to provide convincing evidence that it was capable of finding these out or taking action as a result. Recommendations from these hospital inquiries have led to an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

A recent study by the National Institute for Health Research[1] indicated M&M meetings did not always identify whether a death was unexpected; they lacked a systematic and standardised mechanism for highlighting contributory factors & corrective measures and few recorded proceedings or action plans.

For M&M meetings to focus on quality improvement, they need a systematic and transparent way to examine the causes of a patient's death, highlight contributory factors and identify what can be done to prevent recurrence of avoidable errors.

Furthermore some M&M meetings reported issues to their clinical governance and risk committees, but there was no reporting framework between these committees and the Board regarding mortality data. Because the public focus on patient safety increases, Boards need to be assured that the deaths that occur in their hospitals are not the result of unsafe care in the services they provide. As high quality of care in healthcare organisations occurs when Boards have oversight of data associated with monitoring clinical quality and safety, outcomes from M&M meetings could contribute to the intelligence that the Board receives for assurance. This could be done by having high level mortality monitoring performed by a Mortality Review Group (MRG) with onward reporting through the Assurance Framework.

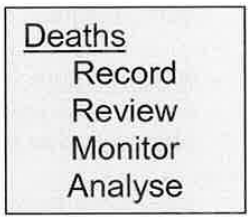
1.2 Purpose

The aim of this policy is to set out clear roles and responsibilities and procedures to ensure that all deaths occurring throughout the BHSCT will be recorded, reviewed, monitored and analysed.

This will ensure that:

A. The details of every death are **recorded** in the patient's clinical record as well as the circumstances surrounding that death.

B. Clinical staff (doctors, nurses, midwives & allied health professionals), throughout the BHSCT, will systematically **review** deaths in their service and, through learning, assure their service is safe and outcomes improve.



C. **Monitoring and analysing** mortality collectively throughout the Trust will provide assurance that the Trust is doing all it can to learn from episodes of care where death or harm have occurred during the course of providing care.

1.3 Objectives:

This policy will ensure in a practical, feasible and thorough manner that:

- the details of every patient death in a BHSCT hospital noted in the clinical record.
- where a death certificate or stillbirth certificate is issued, those details are copied into the clinical record using the BHSCT Mortality Review Form (appendix 1).
- every patient death has the capacity to be part of the mortality and morbidity scrutiny and learning process.
- there is consistency of approach to the review of patient mortality and morbidity within BHSCT and for that approach to be as multi-disciplinary as appropriate and possible.
- the outputs of any such reviews are structured to aid learning.
- the outputs of any such reviews are clearly documented and archived.
- clear reporting mechanisms are in place, to escalate areas of concern identified by M&M meetings, so that the Trust is aware and can take appropriate action.
- existing arrangements and mechanisms for monitoring adverse events will be linked to this analysis of mortality.

2.0 DEFINITIONS/SCOPE OF THE POLICY

2.1 Scope

This policy will apply to all staff in all specialities and all deaths throughout the hospital - secondary care areas - of the Trust. It will not apply to community areas.

2.2 It is primarily concerned with the certification of death & stillbirth or referral to the Coroner and the review of & learning from the causes of death rather than the process of verification of death.

2.3 Definitions:

Mortality – for the purpose of M&M meetings, mortality relates to all deaths occurring in secondary care in the BHSCT ranked by ward, team and/or specialty.

Morbidity – relates to adverse outcomes.

Complication: an additional problem that arises following a procedure, treatment or illness, is secondary to it and complicates the situation. Details of 'Clinically coded complications' are available from the Clinical Coding Dept.

Misadventure - Any injury or adverse reaction resulting from any medical treatment. Some examples are medication errors, IV infection, surgical mistakes and postoperative septicaemia. Details are available from the Clinical Coding Dept.

Avoidable/Preventable – these terms are used interchangeably in the NHS and for the purpose of this policy, 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.

Mortality & Morbidity Meetings (M&Ms)
M&M reviews are a systematic activity designed to enable clinicians and managers at any level (preferably multidisciplinary) in the Trust to understand and learn from the underlying conditions that lead or contribute to death or harm to patients.

There is review and discussion of clinical cases, outcome data (clinician and patient reported) and related information (e.g. complaints, complications, misadventures, SAI or other benchmarking data).

Mortality and morbidity do not have to be reviewed in the same meeting.

Mortality reviews focus on the events of and learning from episodes where death has occurred.

Morbidity reviews could include the examination of re-admission rates, returns to theatre, specific complications of procedures, infections, falls or even prolonged length of stay. Morbidity reviews will vary from specialty to specialty.

3.0 ROLES/RESPONSIBILITIES

3.1 Trust Board

The Trust Board will receive reports on mortality (and morbidity) that provide assurance that safe and high quality care is being provided throughout the BHSCT.

3.2 Medical Director,

- carries overall responsibility for ensuring the BHSCT approach to the review and analysis of mortality is implemented both consistently and comprehensively.
- is responsible for supporting the M&M review process ranging from individual case reviews to that of amalgamated specialty data.
- will ensure that patient safety initiatives support a systematic review of case note samples, using the Global Trigger Tool, to detect adverse incidents, reviewing with mortality data and monitoring trends in related harm.
- will chair a regular Mortality Review Group (MRG) meeting.
- will ensure that the outcomes and learning from M&M reviews is routinely discussed at the Mortality Review Group and, if necessary, the Safety and Quality Steering Group (SQSG).
- is responsible for dissemination of the findings of the review process onwards, ultimately to the Board.
- will respond to external enquiries about mortality.

3.3 **Directors** are responsible for:

- ensuring all deaths are recorded within Directorate.
- ensuring that appropriate multi-disciplinary M&M meetings take place in all specialities and for holding a list of M&M / Audit meetings within their Service Directorates.
- establishing a reporting process from M&Ms; primarily up to their AMD and Directorate and then for further escalation as appropriate.

3.4 **AMDs** are responsible for

- review of Directorate and specialty specific mortality on a regular basis.
- ensuring appropriate multi-disciplinary M&M (audit) meetings take place in each Speciality.
- identifying a M&M (audit) meeting Chair(s).
- ensuring the appropriate escalation process which would initially be to the AMD.

3.5 **M&M (audit) Chairs** are responsible for ensuring:

- appropriate attendance by all relevant disciplines and professional groups.
- every death recorded within their specialty area could be part of a mortality review process.
- If indicated, reviews are undertaken of deceased patients and reported at meetings using the BHSCT Mortality Review form (appendix 1).
- Agenda setting.
- Minutes are taken and archived.
- Collation of review findings, learning points and actions for improvement for each M&M meeting.
- Reporting M&M findings to AMDs / CDs and Directorate.
- Escalating upwards any areas of concern.

3.6 **Medical staff**

- All consultant medical staff are required to participate fully in the M&M process.
- All medical staff are expected to participate fully in all M&M meetings that are relevant to their practice

3.7 **Nurses, midwives, allied health professionals and other clinical staff**

All healthcare professionals should be involved in M&M reviews, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

Midwives may complete stillbirth certificates and therefore may initiate the BHSCT Mortality review process – appendix 1.

4.0 KEY POLICY PRINCIPLES

Following a review of practice in the UK and mirroring changes occurring in Trusts since the Mid-Staffordshire reports, this policy details how deaths occurring throughout the BHSCT will be recorded, reviewed, monitored and analysed. It outlines the processes to be undertaken by

- individual clinicians,
- the teams they work in and
- by the BHSCT as a whole.

While it is accepted that not all deaths occur as a result of an adverse incident or harm and many are not unexpected, the essence of this policy is that each death should have the capacity to be part of a mortality and morbidity review by clinical (doctors, nurses, midwives & allied health professionals) staff as well forming the basis of ongoing monitoring and analysis. The whole process is designed to be practical, feasible and thorough.

4.1 The details of every death in the BHSCT will be entered onto a BHSCT Mortality Review form (appendix 1) shortly after death; a printed copy of which will be kept in the clinical notes.

Record details :-	
Part I	• **cause of death or stillbirth, at or around the time of death.**
Part II	• **surrounding death, complications +/- misadventures.**
	• **M&M review.**

4.2 Every death in the BHSCT will undergo a consideration of

- the cause of death and
- whether there were any
    - complications.
    - misadventures.
    - compliance with any triggers (table 1) indicating further review.

Ordinarily, this will occur on the next 'working' day.

4.3 Every death in the BHSCT must have the capacity to be reviewed at a mortality and morbidity scrutiny and learning process. The triggers detailed in table 1 should be used to aid the selection process to become part of the review. However, when it is obvious there have been no complications and perhaps when death was expected and there are no learning points to be garnered from scrutiny, a death may not become part of the M&M review process. Some departments may have many such deaths and may chose to study randomly selected deaths. On the other hand, some departments routinely examine every death.

Notwithstanding this, those deaths which do fulfil any of the criteria as set out in table 1 must be reviewed at the next M&M review meeting.

The exact process and level of detail will depend on the clinical details of each case with, for example, unexpected deaths receiving greater scrutiny than expected deaths.

The BHSCT Mortality Review form will be used to record details of that review.

4.4 Where the death relates to a reported / reportable incident, an Incident Report form must be completed and the death must be reviewed. This should be flagged up to the Line Manager and the Risk and Governance department.

4.5 In normal circumstances, all individual reviews of in-hospital deaths should be carried out within 6 weeks of a patient's death. Where cases are referred to the Coroner or subject to police investigation, this timescale may not be possible.

4.6 The details of every BHSCT Mortality Review form will be collected by the Clinical Coding Department, collated and analysed. This will be presented to the relevant Directorate, at the Mortality Review Group (MRG) and, if necessary, SQSG meetings.

4.7 M&M meetings

M&M meetings need to:

1. Review the record of all deaths.
2. Using the trigger list (Table 1), identify suitable cases for closer examination.
3. Have a systematic and standardised format.
4. Review any contributory factors associated with these deaths.
5. Formulate learning and action plans if required.
6. Record and archive the meetings.
7. Report findings through their AMD & Directorate and then upwards to the MRG.

4.8 Requirements for M&M meetings

Each M&M group should identify and confirm with the AMD:-

- Chairman.
- Terms of Reference / Objectives.
- Frequency of meetings – may depend on frequency of deaths.
- Membership – (multi-disciplinary and multi-professional).
- Working arrangements with other Specialty M&M groups and frequency of joint meetings.
    - Surgical Specialty M&M Groups should agree working arrangements and joint meeting frequency with Anaesthesia and vice versa.
- Working arrangements with other Quality Groups within Service Directorate.
- Arrangements for minutes / notation / archiving.
- Mortality 'inclusion/exclusion' criteria for routine patient case note review.
- Morbidity (e.g. complications and misadventures) 'inclusion/exclusion' criteria for routine patient case note review.
- BHSCT Mortality Review Form to be used.
- Completion of M&M Review Form and collation of finding, learning points and actions from each meeting.
- Storage and retrieval of minutes in line with the Trust requirements.
- Reporting arrangements, especially when there are several groups (e.g. anaesthetists and surgeons) and to include escalation of concerns.

4.9 Review and learning

Specifically, clinical staff will:

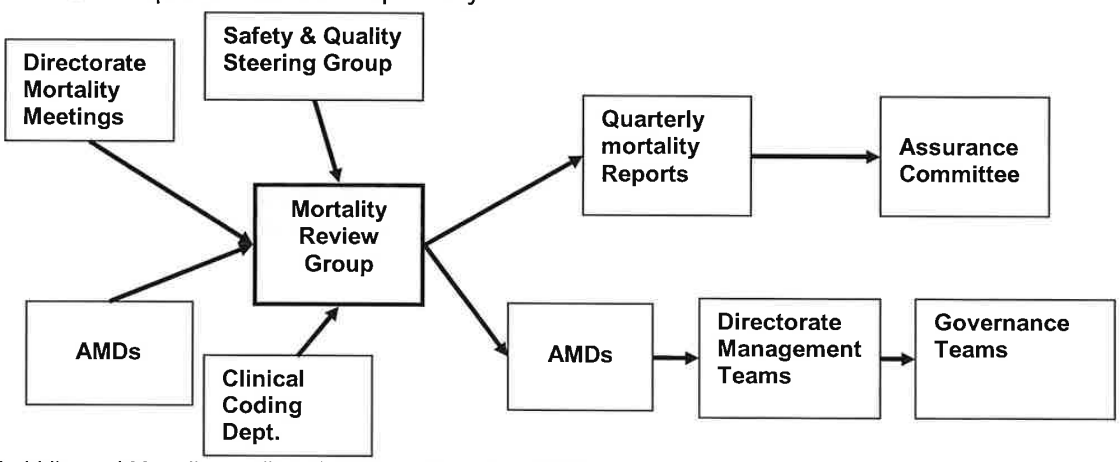
- attend mortality and morbidity review meetings.
- contribute knowledge and experience to those meetings.
- openly look for prevention strategies, without resorting to blaming others.
- help colleagues to deliver safer care on the basis of what has been learned, by building safeguards into existing practice and challenging practice that has been demonstrated to be unsafe.
- look to improve and standardise palliative care for patients and their families.
- be able to provide evidence of how they have used learning from M&M reviews at their individual appraisal or team performance review meetings

4.10 Mortality Review Group

The Mortality Review Group (MRG) will

- consist of the
    - Medical Director
    - Director of Nursing
    - Deputy Medical Director
    - AMDs
    - Risk and Governance
    - Director of Performance
    - Co-Chair of Standards and Guidelines
    - Clinical Coding Department

- function as an overview group for monitoring mortality.
- ensure the Trust's stance on mortality surveillance is one of total vigilance and includes examining clinical processes, coding architecture and follows evidence based improvement strategies.
- use information from regular reporting groups such as M&M meetings, clinical coding dept and ensure this flow has centralised co-ordination.
- harmonise trust wide mortality review processes by actively encouraging greater coordination between the clinical M&M review of individual mortality and the centralised clinical coding assessment of mortality.
- Set out the background to the HSMR and chart the Trust's previous and current performance.
- ensure the underlying clinical coding data which constitutes the HSMR is robust and reliable so that the Board and clinicians have absolute confidence in the data.
- understand the reasons behind the Trust's current HSMR and evolve change strategies.
- enable Trust leadership to identify whether any problems are administrative or whether further clinical investigation is necessary in specific areas.
- Use regular case note review techniques [Global Trigger Tool (GTT)] to identify avoidable deaths.
- Use Hospital Standardised Mortality Rates (HSMR) and individual mortality data to help shine a light on potential areas for further analysis or investigation.
- make recommendations based on the findings of all of the above.
- ensure there is dissemination of lessons learnt and derive organisational learning from these multiple assessments of mortality.
- explore and learn from other organisation's mortality review processes that have successfully reduced mortality rates.
- Report to the Board quarterly



5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy requires dissemination throughout the Trust, especially to patient areas.

5.2 Resources

These will be needed for audit leads and the hosting of the BHSCT mortality review form on the Intranet.

6.0 MONITORING

Monitoring of this policy will be done by

- comparison of the mortality returns from the wards and that obtained from the Registrars returns to the General Register Office.
- audit comparison using the Global Trigger Tool.

7.0 EVIDENCE BASE / REFERENCES

Mortality and Morbidity policy - Leeds Teaching hospitals NHS Trust - September 2009
Mortality & Morbidity Reviews Policy – University Hospitals of Leicester - January 2011.
Guidelines for Morbidity and Mortality review meetings – The Royal Children's Hospital, Melbourne – March 2010.
Departmental Mortality Review – The Royal Children's Hospital, Melbourne – March 2010.
Board Assurance Report on Hospital Mortality : Royal Wolverhampton Hospitals; Feb. 2011

1. J Higginson, N Fulop and M Marrinan. NIHR King's Patient Safety and Service Quality Centre. March 2011. Mortality and morbidity meetings: a study of the structure, format and reporting framework in a hospital setting. ISBN 978-0-9568550-0-8.

8.0 CONSULTATION PROCESS

Medical Advisory Group, Safety & Quality Steering Group, Policy and Standards and Guidelines Committees, Mortality Review Group

9.0 APPENDICES / ATTACHMENTS

Flowchart
Appendix 1 = BHSCT mortality review form
Table 1 = Triggers for M&M Review of Deaths

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

No Impact

SIGNATORIES

Name
Title

Date: _____June 2012____

Name

Date: ___June 2012_____

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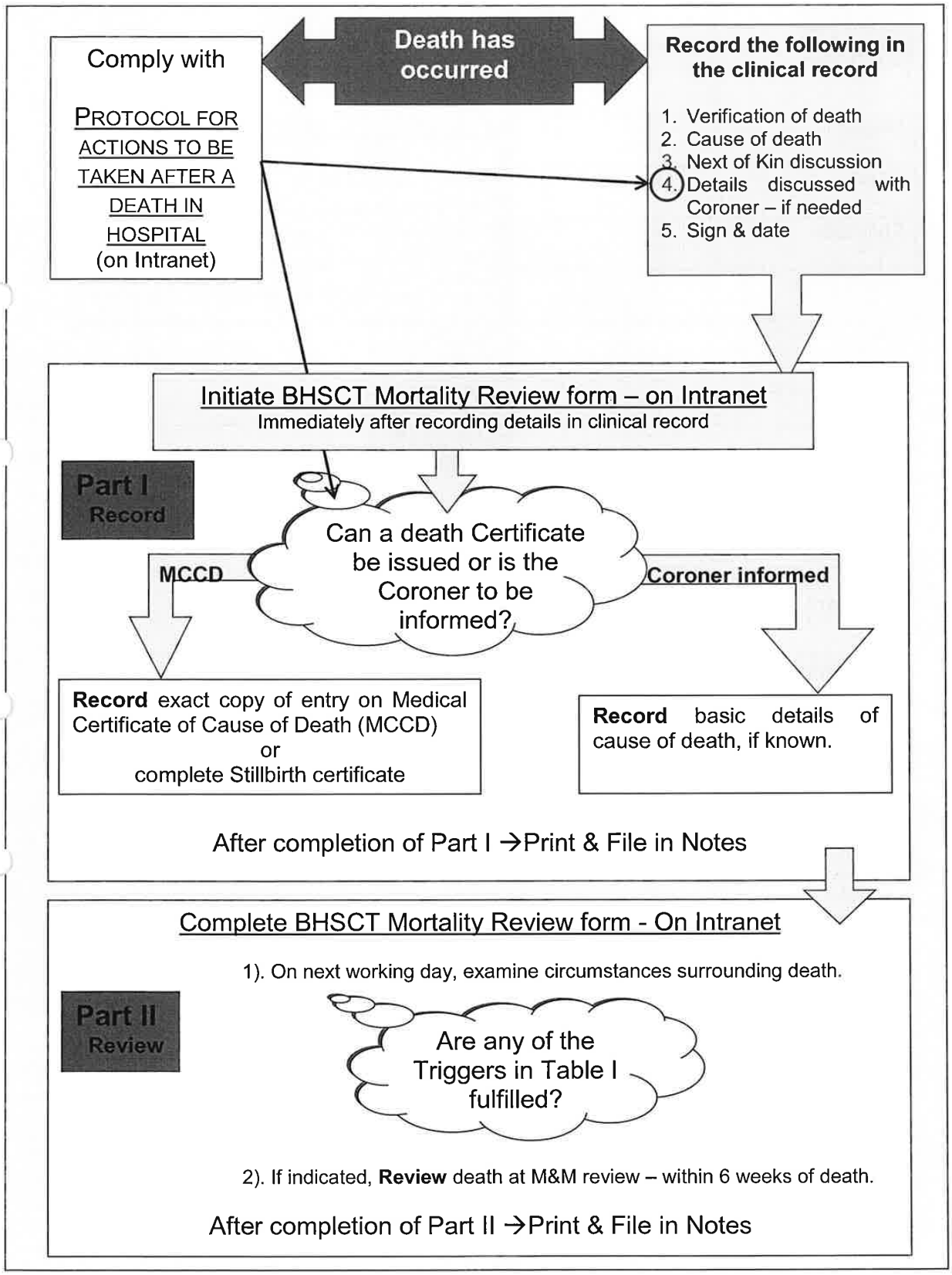

Belfast Health and Social Care Trust

Appendix 1.

Part I **BHSCT Mortality Review form**
to be completed for all patients who die – AT or AROUND TIME OF DEATH

Hospital		Use addressograph-otherwise write in capitals Surname: _____ First names: _____ Consultant: _____ Ward: _____ Hospital no: _____ DOB: _____ Health and Care no: _____	
Ward			
Specialty			
Consultant			
Date of Death		**Time of death**	
Printed Name		**Signature**	
Grade		**GMC / NMC number**	

Admission Diagnosis:	
Cause(s) of Death: (if known)	

Following death:	**Death Certificate issued →** If Yes →record copy of MCCD details below	Y or N
	Death Certificate – a Coroner requested proforma issued If Yes → record details in Clinical Notes	Y or N
	Coroner informed – for post mortem If Yes → record details in Clinical Notes	Y or N
	Stillbirth Certificate issued → If Yes →record copy of SBCD details below	Y or N

Medical Certificate of Cause of Death

	Details on Death Certificate	
	Cause of Death	**Interval**
Ia		
Ib		
Ic		
II		

Issued by:		**GMC number:**	

Stillbirth Certificate

Part I	**Certificate of Still-birth** **To be completed in respect of a child which has been completely expelled or extracted from its mother after the twenty-fourth week of prefnancy and which did not at any time after such expulsion or extraction breathe or show any other evidence of life.**

I was present at the still-birth →			Y or N
I have examined the body of a child which I am informed and believe was born			Y or N
at			
on		**to**	
of			

I hereby certify that:

The child was not born alive	Y or N
The sex was	M or F

To the best of my knowledge and belief the cause of the still-birth and estimated duration of pregnancy were as stated below:

Cause of the still-birth	
Ia	
Ib	
Ic	
II	
Estimated duration of pregnancy (weeks)	
Weight of foetus	

Insert a tick in the appropriate box

☐ 1. **The certified cause of the still-birth has been confirmed by post-mortem**

☐ 2. **Post-mortem information may be available later.**

☐ 3. **Post-mortem not being held.**

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Part II	**BHSCT Mortality Review form** **Complete the following for all patients – ON NEXT 'WORKING' DAY.**

Was death the likely or anticipated outcome *on admission*?	Y or N
Was the patient entered onto a Palliative Care Pathway?	Y or N
Did the palliative care team see the patient?	Y or N
Was an adverse incident identified? Document details in the notes.	Y or N
Incident Form Number?	
Are any of the Triggers in Table I fulfilled?	Y or N
If YES, complete a M & M review within 6 weeks of death.	

Complete the following after M&M review

Date of M&M Meeting :		**Chairman.**	
Summary of M&M discussion:			

Learning Points and Actions

Learning point / Issue	Action to be taken	Person Responsible	Due Date

Table 1. Triggers for M&M Review of Deaths

Departments, Units, Areas, Specialties & individual clinicians will review deaths when the following triggers apply:-

1. It is Area, Unit or Specialty policy to review all deaths.

2. Unexpected death e.g. following
    - fall in hospital.
    - pulmonary embolism.

3. Following Complications / Misadventure / Incident. The following are examples:-
    - Due to treatment / procedure / operation.
    - Cardiac arrest / crash calls.
    - Medicine related incident e.g.
        - prescription error.
        - over coagulation related to warfarin prescription.
    - Surgical
        - Unplanned return to theatre.
        - Change in planned procedure.
        - Unplanned removal / Injury/ repair of organ.
    - Infection
        - MRSA bacteraemia.
        - C. difficile.
        - VRE (vancomycin-resistant enterococcus).
        - Wound infection, deep surgical sepsis.
        - Nosocomial pneumonia.
    - Readmission to Intensive Care or High Dependency Care.
    - Unplanned transfer to Intensive Care or High Dependency Care.
    - Readmission within 30 days of previous hospitalisation.

4. Elective admission – except cancer / haematology.

5. All deaths in low risk HRGs i.e. unexpected. For example,
    - Minor ENT procedure
    - Tonsillectomy
    - Hernia Repair
    - Arthroscopy
    - Minor skin procedures
    - Vasectomy
    - Varicose vein surgery

6. All paediatric (18 years or less), Neonatal, Obstetric.

7. Cases referred to the Coroner's Office.

8. Complaint(s) received which is M&M related.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 17/12

Title:	**Guidance for the Regional Mortality and Morbidity (M&M) process:** recording, reviewing, monitoring and analysing hospital deaths at Specialty Mortality Review and Patient Safety meetings (SMR&PSm).			
Author(s)	BHSCT author – Colin McMullan - Senior Manager, Risk and Governance Regional Authors: Dr Julian R Johnston, Medical Adviser, Death Certification Policy and Legislation Unit, DoH. David Best, Head of Death Certification Policy and Legislation Branch, DoH. Sharon Wright, Death Certification Policy and Legislation Branch, DoH.			
Ownership:	Dr Cathy Jack, Director, Medical; Directorate			
Approval by:	Policy Committee Executive Team		**Approval date:**	07/06/2017 28/06/2017
Operational Date:	July 2017		**Next Review:**	July 2022
Version No.	V 2	**Supercedes**	V1.2 – April 2012-2015	
Key Words:	Mortality, Death, Morbidity, M&M lead, M&M meeting			
Links to other policies	Trust Policies for - Actions after a Patient's Death, Verification of Death, Contacting the Coroner, '*Being Open'*, Adverse Incident Reporting & Management, Shared learning.			

Date	Version	Author	Comments
08/12/2015	0.1	Lauren Megahey	Initial Draft
18/08/2016	1.1	JRJ	Changes 4.3.9, 4.4
25/8/2016	1.2	JRJ	DB, Regional Consultation comments
01/09/2016	1.3	JRJ	CB comments, appendix 2; 4.3.9
14/10/2016	1.4	Sharon Wright JRJ	4.3.9 Changes to Outcome gradings Appendix 3 – Ground Rules
02/11/2016	2.0		Final Version from DoH
07/06/2017	2.0	P Connolly	4.1 Change to table, 4.6 changes to shared learning process.

Contents

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

There are many different methods available for studying adverse events and hazards that arise within a healthcare system and each has its strengths and limitations. Their primary aim is to reduce the frequency of these incidents through learning from past experience and changing practice.

A study of mortality and morbidity (M&M) is one of the oldest quality assurance approaches in health care (appendix 1). It has become increasingly important for Trusts to demonstrate that they are systematically and continuously reviewing patient outcomes and especially mortality and morbidity.

There is a wide variation in how mortality and morbidity (M&M) cases are discussed across different hospital specialties and different Health and Social Care Trusts. There is a need for a standardised approach.

1.2 Purpose

This policy's prime aim is to provide,

- specific guidance for M&M leads; and
- regionally agreed guidance on how M&M meetings should be established, structured, managed and assured across all hospitals within Northern Ireland.

It aims to reduce variation across Trusts regarding the role of M&M leads and the structure and format of M&M meetings. This is in order to ensure consistency so that M&M meetings are effective, produce shared learning from incidents and patient care and, ultimately, improve patient safety throughout Northern Ireland.

2.0 SCOPE OF THE POLICY

2.1 Definitions

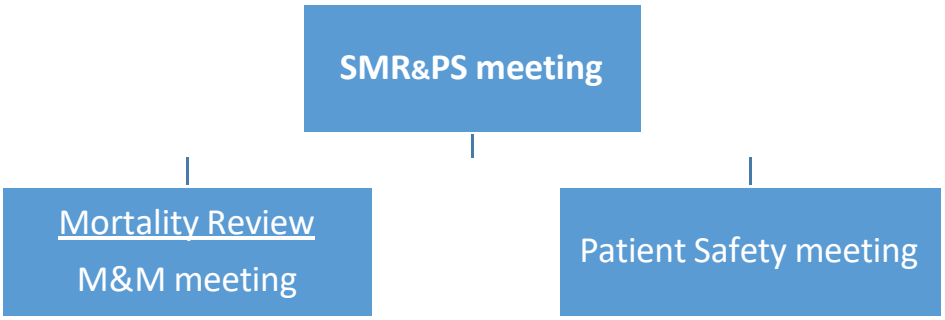
Mortality – for the purpose of M&M meetings, mortality relates to all deaths occurring on a hospital site (including those being brought in deceased to the ED) ranked by ward, team and/or specialty.

Morbidity – is a diseased state, disability, or poor health due to any cause and often relates to complications or adverse outcomes from care and/or treatment. It can be scored to determine disease severity and the need for medical intervention.

Complication - an additional problem that arises following a procedure, treatment or illness, is secondary to it and complicates the situation. This is often viewed in a similar fashion to morbidity.

Misadventure - Any injury or adverse reaction resulting from any medical treatment. Some examples are; medication errors, IV infection, surgical mistakes and postoperative septicaemia.

Specialty Mortality Review and Patient Safety meeting (SMR&PSm)
Discussions regarding mortality and morbidity are increasingly combined with discussion of patient safety matters e.g. safety alerts, medication issues, recommendations from serious adverse incident (SAI) investigations. Combining these 2 broad topics into one meeting results in a SMR&PS meeting; made up of 2 segments or sections. It has been agreed to formally call these meetings 'Specialty Mortality Review and Patient Safety meetings' – see section 4.2.



These SMR&PS meetings can be an efficient method of using the time and opportunity to discuss all these matters during the same meeting. However, some specialties and units may still wish to perform these discussions in separate meetings e.g. those with a large number of deaths to discuss.

However, it is accepted that custom and practice may lead to many continuing to use the term 'M&M meeting' for all of this type of clinical outcome and patient safety meeting.

For simplicity, this guidance will usually refer to 'M&M' meetings.

Mortality & Morbidity Meetings (M&Ms)
M&M meetings are *'a routine forum for the open examination of adverse events, complications and errors which have led to illness or death of a patient, and which are reviewed in order to learn from these events so as to improve the management and quality of care.'*[1]

They are a systematic activity designed to enable clinicians and managers at any level (preferably multidisciplinary) in the Trust to understand and learn from the underlying conditions that lead or contribute to death or harm to patients.

There is review and discussion of clinical cases, outcome data (clinician and patient reported) and related information (e.g. complaints, complications, misadventures, SAI or other benchmarking data).

Mortality and morbidity do not have to be reviewed in the same meeting.

Mortality reviews focus on the events of and learning from episodes where death has occurred.

Morbidity reviews could include the examination of re-admission rates, returns to theatre, specific complications of procedures, infections, falls or even prolonged length of stay. Morbidity reviews will vary from specialty to specialty.

Mortality Review Committee / Outcome Review Group

Evidence has shown that the development of a Mortality Review Committee can lead to measurable improvement in mortality associated with improvement initiatives[2].

The Mortality Review Committee is based at a corporate level in a hospital organisation. It can have different names in different Trusts e.g. Outcome Review Group. Health and Social Care Trusts should develop such a group to oversee M&M meetings. Its makeup can be drawn from senior medical and nursing management along with Directors and governance senior staff.

M&M meetings provide the ideal opportunity to identify areas for potential service improvement with the overall assurance for learning and action resting with the Mortality Review Committee.

This group should meet regularly, to review aggregated mortality data and information such as Standardised Hospital Mortality Ratios and Risk Adjusted Mortality Indexes (RAMI) for comparison purposes e.g. Summary Hospital-level Mortality Indicator (SHMI).

The Committee should also work with M&M leads to ensure that the composition of M&M groups is appropriate and to ensure that M&M meetings are occurring in a coordinated way, with appropriate case discussions, follow up from action points and sharing of learning. Any system issues highlighted by the M&M processes should be addressed.

It would be unusual for this group to consider individual patient information unless there were particular patient safety issues that are serious enough to warrant discussion at a corporate or management level. It will have overall corporate management responsibility for M&M meetings and act as forum for discussion of high level issues arising from the M&M meetings.

Regional Mortality and Morbidity Review system (RM&MRs)

The RM&MR system is hosted on the Northern Ireland Electronic Care Record (NIECR). It allows the;

- accurate **recording** of the details from all patient deaths, completion of the Medical Certificate of Cause of Death or notification to the Coroner;
- **review** by the Consultant, followed by the;
- **monitoring**, examination and scrutiny of any avoidable factors or areas of learning and subsequent actions associated with the patient's death by;
- 'ward or unit based' multidisciplinary (M&M) clinical teams, aimed at identifying and **analyzing** the causes of harm, learning and thus avoiding the repeating of harm.

3.0 ROLES/RESPONSIBILITIES

Each Health and Social Care Trust will take responsibility for ensuring M&M meetings occur according to this guidance.

3.1 Medical Director

The Medical Director in each Health and Social Care Trust is the ultimate Lead within their Trust for this process and has ownership of this document, and therefore responsibility.

The Medical Director in each Health and Social Care Trust should clarify and outline the formal requirements for M&M Leads / Chairs and M&M meetings and then ensure that the whole process outlined below is introduced throughout their particular Trust.

They should also incorporate the M&M process into the appraisal and revalidation process for Consultants and other clinical staff.

3.2 M&M Leads / Chairs

Each Trust should appoint a M&M 'Lead' or 'Chair,' for each specialty M&M meeting.

M&M Leads will take responsibility for the operational management of their specialty's meetings. It is accepted that establishing this process may be new to some specialty areas and in some specialties more onerous than others. Additional remuneration or 'PA' allowance should take this into account and be agreed within each Trust.

Responsibilities of M&M Leads will include:

- Working with their Clinical Director and Associate Medical Director[a] to ensure the format of their M&M Meetings allows robust discussion and learning.

- Ensuring that 'their' team is of a sufficient size to allow robust discussion i.e. not too big or too small and which also contains the right mix of staff to allow a degree of robust scrutiny of cases. It is advised that a team with less than 5 senior medical members would be viewed as being too small. Achieving this should be done in conjunction with corporate bodies such as the Mortality Review Committee/Outcome Review Group.

- Ensuring that there is a multidisciplinary format to meetings, by facilitating regular attendance by medical (consultants, trainees and other grades), nursing, governance, management, pharmacy and other staff.

- Ensuring, along with their Consultant colleagues, that every death within their specialty area is recorded on the Regional Mortality and Morbidity Review system (RM&MRs) and reviewed by a Consultant.

[a] or equivalent grade of Senior Clinician in a management role.

- Coordinating, along with their Consultant colleagues, how all their patient deaths, after being tabled for discussion, are reviewed at their M&M meeting. Some teams will review every patient death in detail while others, depending on their specific specialty, may have to prioritise those deaths which will capture valuable learning.

- Reviewing the monthly performance statistics of recording deaths.

- Coordinating M&M meetings along with the patient safety, audit and educational elements which may be discussed concurrently – the SMR&PS meeting.

- Preparation for meetings and using the standardised agenda/record of meeting template (appendix 2).

- Reviewing outstanding learning and action points from previous M&M meetings.

- Chairing discussion on Mortality Review, with a focus on producing learning, including:
    - Contributing knowledge and experience to those meetings.
    - Openly looking for prevention strategies, without resorting to blaming others.

- Helping colleagues to deliver safer care on the basis of:
    - Fostering an open culture for discussion of cases;
    - Learning from discussion;
    - Building safeguards into existing practice; and
    - Challenging practice that has been demonstrated to be unsafe.

- Producing a record of the review of each death on the RM&MR system.

- Collation of review findings, learning points and actions for improvement from each M&M meeting.

- Reporting significant findings to Associate Medical Directors[b] / Clinical Directors and onwards to Governance Systems within their Directorate, and escalation of concerns as appropriate.

- Assisting communication with other specialties by the onward referral of M&M cases for discussion and also by introducing cases from other specialties for discussion.

- Escalating concerns to their Clinical Director / Associate Medical Director[b]/ Medical Director if consultants or teams are not recording or reviewing deaths.

[b] or equivalent grade of Senior Clinician in a management role.

- Acting as (potentially) a first point of observation of the performance of medical staff, including senior staff, and escalation of any concerns. The M&M Lead's role is to observe and warn, and the Clinical Director / Associate Medical Director's role is to manage performance.

- Including the performance in this M&M role as part of their appraisal and revalidation.

- Being accountable to their Clinical Director and Associate Medical Director[b] within this role.

- Appointment of a 'deputy' chair who would fulfill these duties in the absence of the M&M lead or if the lead was involved in a case to be discussed.

3.3 Attendees

While each M&M team has a 'core membership' of permanent medical staff, the agreed regional view is that all of these teams are to evolve into multidisciplinary M&M teams (see section 3.4).

All attendees at M&M meetings are expected to:

- Attend meetings whenever possible, and stay for the full duration of the meetings. Some Trusts may elect to rule that credit for attendance at a M&M meeting requires attendance for all of the M&M section of that particular meeting.
- If unable to attend meetings, ensure the record of the meeting is read and any learning points are addressed.
- Adhere to agreed 'ground rules.'
- Actively participate in discussions.
- Raise any concerns to seniors / supervisors.
- Ensure any action points agreed are followed up.
- Contribute to shared learning as appropriate.
- Feedback any relevant learning from attendance at regional events.
- Keep up to date with changes or updates to relevant guidelines.

In addition to this, specific attendee roles will include, but are not limited to:

<u>Consultants</u>

- Use and respond to any Trust emails or Electronic Care Record (ECR) message alerts that are used by the RM&MRs as its method of communication. This includes ensuring that they can log in to their Trust's email system regularly, especially if they have joint employment e.g. University.
- Complete the 'consultant review' sections within the RM&MRs for patients named under their care, within agreed timeframes, to enable the discussion of deaths or incidents at M&M meetings within 6 – 8 weeks of occurrence.

- Attend discussions regarding all patients named under their care whenever possible, including when invited to attend another specialty's meeting.
- Provide peer review and robust but responsible challenge during discussion of cases, raising concerns in a non-confrontational manner.

Specialty Doctors (SAS Grades)

- Attend discussions regarding all patients under their care whenever possible, including when invited to attend another specialty's meeting.
- Provide peer review and robust but responsible challenge during discussion of cases, raising concerns in a non-confrontational manner.

Trainee Doctors

- Attend discussions regarding all patients for whom the trainee doctor has been involved with, whenever possible, including when invited to attend another specialty's meeting.
- Contribute to discussions and raise concerns when appropriate.
- Ensure that any incidents are reported to clinical and educational supervisors, as well as declared on 'Form R.' – their self-declaration form completed for the purposes of registration and revalidation.

Locum Doctors

It is also advised that locum doctors, if at all possible, attend discussions relating to cases they have been involved with, particularly if there have been any concerns raised regarding level of care. 'Longer term' locum doctors should contribute to meetings as per the above lists, depending on their grade.

3.4 Multidisciplinary membership

Traditionally, M&M meetings have been medically led. However, it is now recognised that input from other disciplines is imperative. M&M meetings that function as a 'multidisciplinary' meeting and that hold the concept of the 'team' as a core value are regarded as a best practice model.

Clinicians do not work in isolation – multidisciplinary teams care for patients and avoidable incidents are most often multifactorial (and therefore multidisciplinary) in causation. All team members can bring valuable insights and information to case discussions, and can also learn from these discussions, in order to improve future patient care. It can also be easier to effect change and complete actions when all the relevant professionals are present at case discussions.

Therefore, they should always work towards encouraging team membership and include senior nursing staff, governance, pharmacy, allied health professionals, relevant senior technical and other senior support staff.

Nursing Staff

Nursing input can be particularly valuable, as nursing staff spend significant amounts of time with patients. An example of useful multidisciplinary discussion would include a deteriorating patient not being seen by the medical

team promptly, either due to delay by nursing staff in contacting doctors, or due to delay by doctors in responding.

It is acknowledged that time can be a barrier for nursing staff attending meetings, as can the size of available meeting venues. Each specialty should agree the level of nursing input into meetings. Suggestions include rotation of nursing staff attendance at meetings, having a nursing representative attend from each ward, or having ward managers / Heads of Service attend initially.

Roles of nursing staff include:

- Attend discussions regarding all patients under their care, whenever possible, particularly when a concern has been raised. This includes when invited to attend another specialty's meeting.
- Contribute to presentations, providing information on care.
- Contribute to robust discussion, challenging care where appropriate.
- Present summaries of relevant nursing meetings to the group.
- Feedback discussions and action points to colleagues.
- Specialist nursing staff may provide expertise to a number of hospital departments, as relevant.

Administration Staff (also see section 4.4)

- Work with M&M leads to agree meeting agendas, ensuring case presentations have been prepared and are available for the meeting.
- Ensure that, wherever possible, clinical notes are available to aid discussion, if requested by the M&M Lead.
- Take a note of the discussions, send these to M&M Leads for approval, and then disseminate as appropriate.
- Ensure a central repository of all meeting records is held securely.

Other professionals

M&M Leads should decide on the appropriate frequency at which to invite other professionals, such as pharmacists, governance team members, Allied Health Professionals, microbiologists, laboratory staff etc. as this will vary across specialties. It may be appropriate to invite some professionals to attend for the full duration of meetings, or for an identified time 'slot.' Some professional groups may rotate around the various specialty meetings, while others may choose to send a representative to each meeting.

Roles of other professionals include but are not limited to,

Governance Leads

Governance professionals can perform a vital 'conduit' function by bringing learning from Serious Adverse Incidents to the meetings and also by:

- Relaying outwards any learning points raised at meetings that require circulation and further action elsewhere in the Trust and beyond;
- Flagging up if any of the cases being discussed have already been reported as a Serious Adverse Incident (SAI) and this is not known by the M&M Lead/Team.

- Providing, on occasion, short (5 - 10 minute) teaching sessions e.g. SAI processes, incident reporting procedures.
- Ensuring SAI and Coroners reports and their recommendations are cascaded once investigations are completed.
- Reconciling M&M discussions with SAIs – possibly have reports or else a list of screened cases available for the M&M Lead. (This would be a joint effort with the M&M Lead.)
- Considering agreeing a formal process of how cases should be flagged up / should be checked for SAIs.

Pharmacists

Pharmacists may already attend more corporate, directorate governance and/or medicine safety meetings. However, attendance at M&M meetings will offer an opportunity to bring pharmacy communication to ward, unit or specialty level as well. It is not expected that every M&M team would have to have such an attendance at every meeting.

Scheduling of expected timings during the SMR&PS meeting will allow pharmacists to attend only their section of the meeting, thus providing a more efficient use of their time.

Attendance at M&M meetings will allow or enable,

- Dissemination of 'local' learning from clinical pharmacist(s) working in specialty wards and who know the frequent errors or error categories.
- Review of medication incidents and share learning points as appropriate.
- Identify and present good practice topics, review medication incidents, identify main learning points, produce regular learning bulletins and then present these at M&M meetings.
- Provide expertise during case discussions, challenging and raising concerns as appropriate.
- Advise on medication updates, as appropriate.
- Provide short teaching sessions, when relevant.

Resuscitation Officers

- Present a summary review of cardiac arrest calls.
- Participate in case discussions as appropriate, providing expertise.
- Raise concerns or suggestions to improve practice.
- Consider whether decisions regarding resuscitation status are appropriate.
- Consider whether escalation of NEWS scores appropriately carried out.
- Provide updates as relevant.

Microbiologists / Infection Prevention and Control Team

- Provide updates when relevant, including information about healthcare associated infections (HCAI) within each department, antibiotic wards rounds, audits and any new or updated guidelines.
- Provide expertise in the discussion of cases as appropriate.
- Deliver occasional short teaching sessions.

Others

Others, including but not limited to, Allied Health Professionals, laboratory staff, haemovigilance teams, blood transfusion services, specialist liaison services etc.:

- Provide updates and expertise as appropriate.
- Deliver short teaching sessions when relevant.

It may be beneficial for Health and Social Care Trusts to collate a list of all professionals who may add value to case discussions at M&M meetings, along with their contact details. M&M Leads can then approach each professional and agree a suitable frequency of attendance at meetings. This list may include professionals in the fields of pharmacy, resuscitation, infection prevention and control, patient experience, governance leads and others as appropriate.

3.5 Patient Experience & Personal and Public Involvement (PPI)

M&M teams may consider bringing information from patient experience questionnaires to meetings.

Regarding personal and public involvement, it is considered likely that any proposed future PPI participation in M&M discussions will only occur at a corporate level where they might view aggregated information rather than detailed material related to individual patients.

3.6 Governance – Local and Corporate

Establishing links internally to other governance committees in the organisation is an essential constituent of successful and meaningful M&M meetings. This will allow the 2 way communication of governance issues both 'upwards' and 'downwards' within the organisation.

Attendance and indeed participation of Operational and Governance Managers in meetings, as well as regular reporting and feedback mechanisms, will enable two-way communication with frontline staff.

4.0 KEY POLICY PRINCIPLES

This policy applies to the discussion of all patient deaths and morbidity cases that occur within any hospital site in Northern Ireland. All inpatient deaths should be discussed in at least one M&M Meeting.

Based on available evidence, the factors considered to be important for the success of M&M meetings are detailed in the table below[1].

Table 1 **Factors considered important for an effective M&M case review**
Facilitation of the case review by the M&M lead
Mandatory department members' attendance
Audience participation in the process
Decreasing defensiveness and blame
Focused analysis of error
Integration of evidence-based literature into the M&M discussion
Providing educational points related to the complication
Allowing for a consensus to be met with respect to analysis of the cases presented
Improving the efficacy of the case presentations
Use of slides
Use of radiographic images

Following this advice, the principles outlined below aim to establish how these factors can be incorporated to produce a successful M&M meeting programme.

4.1 M&M Leads

The role and responsibilities of M&M Leads are covered in section 3.2 and, could be regarded as a 'job description' for such a posting.

The chair of the meeting is responsible for enabling an open and constructive discussion that can fulfil the meeting's purpose. They will be aided in this by the commitment to the meeting of all the participants and the quality of their interactions plays a crucial role in the effectiveness of an M&M meeting.

Therefore, an M&M lead needs to foster an environment in which all participants can contribute to constructive and non-judgemental discussion without fear of criticism from their peers. On the other hand, all participants have a shared responsibility to also behave in a way that is conducive to learning and supports service improvement and to challenge conduct that may be detrimental to those shared goals.

Training

M&M Leads should be supported within each Trust and receive any relevant training opportunities, where appropriate. Training in areas such as Human Factors and Root Cause Analysis may be useful.

Support

Each Trust should ensure that M&M Leads meet together regularly to provide peer support, as well as to discuss M&M processes, identify areas of good practice and identify areas for improvement.

It is likely that there would be a benefit in M&M Leads from the different Trusts meeting to discuss items of interest and to help with development of the RM&MRs.

4.2 Specialty Mortality Review & Patient Safety meeting

As covered in section 2.1 and as the dual title suggests, Specialty Mortality Review & Patient Safety (SMR&PS) meetings encompass both a mortality review function (M&M meeting) and a patient safety function. This allows discussion of patient mortality, morbidity and safety issues; enabling robust discussion and peer challenge. It is accepted that they may continue to be called by the shorter name – 'M&M meeting'.

4.2.1 SMR&PS meeting Agenda/Record of meeting

To facilitate the standardisation of meetings across all M&M teams, a SMR&PS meeting Agenda/Record of Meeting Template (appendix 2) has been developed and agreed by all HSCT Medical Directors. This will be modified from time to time, as this policy document is updated.

The SMR&PS meeting Agenda/Record of Meeting Template will be used by every M&M Lead / Chair to determine the areas of discussion at each SMR&PS meeting. Some of the topics to be covered during the meeting will include,

1. Review of last meeting
    a. Verification of M&M meeting report
    b. Outstanding actions from last M&M meeting
2. Mortality & Morbidity (M&M) review of deceased patients
3. Review of Safety Graphs
    a. Crash Call Review
    b. Safety graphs
4. Shared learning from Complaints / Serious Adverse Incidents / other M&M meeting / any other source.
5. Shared learning from Litigation / Coroner Cases
6. Safety Alerts – DoH, HSCB, PHA, Trust
7. Medication issues
8. NCEPOD / National / Speciality
    a. Consultant Outcome data.

While the SMR&PS meeting is functionally made up of 2 segments; it is acknowledged that each specialty may have slightly different issues to discuss at meetings, especially of the patient safety segment. Time spent on each agenda section may vary considerably between specialties, depending on clinical caseloads, and so these headings can be adapted as necessary.

It is suggested that each SMR&PS meeting should last for 2-3 hours in total, with a recommendation that each segment i.e. mortality review and patient safety discussion being afforded equal time. Some teams may elect to hold the 2 segments on different days and may also elect to have different leads for each segment.

If M&M meetings are organised in a way which departs significantly from the suggested agenda template, this should be reviewed by the Mortality Review Group/Outcome Review Group in the Trust.

As every specialty will be using the same agenda/record of meeting template the following naming convention should be used:

M&M Team Name - Venue - Date of Meeting

It will be the responsibility of the M&M Lead / Chair (or their alternate) to set a date for each meeting and therefore establish the agenda for each meeting.

All relevant documentation for discussion should be appended to the agenda/record of meeting template and/or signposted by hyperlinks by the relevant lead (i.e. Governance, Litigation, Pharmacy, Safety Alert).

A copy of the suggested SMR&PS meeting Agenda/Record of Meeting Template is attached at appendix 2.

4.3 M&M meeting

The mortality section of the meeting should be timely, within 6-8 weeks of deaths, incidents or events, to ensure that details remain clear in the minds of those involved. Meetings should be dynamic, with an open and transparent culture. Blame should be avoided, and everyone should feel able to speak up and challenge others when appropriate, in a non-confrontational manner.

Learning should be shared, in order to prevent unnecessary repetition of errors, and to optimise patient care. Frontline staff can work together with governance teams to develop solutions to issues that arise.

As well as a platform for review, M&M meetings also have a valuable role in medical education. It is also important to highlight areas of good practice, from which others could learn.

4.3.1 How to set up an M&M team

Many hospitals in Northern Ireland already have M&M teams and meetings in place, although these often vary in structure and format between specialties and sites. The aim of this guidance is for a standardised approach to M&M meetings across the region.

For those hospital teams that do not currently have any meetings, the first step is to form M&M teams:

- Identify teams and specialties that do not participate in M&M meetings.
- Discuss (with all involved) the rationale and evidence for M&M meetings (see appendix 1).
- Establish specialties and team units that could form a M&M team and hold meetings.
- Decide on the size of teams required - this will depend on the size of the specialties involved.
    - Teams should not be too big as they will be difficult to manage and have time to discuss all their deaths within the 6 – 8 week period.
    - Teams should not be too small because this will limit the robustness and degree of challenge of peer review. It is advised that a team with less than 5 senior medical members would be viewed as being too small.

- Appoint an M&M Lead for each team and meeting.

Once the teams are all established, the following steps need taken:

- Set dates for (approximately) monthly meetings, ensuring suitable venues are booked and that appropriate IT equipment is available.
- Always remember to include the appropriate multidisciplinary team members, as well as others, to invite to meetings. This should include Ward/Nurse Managers, Pharmacists, Governance and managerial staff. Some teams may include certain technical staff. See section 3.4.
- Screen cases, to decide those that are to be discussed in a greater level of detail.
- Adopt an agenda for meetings, using the suggested Agenda / Record of Meeting Template (appendix 2) provided in this guidance, adapting this as appropriate.
- Arrange for a note of the meeting to be taken using the suggested Agenda / Record of Meeting template (appendix 2) provided in this guidance, and adapting this as appropriate.
- Ensure learning points are noted on the RM&MRs and that action points from meetings are followed up.

4.3.2 Code of Conduct

All participants in the M&M meeting share a responsibility for creating and maintaining an environment which is conducive to an objective, honest and non-judgmental review.

It may be helpful to establish a code of conduct or ‘ground rules’ for each meeting. These should be agreed by the team and approved by the M&M Lead. It is advised that M&M Leads remind the group of the ground rules at the beginning of each meeting e.g. by showing a standard slide of the rules to remind everybody (appendix 3).

The precise content of the code of conduct will vary according to the setting and it is important that participants are involved in developing the code before committing to it. Suggested principles to incorporate include:

- mutual respect and trust between participants;
- commitment to the task of an objective review of adverse outcomes;
- encouragement of contributions from all participants;
- constructive discussion and debate;
- valuing different opinions;
- challenging those in the group who do not adhere to these principles.
- focussing on the adverse outcomes, their causes and the learning rather than on personalities and ‘who did what and why’.

Some suggestions of ground rules include:

- Discussions should be open and transparent.
- Listen to others when they are talking and do not interrupt them.
- All attendees should be given the opportunity to speak.
- Avoid a blame culture.
- Show professional courtesy and respect for everyone.

- Presentations should be factual and objective. They should focus on the issues and the learning; not on personalities or the actions of individuals.
- Style and tone of presentations should be respectful.
- As far as possible, the clinicians involved in the management of a difficult or complex case should be aware in advance and be present when the (their) case is being discussed at M&M.

4.3.3 Support for Staff

Although patients are the prime concern when an error has been made they are often not the only victim of a medical mishap. The healthcare worker or workers involved are also affected; they can be the second victims. They can feel personally responsible and having failed the patient. The severity of this reaction is obviously related to the severity of the error itself but is also affected by the culture within the Trust, the attitude of colleagues and the conduct of any enquiry and/or legal proceedings. This can have long term consequences in maintaining a suitably open and transparent culture necessary in a safety orientated clinical environment.

Therefore, sitting alongside the necessary systems to recognise and learn from medical mishaps and processes of support for patients, carers and families, there must be systems of support for the affected staff.

To support any staff affected, a Trust should:

- actively promote an open and fair culture that fosters peer support and discourages the attribution of blame.
- create an environment in which staff are encouraged to report patient safety incidents but should also feel supported throughout any incident investigation process.

Some tools that Trusts might have available to help promote this culture are,

- an active and supported '*Being Open'* policy.
- an attuned Occupational Health Department who are aware of the processes being encouraged within a M&M process.
- other programmes which can be of use in supporting staff, offering strategies to help cope with stress e.g. *Here4you*.

4.3.4 Suggested calendar of dates

An important guiding principle is for cases to be discussed within 6-8 weeks of death / incident. In order to achieve this, it is recommended that M&M meetings occur regularly, on a monthly basis.

The rationale behind having a regional standardised calendar for M&M meetings is as follows:

- To ensure time for meetings is protected, with sufficient notice to rearrange clinical work.
- To enable shared learning and cross-specialty and cross-site participation when required.

- To enable trainee doctors to return to meetings from previous posts, to present and take part in discussions regarding cases in which they have had involvement.

It is recommended that M&M meetings follow the GAIN[3] Regional Audit Dates. This will facilitate the participation in Regional Meetings. These dates are planned well in advance and can be found at http://www.gain-ni.org by searching for 'rolling audit calendar.'

It is recognised that some specialties may wish to have meetings on a more regular basis, such as weekly. If this is the case, it is recommended that these groups ensure they pay attention to the GAIN Regional Audit dates and coordinate their weekly meeting on these dates each month, to facilitate cross-specialty discussions where necessary.

4.3.5 Inputs and Outcomes of Meetings

The standardised SMR&PS agenda headings are detailed in appendix 2.

A record of a meeting should be made onto the Agenda / Record of Meeting template. This record should be circulated to members of each meeting, to verify the note at the next meeting and so that action points can be followed up.

The note of the M&M discussion is to be kept on the RM&MRs i.e. on NIECR, as evidence of case discussion and learning outcomes.

4.3.6 Specialty input

Intraspecialty 'split' meetings

In order to facilitate case discussions within larger specialties, this may require having 'split' meetings. For example, Surgical M&M meetings may alternate each month, between a large meeting that includes all surgical specialties, and multiple smaller sub-specialty M&M meetings.

Experience has found that, on average, approximately 60 - 90 minutes is required to discuss 10 cases. A balance needs to be achieved between meetings being small enough to be able to discuss all deaths, while being large enough to ensure there is robust and challenging discussion.

Interspecialty 'joint' meetings

Some specialties that work closely together may find value in holding 'joint' meetings. These can be organised to occur regularly or once a cohort of interesting cases have built up to allow discussion. The RM&MRs will allow the organisation of 'joint' meetings.

Specialty interfaces

Regarding interfaces between specialties, the case will usually be discussed by the team looking after the patient immediately prior to death (or prior to any incident) i.e. the primary team. If discussions are potentially going to involve 'criticism' of another specialty, they should be given the opportunity to respond. This could be by,

- being invited to the M&M meeting;
- enrolling them as an 'Additional Team' using that function in the RM&MRs and forwarding them the discussion for their input; or
- holding 'joint' meetings as above.

On some occasions, it may be valuable for health professionals from another specialty to attend case discussions during SMR&PS meetings e.g. if a patient's care has involved input from multiple specialties.

Having all professionals involved present at the case discussion can be very useful, as the full picture of events is then available. This can also prevent the need for multiple discussions at different meetings regarding the same patient.

It is up to the M&M Lead to decide the appropriate course of action to take and, if necessary, who should be invited to each case discussion. They may discuss this with the named Consultant and other health professionals in order to make this decision.

If requesting a health professional from another specialty to attend, sufficient notice should be given for this. The request should be made as early as possible. If requested to attend a case discussion at another specialty's meeting, this should be facilitated wherever possible. A mutually convenient time slot in the meeting should be agreed, in order to minimize disruption to other meetings. It is advisable that joint cases be discussed at the beginning of the meeting, if possible.

4.3.7 Selecting cases for detailed discussion

All deaths should be offered for discussion to at least one M&M meeting, but, in certain specialties, it may be appropriate and permissible, in certain individual cases, to limit the discussion and thus discuss some cases in greater detail than others. This may not be allowed in some specialties and in some categories of cases e.g. where an incident has occurred or a death is unexpected.

The use of 'trigger lists' can be helpful to set the rules to identify cases that may require more detailed discussion, including morbidity cases. Appendix 4 provides a suggested template 'trigger list', although each specialty may need to adapt this to include additional relevant triggers.

4.3.8 How to present cases: Using the SBAR format

For brief case discussions, the following points need to be covered:

- What was the diagnosis and cause of death?
- What were the circumstances leading up to the death?
- Were there any issues of concern in the management of the patient leading up to the death?
- What learning points have come from this case?
- How will these learning points be implemented?

However, a recent review of the evidence-base on M&M meetings concluded that, '*the lack of a consistent approach contributed to substantial variation in*

presentation quality and educational outcomes achieved'[1]. Therefore, it is important, where possible, to minimise potential barriers to the discussion arising from attendees' different communication styles. In order to facilitate this, participants should adopt a standardised model for presenting cases.

Based upon the factors outlined in Table 2, a standardised

Situation,
Background,
Assessment,
Recommendation

(SBAR) communication format is recommended. The aim is to maximise the learning value of the M&M meeting by using this structured format for presenting cases at M&M meetings, thus improving presentation quality and learning outcomes for attendees[4].

SBAR is a structured communication technique for providing patient information. An enhanced form for use as a presentation tool for M&M meetings is described below (table 2) with a much more detailed version provided in appendix 5.

Template slides for the structure of M&M presentations can be downloaded freely from the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland websites[4].
https://www.aagbi.org/sites/default/files/SALG-M%26M-TOOLKIT-2013_0(1).pdf

Table 2

Components of an M&M presentation[4]

Components of SBAR	Items considered important to enhancing the educational value of the M&M presentation
S Situation	Brief description of the case presented – statement of the problem(s).
B Background	Essential clinical information pertinent to the death.
A Assessment and Analysis	Focused error analysis and summary of factors contributing to the death.
R Review of literature	Identify learning points for the case with review of the literature pertinent to the death.
Recommendations	Propose actions for prevention of future similar problem.

Mitchell et al[5] conducted a prospective observational study to develop a psychometrically robust assessment tool based on the SBAR format, to be used to assess cases presented at M&M meetings. This was validated to

identify and improve the overall quality and educational value of the surgical M&M conference. It is easy to use, requires little training, and is potentially applicable to other specialties (appendix 5).

Time is limited at each M&M meeting and the agenda is often busy. So to facilitate timeliness of presentations, the following may be helpful:

- Aim to keep each presentation to a maximum of 10 minutes.
- For case presentations, use the SBAR format.
- For other presentations, such as audit reports, pharmacy updates, infection control updates etc. aim to keep to main points.
- If using slides, aim for no more than 5-7 slides. Avoid excessive amounts of words / data on each slide. Only include content that is informative and relevant.
- Having 2-3 key messages / take home points will be more effective than a lot of information, as people will be more likely to remember these.
- Please note that more detailed information can be sent to the M&M Lead, for inclusion in meeting record, so that all relevant health professionals can access this.

<u>Entry onto the Regional M&M Review system</u>

The format for the recording of a patient death onto the RM&MRs follows the principles behind the SBAR technique. There are data entry boxes to allow the structured entry of,

1. Situation - statement describing the admitting diagnosis, cause of death
2. Background – Clinical information pertinent to the death: past medical history, clinical course, procedural details and investigations.
3. Assessment – If required, a statement of the cause of any avoidable incident or complication; an evaluation of what happened and why it happened.
4. Recommendation – If required, a statement of what needs to be done to avoid a repeat; proposed actions.

It is expected that items 1 & 2 i.e. Situation and Background, will be completed when entering the *Initial Record of the Death* onto RM&MRs.

Items 3 & 4 i.e. Assessment and Recommendation, may wait to be completed, if thought necessary, until the peer review is performed at the M&M meeting. Assessment will then be completed under the section regarding Learning Lesson and Recommendation(s) will be completed under the section detailing Actions.

4.3.9 Final Grading of Outcome and Care

One of the core components of a case based mortality review is to grade or score the overall quality of care. NCEPOD[6] recently considered these core components and found strong support for including a data point related to considering overall quality of care - a quality of care score was strongly or very strongly supported. However, there were concerns a grading of care would lead to performance management and negative publicity.

There are a range of grading schemes already available or in development, which have variations in their complexity.

a. Preventability of Death scale or score.
b. Overall Quality of care scale.
c. Scale/Score based upon Learning and identification of Improvement.

The Regional Mortality and Morbidity Review system (RM&MRs) adopts the latter approach with a scale based upon learning, improvement and identification of good practice while still acknowledging where the care provided needs investigation and perhaps change. Section 4.3.9 provides details of this scheme.

It is expected that when a score is used indicating that the quality of care provided could have been better, that that is done responsibly and is accompanied by,

- a note explaining the reasoning behind the score;
- learning and action being taken to prevent a repeat;
- informing Trust governance structures, if necessary; and
- informing the family and next of kin, in keeping with 'Being Open'.

Therefore, following discussion of each case, the attendees at the M&M meeting should reach a consensus as to which of the following statements best describes the overall care provided:

The care provided in the management of this patient,

1	was Satisfactory. There were no particular Learning Lessons.
2	contained aspects that COULD* be improved (learning identified); the patient's eventual outcome was NOT affected.
3	contained aspects that SHOULD¥ be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported.
4	contained aspects that have already been, or SHOULD¥ be, referred to Trust Incident Reporting System.
5	contained aspects that were Exemplary and the learning SHOULD¥ be shared appropriately.

* Opinion may be divided and there may be issues that required debate.
¥ General agreement that issues and learning have been identified and change is needed.

4.4 Record of the M&M meeting

Taking a note and therefore making a record of the meeting is a vital element of the process of reviewing a patient death. Without that note there is no record that the discussion took place, the issues were aired or that learning was identified and action(s) taken. It is not a requirement that there is a verbatim 'minute' of the meeting; it is however necessary that there is a factual and objective note which focuses on the issues, learning and actions identified, not on personalities or the actions of individuals.

The note of the meeting will provide a mechanism to monitor the effectiveness of meetings in terms of patient safety driven change. It also ensures that mortality review and patient safety discussions are open and transparent. Remember that some of these details could be discoverable.

There are various models available for making a record or note of the meeting. Teams may choose to:

- type them live at the meeting which ensures everybody is content with the record immediately, although verification will be required at the next meeting.
- take notes and type them up afterwards; these will need verified at the next meeting.
- arrange administrative support from within each specialty rotating this role; again to either type the record live or at a later date.

It is advised that each team and Trust reviews the various methods remembering that each M&M Lead needs to review the record for accuracy and completeness prior to distribution with full verification occurring at the next M&M meeting.

The SMR&PS Agenda / Record of Meeting template has been designed to allow for a note to be recorded against each agenda item. By incorporating the agenda items into one document, this makes all the accompanying documents for the meeting available for review.

A copy of the suggested Agenda / Record of Meeting Template is attached at appendix 2.

4.5 Shared Learning

Learning from M&M meetings is vital, as the whole purpose of meetings is to learn from incidents and events in order to avoid the unnecessary repetition of mistakes and improve patient care in the future. Learning needs to be simple, relevant and not just a tick-box exercise.

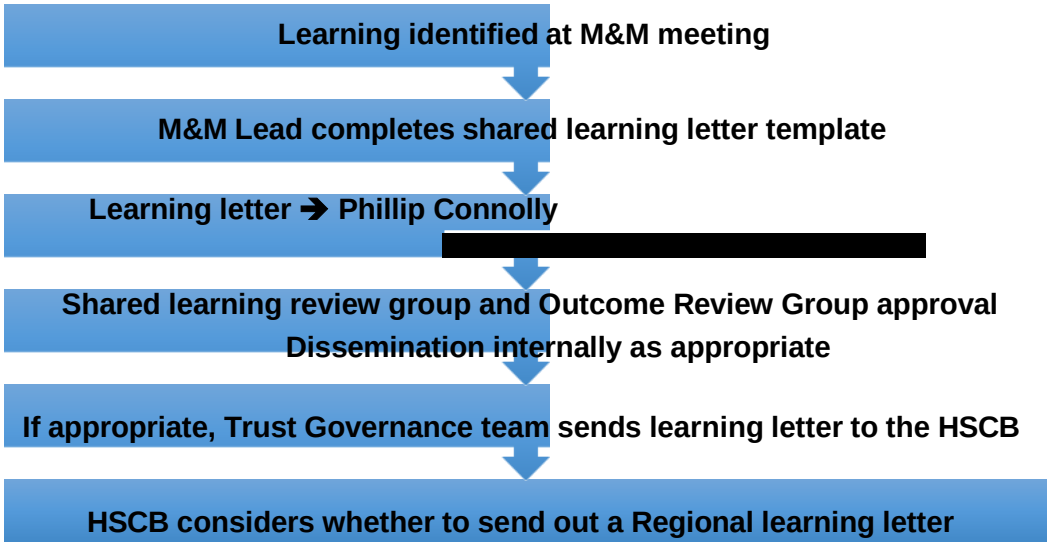
Regional shared learning letter templates are available (example at appendix 6) and should be used, particularly when a learning point has been identified that is applicable across specialties and / or Trusts. In order for learning letters to be effective, it is advised that Trusts ensure they are not only disseminated to the relevant professionals, but they should also be discussed at M&M meetings to review how action points may apply to each specialty.

Other methods of sharing learning points arising from M&M meetings should also be considered, for example:

- Targeting particular groups with regards to relevant learning, such as trainee doctors at induction to new posts.
- Incorporating learning points into local and regional teaching sessions.
- Making use of available technology, such as having a ‘lesson of the week’ on the Trust intranet sites.
- Incorporating learning into regional learning events, in collaboration with other organisations.

It is also important to consider systemic issues, therefore giving the opportunity to look for systemic solutions, with the aim of preventing incidents and poor practice from recurring.

A suggested procedure for using learning letter templates to disseminate learning points identified at M&M meetings is as follows:



Within the Belfast Trust there is a Shared learning review group. All shared learning will go through this group before onward approval by the Outcome Review Group.

4.6 Assurance

Each Health and Social Care Trust should put an assurance process in place to provide a second level of scrutiny for a percentage of cases, to ensure robust discussions have occurred. This should be under the auspices of the Mortality Review Committee/Outcome Review Group. This may include independent review of a number of cases in the future e.g. by another Trust team or other external agency.

One suggestion is use of the Institute for Healthcare Improvement's Global Trigger Tool for Measuring Adverse Events[7]. A UK version is available[8]. This tool advises the use of small samples over time, choosing ten samples every two weeks. The maximum time spent by the review team on each chart is twenty minutes. Case notes are reviewed for given triggers, and then, if these are present, to determine if an adverse event has occurred[8]. It may be useful to then look back over the M&M discussion note, to see if identified incidents had been discussed.

It is acknowledged that some Trusts may prefer to use other methods of reviewing case discussions for assurance purposes. One suggestion is for 'cross-Trust' peer review of discussions.

4.7 Appraisal and Revalidation

During annual appraisals, doctors are expected to use supporting information to demonstrate that they are continuing to meet the principles and values set

out in *'Good Medical Practice'*[9]. Doctors must demonstrate that they undertake a review of their practice by evaluating the quality of their professional work. The General Medical Council defines a number of mechanisms for this, including regularly reflecting on standards of practice and care provided[9].

Attendance and participation in M&M meetings should play an important role in appraisal and revalidation. This should include:

- the timely completion of Consultant mortality reviews;
- satisfactory attendance at meetings; and
- active participation in learning and discussion at meetings.

With the development of Nursing Revalidation, attendance and participation in M&M discussions should also be considered at nursing appraisals.

It is suggested that each Trust clarifies formal requirements for successful appraisal and revalidation. This should occur at Medical Director level.

5.0 IMPLEMENTATION OF POLICY

It is expected that 100% of deaths occurring within BHSCT are recorded onto the **RM&MR** system from 1st April 2017.
This guidance is designed to support the implementation/ embedding of the entire **SMR&PSm** agenda across all teams and specialties. This will be expected to take place over the next 12 months and will be reviewed at the end of that period.

5.1 Dissemination

This policy currently applies to all deaths physically occurring in hospitals within Northern Ireland. It therefore applies to all hospital teams across Northern Ireland, and will be disseminated across all Health and Social Care Trusts.

5.2 Resources

This guidance will be distributed in a digital format. A named team or department in each Trust should assume responsibility for disseminating this policy, raising awareness, and ensuring that it is adapted to meet local needs, as required.

5.3 Exceptions

This policy currently excludes deaths that occur outside of a hospital setting.

In the near future, this policy will be extended to include community deaths in specific circumstances e.g. those being cared for as part of a, Consultant led, hospital 'Acute Care at home' team when their details will be added to the RM&MR system by that team, for review.

6.0 MONITORING

Monitoring of compliance to the policy will be come under the remit of the Outcomes Review Group who will provide assurance to Trust Board through the Learning From Experience Steering Group.

Also see section 4.6.

7.0 EVIDENCE BASE / REFERENCES

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8.0 CONSULTATION PROCESS

Consultation for version 1.0 was managed as part of the ADEPT programme where identified 'M&M champions' from each of the five HSC Trusts had direct input followed by circulation across the five Trusts for further comments. All comments and suggestions received during the consultation period were adopted. There was also consultation through the Death Certification Implementation Working Group (DCIWG).

This version has also been regionally circulated for consultation and comments to the 5 Trusts which have been incorporated.

9.0 APPENDICES

Appendix 1 = M&M Meetings: Historical background, evidence for and future development
Appendix 2 = SMR&PS meeting agenda and record of meeting
Appendix 3 = Ground Rules shown at beginning of M&M meeting
Appendix 4 = Triggers for a detailed review of Death
Appendix 5 = SBAR Template
Appendix 6 = Shared Learning Letter Template
Appendix 7 = Management of RM&MR system

10.0 ACKNOWLEDGEMENTS

Version 1.0 of this guidance was primarily written by Dr Lauren Megahey during a year as an 'ADEPT Clinical Leadership Fellow,' based in the Southern Health and Social Care Trust supervised by the Medical Director, Dr Richard Wright. This has built upon previous work already done by Mr Stephen Wallace, Project Manager, and Dr John Simpson, the previous SHACT Medical Director.

Particular acknowledgement is given to the 'Medical Champions' in each Health and Social Care Trust:

- Dr Aidan Cullen, Consultant Anaesthetist, SHSCT.
- Dr John Harty, Consultant Nephrologist, SHSCT
- Mr Lloyd McKie, Consultant Surgeon, BHSCT
- Dr Alan McKinney, Associate Medical Director, WHSCT
- Dr William Donaldson, Consultant Anaesthetist, NHSCT
- Dr David Hill, Associate Medical Director, SEHSCT

The Regional Morbidity & Mortality Review system (RM&MRs) has been developed by the Department of Health in partnership with all five Health and Social Care Trusts and the BSO.

11.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date: _____July 2017_____**

Author

_____ **Date: _____July 2017_____**

Director

Appendix 1

M&M Meetings: Historical background, evidence for and future development

The first antecedents of M&M meetings are difficult to trace. During the Crimean War of 1853-1855, Florence Nightingale and her team played a role in reducing the mortality rate of ill or injured soldiers from 40% to 2%, by applying strict hygiene standards and keeping records of mortality.

In 1900, the American Dr Amory Codman conceived his 'end result idea,' that each hospital should study long-term patient outcomes, with the aims of improving treatment[10]. Dr Codman faced intense opposition, but his ideas ultimately contributed to the standardisation of hospital practices by the American College of Surgeons in 1916[10].

Precursors to M&M meetings developed, such as the 'Anesthesia Mortality Committee' in Philadelphia, in 1935, involving Dr Henry Ruth. Dr Ruth described the value of open discussion of problematic cases, but also noted tension between educational goals and fear of incrimination[10].

In the intervening years, M&M meetings have evolved and are now widespread. However, across the world and even within a small country like Northern Ireland, there is significant variation in the structure and format of meetings.

There has been debate in the United States over M&M meetings being supplanted by 'Quality Assurance' meetings. Medico-legal constraints, such as Florida's Sunshine Law allowing for 'full access' of data from M&M proceedings has led to much discussion[7]. However, it is agreed that our common goal should be to learn from our complications, mistakes and adverse events, to improve future outcomes[11].

The Berwick Report[12] 2013, was commissioned to distil lessons learned and changes needed following the tragedy of Mid-Staffordshire. It identified that in the vast majority of cases it is the systems, procedures, conditions, environment and constraints that NHS staff face that lead to patient safety problems[12]. It states that 'the most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.' Berwick is clear that transparency is essential and should be insisted upon[12].

Studies have shown that for M&M meetings to facilitate improvement, they need to be structured and systematic[13]. It has been shown that the introduction of a standardised mortality review process is beneficial, to reduce variation in the way that deaths are reviewed and improve integration of meetings into governance frameworks[13].

A 2009 review[2] of the literature around M&M meetings found evidence to support key strategies to contribute to quality improvement and learning processes. These include commitment from senior staff, a safe and supportive environment, consistency in organisation, an inclusive approach, a structured process and detailed feedback and follow-up.

Learning from discussions at M&M meetings is a vital part of medical education. As described by Epstein in 2012, if physicians do not attend M&M meetings, 'they fail to educate themselves and others, while also imparting the message to their staff and patients that they simply do not care or do not assume responsibility for what has occurred'[14].

Over 100 years on from Florence Nightingale's work, there continues to be evidence[15] of reduced mortality due to M&M meetings, which showed that their use as a mandatory review process resulted in a 40% decrease in gross mortality over 4 years[15]. It is therefore vital that all teams attend and actively participate in M&M meetings, in order to learn from adverse events and errors, reduce repetition of these and improve patient care.

Opportunities for further development.

Although there has been significant progress achieved in Northern Ireland regarding the improvement of M&M meetings, there will always be opportunity for further improvement and development.

Donaldson et al published[16] a thematic analysis of 2,010 incidents (deaths) reported to the UK National Health Service database between 2010 – 2012. These were classified into broad areas of service failure, capable of being addressed by stronger policies, procedures and practices[16]. He also advised that there is an important role for specialty-specific teams or mortality review committees to review their own incidents and implement solutions locally, and to draw attention to generalisable, national risk reduction action. They advised that use of a classification system such as theirs would allow hospital boards and clinicians to identify and prioritise areas for greater scrutiny and intervention[16]. Indeed, this classification of learning from cases discussed at M&M meetings could be mirrored within the RM&MRs.

The improvement of shared learning should be a priority, and there is a need to develop new and innovative ways to achieve this. One idea is to link learning with Continued Professional Development (CPD), for example, by developing a regional website to include relevant shared learning for each specialty, with reflective templates, accrediting CPD points for time spent on this.

Appendix 2

Specialty Mortality Review & Patient Safety meeting
Agenda / Record of meeting

M&M team		Date		Time	
Venue					

Estimated time

1. Welcome, Attendance, Apologies Received by Chair
   Note:
2. Review of last SMR&PS meeting - Outstanding Issues
   Note:
   Action(s):
3. Mortality & Morbidity Review – RM&MRs on NIECR.
   a. Verification of last meeting report
   Note:
4. Safety Graphs
   a. Crash Call Review
   b. Safety Improvement graphs: e.g. HCAIs, Falls, VTE review, avoidable pressure ulcers
   Note:
   Action(s):
5. Local incident themes ; Ward, Unit issues
   Note:
   Action(s):
6. Pharmacy issues, incidents and medicine/safety alerts
   a. *Insert list of documents discussed*
   Note:
   Action(s):
7. Shared learning from Complaints / SAIs / other M&M meeting / any other source.
   a. *Insert list of documents discussed*
   Note:
   Action(s):
8. Shared learning from Litigation / Coroner Cases
   a. *Insert list of documents discussed*
   Note:
   Action(s):
9. Safety Alerts and Circulars– NICE, NCEPOD, DHSS, HSC (SGSD), HSCB, PHA, BHSCT.
   a. *Insert list of documents discussed*
   Note:
   Action(s):
10. Local Audit reports (Specialty Specific)
    a. *Insert list of documents discussed*
    Note:
    Action(s):
11. Consultant Outcome data - NCEPOD / National / Specialty
    Action(s):
12. A.O.B.
    Note:
    Action(s):
13. Date of Next Meeting

Appendix 3

Ground Rules shown at beginning of M&M meeting

1. The Chairs of M&M are responsible for highlighting these values and principles at the commencement of each M&M.
2. There must be professional courtesy and respect for everyone.
3. Presentation should be factual and objective.
4. Style and tone of presentation should be respectful.
5. Respect others when they are talking and do not interrupt them.
6. There should be a pause following presentation of difficult or complex cases, prior to discussion from the floor.
7. As far as possible, clinicians involved in the management of a difficult or complex case should be aware in advance and present when the case is being discussed at M&M.

   However, where it is not possible for all relevant clinicians to be present, as a minimum their consent and input should be sought in advance.
8. Where there is a perceived significant and potential ongoing risk arising from cases which may be undergoing serious adverse incident or internal review, the learning points / overarching issues should be presented to M&M as soon as possible, with engagement as outlined in the above point.
9. M&M meetings are not a forum for axe grinding, witch hunts or soap box issues.
10. The Chair of M&M has authority to terminate discussions where appropriate.

Acknowledgements to Dr J Harty, Daisy Hill Hospital.

Appendix 4

	Triggers for a Detailed Review of Death.
1.	Unexpected death e.g. following a fall in hospital or a pulmonary embolism.
2.	Following Complications / Misadventure / Incident. The following are examples: • Due to treatment / procedure / operation • Associated with transfer e.g. between ED & CT scanner, intrahospital. • Cardiac arrest / crash calls • Medicine related incident e.g. - Prescription error - Over coagulation related to warfarin prescription • Surgical: e.g. - Unplanned return to theatre - Change in planned procedure - Unplanned removal / Injury/ repair of organ. • Infection e.g. - MRSA bacteraemia - C. difficile - VRE (vancomycin-resistant enterococcus) - Wound infection, deep surgical sepsis - Nosocomial pneumonia. • Readmission to Intensive Care or High Dependency Care • Unplanned transfer to Intensive Care or High Dependency Care • Readmission within 30 days of previous hospitalisation.
3.	Unexpected deaths following elective admission – except cancer / haematology.
4.	All deaths in low risk HRGs i.e. unexpected. For example: • Minor ENT procedure • Tonsillectomy • Hernia Repair • Arthroscopy • Minor skin procedures • Vasectomy • Varicose vein surgery
5.	All paediatric deaths (18 years or less), all neonatal deaths and all obstetric deaths
6.	Cases referred to the Coroner's Office*
7.	Complaints received which are M&M related*

* Note that these cases should be revisited once the outcomes of investigations are known.

Appendix 5

SBAR Template[2]

SBAR-STANDARDISED FORMAT FOR M&M PRESENTATIONS	
Situation Statement of the problem	Admitting diagnosis Statement of procedure or operation Statement of adverse outcome
Background Clinical information pertinent to adverse outcome	**Patient History:** Present pertinent HPI/PMH/PSH/Meds **Indication for intervention:** Describe reason for intervention **Labs and imaging studies:** Present studies relevant to outcome **Procedural details:** Describe technical or physiological details related to outcome **Hospital course:** Present non-procedural events related to outcome **Recognition of the complication:** State how/when complication was recognised **Management of the complication:** Describe how the complication was managed
Assessment and Analysis Evaluation of what happened and why it happened	**What happened? Error analysis:** Describe sequence of events leading to adverse outcome **Why did it occur? Root Cause Analysis:** Provide description of fundamental cause(s) of the adverse outcome in relationship to: **1 Human Errors** Error in diagnosis, technique, judgment, communication **2 Systems Errors** Error(s)/problems in care system/organisation (e.g. poor supervision, low staffing, inadequate co-ordination of care, etc.) **3 Patient related factors** Patient disease or non-compliance
Review of Literature Evidence-Based Practice	Present literature pertinent to the complication
Recommendations Proposed actions to prevent future similar problem	Identify how problem could have been prevented or better managed Identify learning point(s) from case

Note: HPI, history of present illness; PMH, past medical history; PSH, past surgical history.

Appendix 6

Shared Learning Letter Template

Trust Logo **Shared Learning**	**Incident / SAI / Complaint / Compliment / Audit / External Letter / M&M Review / CMR / Litigation** **Ref. No:** "Insert text and Type"	**Date issued:**

Safety Message:
"Insert text and Type"

Summary of Event

"Insert text and Type"

Learning Points

"Insert text and Type"

Learning applicable to:

Specific Directorate(s) (specify): "Insert text and Type"		Trustwide	
Other (specify): "Insert text and Type"		Regional	

Action Required (*for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group*)

"Insert text and Type"

Approved by:	Designation:	Date approved:

Appendix 7

Regional Mortality & Morbidity Review System
Recording a death

Logon to NIECR

- Using your Trust NIECR logon details, logon to NIECR.
- If you do not have NIECR logon credentials, they have to be obtained using the details in the final box.

Access to RM&MRS and Finding Patient

- Ensure you know the deceased patient's name and H&C number.
- Identify the deceased patient by using the 'Patients' tab from the Home Page.
- If the patient record is locked down, contact NIECR Team to release.
- Once you have entered the patient summary click on 'Pathways' tab along the top of the screen.
- Click on 'Enroll in Pathway' (located just below 'Pathway Enrollment' heading at top of page).
- From the drop-down list select 'Mortality Pathway' and click on 'Enroll'.
- If you enroll the wrong patient into the pathway, you can deactivate the pathway.

Record a death

- A form will pop up on the left hand side under 'Mortality Pathway' entitled 'Mortality Initial Record of Death'. Click on this.
- Enter required information on form. Some information will be pre-populated.
- Please note that when indicating the place of death this must either be selected from the last patient encounter or manually selecting the hospital and ward.
- Also, when entering date and time of death, please ensure these are the same as recorded in the handwritten notes as verification of death.
- Then, an appropriate Consultant and M&M team must be selected to review the death.
- If you do not know the correct Consultant, select the M&M lead for that team. The M&M lead is identified within the team descriptor when you select the M&M team.
- Complete all the required boxes.
- Click 'Complete' at bottom of form.

Printing MCCD and/or Clinical Summary

- Once you have clicked complete on the Initial Record of Death Form there may be output documents for you to print, depending on the outcome you have chosen. These will be an MCCD, a Clinical Summary (for the Coroner), or both.
- To access these click on 'Dynamic Patient Summary' along the left hand side of your screen. A document view box will appear and the documents can be found under 'Notification & Legal Documents'. If you would prefer this to appear in a separate window you can select 'Patient Summary Popup' at the top of the screen.
- After you have clicked on the relevant document there is an option to Print at the top of the screen.
- When printing, in the PRINT dialog box ensure that 'Fit to Size' is selected. Otherwise the borders of the MCCD will be cut off.
- Similarly for printing the Clinical Summary.

Contact details

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or supportteam@hscni.net (BHSCT & WHSCT)

Regional Mortality & Morbidity Review System
Consultant Reviewing a Death

Access to RM&MRS / Selecting patients for review

- Once a death has been recorded onto the system & submitted for review, an email/message will be sent to the named Consultant – to their TRUST email account.
- When the email/message has been received, the review should be completed within 48 hours.
- The Consultant should log on to the ECR system.
- Click on M&M Review along the left hand side, then on Deaths Review.
- Simply clicking on 'Search' will show all the deaths for your M&M team; filters at the top of the page can be used to narrow it down to your deaths awaiting Consultant Review.
- If you are a member of more than one team you can filter your searches by selecting the appropriate team.
- Click on the relevant patient, select 'Pathways' at the top of the screen (if necessary) and click 'Mortality Consultant Review Task' along the left hand side.

If you are NOT the Reviewing Consultant

If you are NOT the correct Reviewing Consultant for a case:

- Follow the above steps, select the patient & access the patient Consultant Review form.
- At the top of the form there is an option to change either the team or Consultant or both.
- Complete the necessary changes and click on the 'Save Draft' button at the bottom of the page. This will re-assign the death.

If you ARE the Reviewing Consultant

If you ARE the reviewing consultant, select the case awaiting review.

- Answer relevant questions and review content submitted by recording Doctor. You should check information recorded in the Initial Record of Death, particularly information recorded for the MCCD. To see this click 'All' under 'Patient Tasks' at the top-left of the screen. The Initial Record of Death form will appear under 'Mortality Pathway' along the left-hand-side.
- Details entered previously by recording Doctor in the SBAR boxes can be amended however a record of what was previously entered will be retained for audit purposes. Further notes can be entered under the Consultant Notes section.
- Deaths will automatically default to 'Yes' for detailed review at M&M meeting. If a detailed review is not required this should be changed to 'No'.

Completing

- You must declare that you have reviewed the patient entries and accept them as correct.
- If you click 'No', you will be asked to enter your reasons and select which element you would like to correct.
- To finish, click 'Complete' at bottom of the screen.
- The case is then ready for review by the M&M team at the next team Specialist Mortality Review & Patient Safety meeting (M&M meeting).

Contact Details

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or supportteam@hscni.net (BHSCT & WHSCT)

Regional Mortality & Morbidity Review System
Setting Up a Mortality and Morbidity Meeting

Setting Up Mortality & Morbidity Meeting

- Access through logging into ECR system.
- Along left-hand-side of screen click on 'M&M Review', then click on 'Scheduled M&M Meetings'.
- At the top of the screen click on 'Add New Meeting'.
- Fill out the details and click 'Complete'. Room venue should be included under 'Meeting Details'.
- Meetings can be created in advance or at the time of the meeting.

Setting up Joint Meeting

- If you wish to hold a joint meeting with another team or teams these must be added under 'Additional Team(s)'.
- The meeting will appear on top of the list when 'Scheduled M&M Meetings' is clicked on.

Please note that this will not inform the rest of the team of the details of the M&M meeting. This should be done separately e.g. via Outlook.

Contact Details

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or supportteam@hscni.net (BHSCT & WHSCT)

Regional Mortality & Morbidity Review System
Running an M&M Meeting

Opening Meeting

- For setting up an M&M meeting, see previous how-to guide.
- To open an M&M meeting, log on to NIECR and click on 'M&M Review' along the left hand side and then click 'Scheduled M&M Meetings'.
- You will see a list of scheduled M&M meetings with the newest at the top. Select the meeting you wish to conduct.
- The first tab is 'Meeting Details'. Here you can amend the Chair of the meeting, add further details and add or remove attendees. It is recommended that you complete this tab at the end of the meeting and click 'Complete'. Please note that once the 'Complete' button has been clicked the attendees for the meeting are locked.

Deaths NOT for detailed Review

- The M&M lead is responsible for showing the list of deaths which have not been selected for detailed review to the attendees of the meeting.
- To do this click on the 'Deaths for Review' tab at the top, select 'No' for 'Death Awaiting for Review', select 'Pending Patient M&M Review' for 'Status' and click the 'Search' button. This will bring up the full list of deaths which have not been selected for detailed review.
- If everyone is content that these are not for detailed review, the M&M lead should click into each death, then on 'Patient M&M Review'. These will be defaulted to 'Not for Detailed Review' and M&M lead should simply click 'Complete'. The M&M lead may choose to complete these at the end of the meeting.
- To change the status of a death to needing a detailed review, click into the death from the list, click on 'Patient M&M Review Task' and change the Death for Detailed Review status from 'No' to 'Yes'. This will bring up the full Patient M&M Review Task Form.

Reviewing a Death

- To bring up a list of deaths awaiting detailed review, select 'Yes' beside 'Death Awaiting for Review', select 'Pending Patient M&M Review' for 'Status' and click 'Search'. This will bring up the list of deaths remaining to be reviewed by your team.
- To review a death, click on the relevant patient, then click 'Mortality Patient M&M Review Task' along the left hand side.
- Complete this form, including any lessons learned and actions identified, select the relevant outcome and click 'Complete'.
- To move quickly to the next death for review click on the three small horizontal bars at the top right of the screen (between two arrows) which will bring up a quick list. Otherwise click the 'X' at the top right and go back into the meeting.

Signoff

- Once a death has been reviewed, it requires sign-off at the next meeting, once the record of the meeting has been distributed.
- Assuming that all attendees are content that they are a true record, the M&M lead should click on the pending signoff tab. Each death should be clicked on, then 'Mortality Patient M&M Signoff'. The M&M lead should then select 'Yes' and click 'Complete'.
- All steps for the recording and review of this death have now been complete and the death is now signed off.

Record of Meeting

- Once all deaths have been reviewed and relevant deaths have been signed off, the M&M lead should review the attendance, then click 'Complete' under the 'Meeting Details' tab. This meeting has now been completed and no further deaths can be reviewed as part of this meeting.
- To view a record of deaths discussed, including lessons learned and action points, click on the 'Previous M&M Meetings' tab. When you click on a particular meeting, a record of the meeting will pop-up. This can be exported as a PDF or Excel file.

Regional Mortality & Morbidity Review System
Process for Additional Review Teams

Finding Deaths when Nominated as Additional Review Team

- On some occasions your M&M team may be nominated as an additional review team for a death. This may be because your team was previously involved in the care of the patient or for other reasons.
- If your team has been nominated to conduct an additional review, RM&MRS will allow you to conduct a review at an M&M meeting without having to complete an Initial Record of Death or Consultant Review Form.
- Deaths for which you have been selected to review as an additional team will appear on your deaths review list for your team.
- This can be accessed by clicking on 'M&M Review' along the left-hand-side followed by 'Deaths Review'. For these deaths your team will appear under the 'Additional Review Teams' column.
- If you are selected as an additional review team, the M&M review should be conducted as an 'ad-hoc task'.

Additional Review Teams

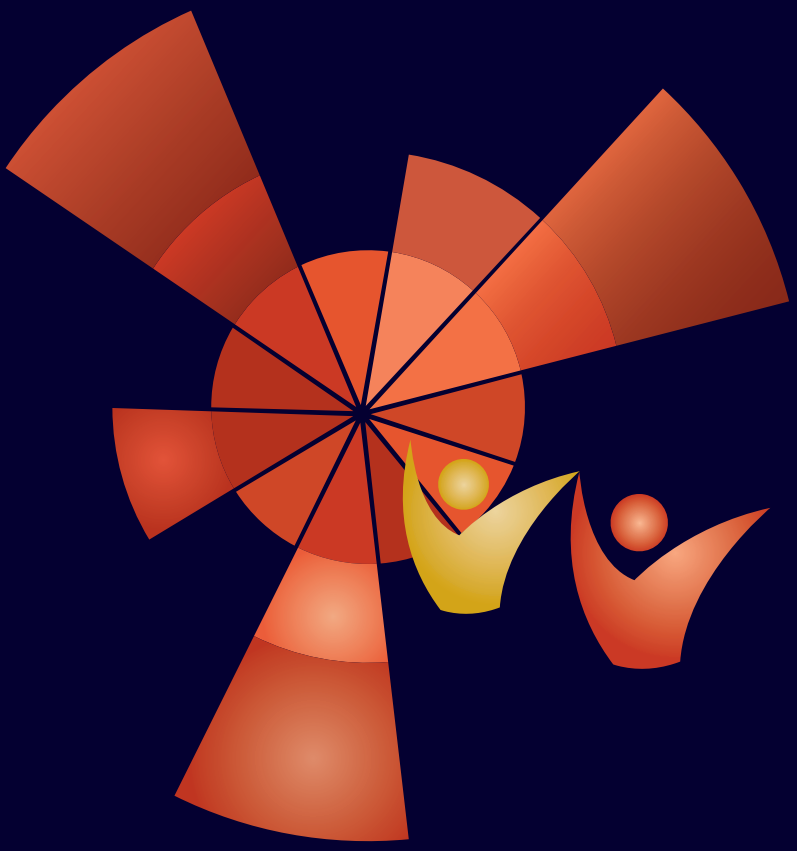
- If you are selected as an additional review team, the M&M review should be conducted as an 'ad-hoc task'.
- To do this, click on the patient on the death review list followed by 'Pathways' at the top if necessary.
- Click on the '+' at the top left of the screen beside 'Patient Tasks' and a drop down menu will appear. Select 'Mortality Additional Patient MM Review Task' and click 'Add Task'.
- The 'Mortality Additional Patient MM Review Task' form will then appear on the left-hand side of the screen under 'Mortality Pathway'.
- Discussions on this death should be recorded in the usual way.
- However as an additional team you will not be recording an outcome or grading of care for the death. Click 'Complete' once the form has been finished.
- If you are an additional review team, you should always use the ad-hoc task function as it will be up to the primary/initial team to conduct the pathway Patient M&M Review task.

Contact Details

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or supportteam@hscni.net (BHSCT & WHSCT)

HQIP
Healthcare Quality Improvement Partnership

Best Practice in Clinical Audit



September 2016

Contents

1 Introduction

In 2009, HQIP published 'Criteria and Indicators of Best Practice in Clinical Audit'. The purpose of that document was to 'define the markers or indicators of good quality clinical audit, at both national and local level'. The document was the result of wide consultation with clinicians, service managers and clinical audit staff, as well as representatives of a range of professional bodies including the Academy of Medical Royal Colleges. Since then the principles of good quality clinical audit have remained unchanged, but the context in which clinical audit is carried out has evolved. The statutory and contractual requirements for clinical audit that healthcare providers must meet have changed, and are continuing to develop.

In 2013, HQIP held workshops for clinical audit practitioners to review its guidance. The group that reviewed 'Criteria and Indicators' included clinical audit managers who had used the earlier guide as a resource to review and improve practice within their own organisations. It was felt that while the guide represented the gold standard of best practice, and was still useful, it needed updating to reflect contemporary practice.

There is now a greater understanding and appreciation of the relationship between clinical audit and other quality improvement activities. At a local service delivery level, clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes for service users. At a national level, projects such as the National Clinical Audit and Patient Outcomes Programme (NCAPOP) allow service providers to compare their performance with others and against nationally agreed standards, but the improvements that should flow from these comparisons must be made at the local service delivery level.

Many of the criteria described here also apply to national projects, but there are complexities in designing and carrying out national clinical audit and quality improvement projects that are beyond the scope of this document. The NCAPOP has continued to develop, and in 2014 HQIP published *'The Audit of Audits'*, which identified good practice within audit work streams. By providing advice for improvements to national clinical audit design and delivery, HQIP aims to help individual national audit providers enhance their roles in delivering high quality national audits that can contribute to improvements in the quality of patient care provided in NHS organisations.

The purpose of this document is to set out updated criteria for best practice in local clinical audit. These criteria will:

- Provide guidance for **clinicians# and clinical audit staff** on how to plan, design and carry out clinical audit projects that will deliver improvements in the quality of services
- Allow the **Boards and management of healthcare providers** to evaluate and improve the quality of clinical audit activities that take place within their organisations
- Allow **those who commission or monitor healthcare services** to assess the quality of clinical audit evidence provided to them
- Provide **service users*** with information on how they can participate in clinical audit, increasing their involvement and understanding of the process so that they can assess and improve the quality of the projects they are involved in

Where possible we have linked specific criteria to **more detailed and extensive guidance**, which can be found in supporting publications and resources from HQIP and other organisations.

The definition of clinical audit

'Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'

HQIP 'New Principles of Best Practice in Clinical Audit', Radcliffe Publishing, 2011.

The term 'clinician' is used throughout to refer to all clinical professions and staff at all grades, unless otherwise specified

* The term 'service user' includes patients and carers

2 Prerequisites to maximise the impact of clinical audit

If organisations are to gain the greatest benefit from clinical audit, there are certain prerequisites that must be in place. The role of Trust Boards in ensuring that clinical audit within a Trust is undertaken in accordance with best practice standards was emphasised in the 2010 *Francis Inquiry* report.

Recommendation 5:

The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.

The Francis Inquiry report, 2010

	Clinical audit best practice criteria	Links to further information
1	Clinical audit is a quality improvement activity and therefore it functions best as part of a planned programme of quality improvement that has been approved by the Board and/or senior management of the organisation.	HQIP, A guide for NHS Boards and partners: *www.hqip.org.uk/BPCA2016-001*
2	The Board should have dedicated time set aside to review both the clinical audit programme and the outcomes of individual projects.	HQIP, A guide for NHS Boards and partners: *www.hqip.org.uk/BPCA2016-001*
3	An effective clinical audit programme will cover the requirements and needs of a number of stakeholders including the Board, clinicians, service users and commissioning bodies. The programme should be developed in accordance with clear policy and agreed following consultation with clinicians, managers and patient representatives. The programme should be closely monitored and progress reported regularly at Board and service delivery level. An annual report, linked where appropriate to the Trust quality account, should be presented to both the Board and patient groups for scrutiny before publication.	HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007*
4	Service user and public involvement in clinical audit should be embedded in the organisation's public engagement strategy. The clinical audit programme should include patient-focused projects, and the roles played by service users and lay representatives should be acknowledged in clinical audit reporting at all levels.	HQIP, Patient and Public Involvement (PPI) Strategy: *www.hqip.org.uk/BPCA2016-003* HQIP, Patient and public involvement in quality improvement: *www.hqip.org.uk/BPCA2016-004* HQIP, Developing a patient and public involvement panel for quality improvement: *www.hqip.org.uk/BPCA2016-005* HQIP, Introduction to quality improvement for patients and public: *www.hqip.org.uk/BPCA2016-006*

5	In deciding which clinical audits should be undertaken, the following factors should be considered: • Clinical priorities, including clinical risks, adverse incidents and patient safety • Organisational priorities, including service redesign and development • Patient and service user priorities • Commissioner priorities and specifications, including Commissioning for Quality and Innovation frameworks (CQUINs) and NHS Standard Contract requirements • The outputs from the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and other national clinical audits • Professional revalidation, appraisal and training needs	HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007* Using clinical audit in commissioning: *www.hqip.org.uk/BPCA2016-008* HQIP, Statutory and mandatory requirements for clinical audit: *www.hqip.org.uk/BPCA2016-009* HQIP, Guide to involving junior doctors in clinical audit: *http://www.hqip.org.uk/resources/involving-junior-doctors-in-clinical-audit/* GMC, Guidance on revalidation: *http://www.gmc-uk.org/doctors/revalidation.asp*
6	Clinical audit is only one of a range of quality improvement methodologies and should not be used if another is more appropriate.	HQIP, Guide to quality improvement methods: *www.hqip.org.uk/BPCA2016-010*
7	Organisations must have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. The findings from clinical audits may be used as part of the Board Assurance Framework, but full assurance can only be obtained if the quality improvement aims of the project have been achieved. Governance plans should include arrangements for participation in local and regional cross-organisational audits.	HQIP, A guide for NHS Boards and partners: *www.hqip.org.uk/BPCA2016-001* HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007*
8	Policies and procedures must be in place to ensure that clinical audits (and all other quality improvement activities) are undertaken in a way that complies fully with current information governance legislation and guidance, and in consultation with local information governance leads and Caldicott guardians.	HQIP, Information governance for local quality improvement: *www.hqip.org.uk/BPCA2016-011*
9	All staff within an organisation should be made aware of, and comply with, the governance arrangements in place, including local policy and protocols on proposing, registering, undertaking and reporting on clinical audits.	HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007* HQIP, Guide for clinical audit leads: *www.hqip.org.uk/BPCA2016-012*

10	The organisation must enable the conduct of good quality clinical audit by providing appropriate resources to support the process. This includes dedicated time for audit and an appropriate level of funding. Organisations should have in place: • A senior clinician able to lead on clinical audit across the whole organisation • Clinical leads for quality improvement at service delivery level • Clinical audit practitioners who can manage the audit programme and support the process • A programme for supporting doctors in training to ensure that the clinical audit and quality improvement activities they undertake as part of their training deliver benefits to the organisation	HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007* HQIP, Guide for clinical audit leads: *www.hqip.org.uk/BPCA2016-012* HQIP, Guide to involving junior doctors in clinical audit: *www.hqip.org.uk/BPCA2016-014*
11	The organisation should seek to improve the knowledge and skills of all staff in quality improvement. Training in clinical audit should be available for all staff and where appropriate for lay representatives. All staff should be encouraged to participate in clinical and other networks that provide knowledge sharing and opportunities for staff development.	A promise to learn – a commitment to act: improving the safety of patients in England (the Berwick report): *https://www.gov.uk/government/publications/berwick-review-into-patient-safety* HQIP, Guide to involving junior doctors in clinical audit: *www.hqip.org.uk/BPCA2016-014* HQIP, Developing a patient and public involvement panel for quality improvement: *www.hqip.org.uk/BPCA2016-005*

3 Stages of the clinical audit cycle

Stage 1: Preparation and planning

	Clinical audit best practice criteria	Links to further information
1	Every quality improvement project should be reviewed to ensure that the topic is amenable to improvement and to determine the quality improvement method most likely to deliver improvement. Clinical audit should only be undertaken if it is deemed the most suitable methodology.	HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007 HQIP, Guide to quality improvement methods: www.hqip.org.uk/BPCA2016-015
2	Every clinical audit should have a clearly-stated quality improvement aim and objectives.	HQIP, Guide to ensuring data quality in clinical audit: www.hqip.org.uk/BPCA2016-016
3	The audit should measure performance against standards for process and outcomes that are based on the best available evidence and is clearly referenced.	HQIP, Guide to ensuring data quality in clinical audit: www.hqip.org.uk/BPCA2016-016
4	Every clinical audit should be carried out under the leadership of a named clinician. If the named lead is a junior doctor working on rotation, a more senior clinician should oversee the project to ensure that it is completed and that the quality improvement aims are met.	HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014

5	All clinical audits should be carried out in compliance with local governance arrangements, including local policy and protocols on proposing, registering, undertaking and reporting on clinical audits.	HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007*
6	All aspects of the clinical audit must be carried out in full compliance with the law and best practice on information governance and data security. This includes sample identification, data collection and analysis.	HQIP, Information governance for local quality improvement: *www.hqip.org.uk/BPCA2016-011*
7	All members of the clinical team engaged in delivering the service to be audited should be informed about the project from the start. In addition, a stakeholder group should be identified and engaged in the project. This should include: • Representatives of the clinical team • Other clinicians whose practice may be impacted by the findings of the audit • Service managers responsible for the service to be audited • Relevant service users, carers and lay representatives Requirements for the registration and monitoring of clinical audit should ensure that senior clinicians and management are aware of the project, but in some projects the stakeholder group might include senior clinicians and managers, Board members, commissioners and others. NOTE: The size of the stakeholder group and the degree to which members are engaged in the project will depend on the nature of the audit and this criterion should be applied proportionately. The key factor is to ensure that anyone who may be involved in acting on the findings of the audit is engaged from the beginning.	HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007*
8	Any ethical or information governance concerns should be escalated to the appropriate clinical lead and acted on in accordance with best practice.	HQIP, Information governance for local quality improvement: *www.hqip.org.uk/BPCA2016-011* HQIP, Ethics guide for clinical audit and quality improvement: *www.hqip.org.uk/BPCA2016-017*
9	Wherever possible, the stakeholder group must sign off the audit aim, objectives, standards and audit method before data collection begins. Data collection without stakeholder sign off must only be undertaken on the authorisation of the senior clinician leading the project.	HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007*

Stage 2: Measuring performance

	Clinical audit best practice criteria	Links to further information
1	The data set to be collected should be defined with reference to the audit standards, which should then be turned into valid measures of performance. Data that is not required to measure compliance with the audit standards should not be collected.	HQIP, Guide to ensuring data quality in clinical audit: *www.hqip.org.uk/BPCA2016-016*
2	The population of patients to be included in the audit should be defined with reference to the audit standards. The audit sample size should be set, and the sample selected, in accordance with best practice guidance. The rationale behind the size and selection method should be documented.	HQIP, An introduction to statistics for local clinical audit and improvement: *www.hqip.org.uk/BPCA2016-018*
3	Where data is to be extracted from electronic health records, the data extraction process should be tested to ensure that the correct data source is being used, and the correct sample and data are being extracted.	HQIP, Guide to ensuring data quality in clinical audit: *www.hqip.org.uk/BPCA2016-016*
4	Where the data is to be collected from paper health records, the following factors should be considered: • Design of the data collection tool - an existing validated tool may be used, or a tool should be designed and piloted, and the results from the piloting process reviewed before full scale data collection begins • Data collectors should be appropriately qualified. Where data collection takes place over an extended period, or multiple data collectors are involved, a protocol for data collection should be developed. This should define the data sources and provide all the information necessary to ensure that data is collected consistently. The protocol should be piloted alongside the data collection tool	HQIP, Guide to ensuring data quality in clinical audit: *www.hqip.org.uk/BPCA2016-016*
5	Clinical audit data should be analysed to measure compliance with standards. The statistics used should be appropriate for the purpose and should aim to provide the clearest possible picture of performance.	HQIP, An introduction to statistics for local clinical audit and improvement: *www.hqip.org.uk/BPCA2016-018*
6	In planning the analysis, consideration should be given to the level of granularity* required for reporting, particularly if clinicians wish to use clinical audit findings as part of their appraisal and revalidation. * Should the results be broken down by ward, consultant or clinic etc.	HQIP, Guide to clinical audit reporting: *www.hqip.org.uk/BPCA2016-019*
7	Full details of the clinical audit method must be recorded to ensure that any necessary repeat data collection to measure the impact of interventions is carried out in exactly the same way. Any unavoidable variation in the repeat data collection method must be documented and reported alongside the results.	HQIP, Guide to clinical audit reporting: *www.hqip.org.uk/BPCA2016-019*

Stage 3: Implementing change

	Clinical audit best practice criteria	Links to further information
1	The results should be shared with the stakeholder group. If the findings show non-compliance with standards, the underlying causes for non-compliance must be established.	HQIP, Using root cause analysis techniques in clinical audit: *www.hqip.org.uk/BPCA2016-020*
2	Once the underlying causes have been established, an action plan must be developed to address them. Improvements may be designed through techniques such as process mapping and adjustment, introducing communication tools, decision trees, new technology, 'plan, do, study, act' (PDSA) cycles and Lean Six Sigma. The action plan must be signed off by the stakeholder group and in accordance with local governance arrangements.	HQIP, Guide to quality improvement methods: *www.hqip.org.uk/BPCA2016-015* HQIP, Guide to using quality improvement tools to drive clinical audit: *www.hqip.org.uk/BPCA2016-021*
3	The action plan must be implemented and the effects monitored. Any unforeseen negative impacts must be addressed, and data must be collected to ensure that the impact of the action plan has improved compliance with standards. This will usually be by repeat data collection, although other monitoring methods such as run charts may be used.	HQIP, Guide to using quality improvement tools to drive clinical audit: *www.hqip.org.uk/BPCA2016-021*

Stage 4: Sustaining improvement

	Clinical audit best practice criteria	Links to further information
1	The audit cycle is not complete until evidence has been obtained to demonstrate that implementation of the action plan has resulted in an improvement in the quality of services.	HQIP, 'New Principles of Best Practice in Clinical Audit', Radcliffe Publishing, 2011
2	In order to ensure that the improvement is sustained, the stakeholder group should determine whether the audit needs to be repeated, and if so, when. They should also determine whether refinements are required to the audit protocol and data collection tool for greater focus on shortfalls identified. Alternative approaches to ensuring that quality of service is maintained, such as some form of ongoing monitoring, should also be considered.	HQIP, Clinical audit policy and strategy guidance: *www.hqip.org.uk/BPCA2016-002* HQIP, Developing a clinical audit programme: *www.hqip.org.uk/BPCA2016-007*
3	The results of the audit, including the outcome of the implementation of the action plan, should be documented and shared with key stakeholders and the rest of the organisation. The results and outcomes should also be shared with service users and with the public.	HQIP, Guide to clinical audit reporting: *www.hqip.org.uk/BPCA2016-019*
4	Where possible, share the learning from the audit project with colleagues, both within the organisation and across partner organisations, including commissioners, clinical networks and other professional groups. Learning points could include: • Audit methodology • How change was implemented • Impact on patient care / clinical outcomes • Impact on service efficiency • Challenges and how they were overcome	HQIP, Guide to clinical audit reporting: *www.hqip.org.uk/BPCA2016-019*

HQIP Healthcare Quality Improvement Partnership

Further information is available at: www.hqip.org.uk

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HQIP
Healthcare Quality Improvement Partnership

Developing a clinical audit programme

November 2016

HQIP Healthcare Quality Improvement Partnership

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Contents

1 Introduction

1.1 Background

The Healthcare Quality Improvement Partnership (HQIP) has published guidance on a range of topics associated with clinical audit and quality improvement. In 2009, HQIP published guidance and templates covering the development of clinical audit strategies and policy, clinical audit reports, and how to devise and manage the annual clinical audit programme. Many NHS organisations and other healthcare providers have used these publications to develop their own policies, strategies, programmes and report templates.

The guidance was updated in 2012, and reviewed as part of a series of workshops for clinical audit practitioners held by HQIP in 2013. At that time it was felt that while still useful, the guidance needed further updating to reflect contemporary practice.

Although the principles of good quality clinical audit have remained unchanged, the context in which clinical audit is carried out has evolved. There is now a greater understanding and appreciation of the relationship between clinical audit and other quality improvement activities, and many NHS Trusts have moved to integrate clinical audit into wider programmes of quality improvement and service development.

This begs the question as to whether there is a need for a clinical audit policy or programme that stands apart from wider policies and programmes of quality improvement. Some Trusts are now moving towards full integration of all aspects of service improvement, and are reaping the benefits that this can yield. Different approaches to this process of integration work well in different organisations, and at present there is no single consensus on how such an integrated approach should be achieved or governed.

There are distinct statutory and contractual requirements for clinical audit, which healthcare providers must meet. The statutory and mandatory frameworks that regulate clinical audit within the NHS in England continue to evolve, and are detailed within HQIP's publication *Statutory and mandatory requirements in clinical audit*.[1] Our guidance on policy and programme development aims to support NHS Trusts in meeting these requirements, as well as ensuring that they use clinical audit effectively to improve the quality of their services. While the guidance itself refers to clinical audit, many aspects can be applied to other quality improvement methods, and can be used to develop integrated policies. It is for each Trust to determine how they should approach clinical audit and quality improvement, and how they use this guidance.

Introduction to the guidance

HQIP suggests that the four organisational documents below are necessary for the effective management of clinical audit. These documents are intimately linked and should be read together.

- **A policy on the use and conduct of clinical audit:** which sets out the principles, roles,responsibilities and practices a healthcare provider will follow in auditing clinical practice, and improving the quality of services to meet the needs of patients, healthcare commissioners, healthcare regulators, and others
- **A strategy on the development of clinical audit:** which describes how a healthcare provider will implement the policy, and increase the impact of audit on clinical services
- **A clinical audit programme:** which presents a prioritised summary of planned clinical audit activity and outcomes, that is regularly updated and scrutinised in accordance with the above clinical audit policy and strategy
- **A clinical audit report template:** which provides consistency in clinical audit reporting

The aim of this publication is to support healthcare providers in developing their clinical audit programme, with tools for ongoing management and annual review.

A clinical audit programme should:

- **Reflect key national and local drivers for quality improvement**
- **Balance key drivers with directorate/division/service/clinician priorities**
- **Include a system for prioritisation of clinical audit**
- **Enable monitoring to ensure clinical audits selected for the programme are completed**

1.2 Functions of the clinical audit programme

The clinical audit programme may exist in a variety of forms, either paper-based or electronic. At the most basic level, it will be a simple list of all the clinical audit projects planned or undertaken by the healthcare provider in a given period of time – normally a financial year. For a small organisation such as an individual GP practice, a single list may suffice. For a large, acute hospital Trust, the programme may be broken down into several lists, including one for Trust-wide projects, one for projects undertaken in collaboration with other local providers as well as separate lists for each clinical division or directorate. In this case, it is essential that these separate lists are also integrated so that they are monitored as one overall programme.

The programme allows the healthcare provider to fulfil several functions:

- Meeting requirements for external monitoring – see 1.3 opposite
- Monitoring progress made in completing the programme
- Monitoring the quality of clinical audit activity
- Monitoring the impact of the programme

In most cases the list will be incorporated into a database that includes a range of key information about each of the individual clinical audit projects. A minimum data set for a clinical audit programme database is given at *Appendix 1*. It includes basic information that should be obtained when projects are first registered, together with other quality management and monitoring information that should be added as projects progress.

1.3 Requirements for external monitoring

HQIP's *Statutory and mandatory requirements in clinical audit*[1] guidance presents key requirements for clinical audit, which must form the basis of healthcare providers' approach to compiling their annual clinical audit programmes.

The clinical audit programme must:

- Meet the healthcare provider's contractual obligations to those who commission its services; this includes meeting the terms of the NHS Standard Contracts, which requires participation in the National Clinical Audit Patient Outcomes Programme (NCAPOP) audits relevant to the services they provide, and any locally agreed requirements such as Commissioning for Quality and Innovation (CQUIN) audits
- Use the findings from clinical and other audits – including those undertaken at a national level, such as national confidential enquiries and inquiries and national service reviews – to ensure that action is taken to protect people who use services
- Ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development)
- Meet the requirements of the regulatory framework operated by the Care Quality Commission (CQC), which requires registered healthcare providers to regularly assess and monitor the quality of the services provided, to ensure that action is taken to protect people who use services from risks associated with unsafe care
- Provide Foundation Trust Boards with the assurance they need to certify that they have effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients, by using systems, processes and procedures to monitor, audit and improve quality
- Enable healthcare providers, who are required to produce and publish Quality Accounts, to compile the information they need efficiently

2 Compiling the annual clinical audit programme

2.1 Roles and responsibilities

The healthcare provider's clinical audit policy should set out the roles and responsibilities of all the key players who will be involved in compiling and managing the clinical audit programme. For NHS Trusts this should include the role of the Trust Board in setting Trust priorities and requirements, the role of the medical director in ensuring that the annual programme is allied to the Board's strategic interests and concerns, and the roles and responsibilities of the committees/groups that are involved in the prioritisation of the programme and the subsequent review of reports and re-audits.

A key issue is who has overall responsibility for compiling the annual clinical audit programme, and for the purposes of this guidance it is assumed that this will be the clinical audit manager (or the manager who takes overall responsibility for clinical audit, whatever their job title might be). In larger organisations, the manager will need to work closely with the directorate leads for clinical audit, who will have delegated responsibilities including:

- Ensuring that all clinical audit activity within their directorate is registered
- Ensuring that their directorate participates in all national clinical audits, national confidential enquiries and service reviews relevant to the services that it provides
- Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Trust requirements

HQIP's *Guide for clinical audit leads* provides detailed guidance on the role of the clinical audit lead in compiling and monitoring the clinical audit programme.[2]

2.2 Stakeholders

Compiling the clinical audit programme requires close co-operation between all key stakeholders, including commissioners, clinical leads at all levels of the organisation, clinical governance managers, and all those responsible for formulating organisational policies.

All staff working in the organisation should have the opportunity to propose projects, and the views of patients, service users, carers and the public should be sought. Both national and local priorities should influence the development of the clinical audit programme.

2.3 External 'must-do' audits

The first step in developing a comprehensive annual programme is the identification of all the clinical audit projects that **must** be undertaken by the provider.

Every healthcare provider will have a number of clinical audits that it must complete on a regular – perhaps annual – basis in order to meet the external monitoring requirements outlined above.

It is essential to ensure that they are treated as priorities and that appropriate resources are provided to support them. Failure to participate or deliver on these externally driven audits may carry a penalty for the Trust, either financially, or in the form of a failed target, or non-compliance with regulations. They will form the core of the annual clinical audit programme.

The list of 'must-do' audits will vary between types of healthcare provider, but may include:

- *NCAPOP and other national clinical audits relevant to the services provided, and/or where participation must be reported in Quality Accounts**
- *Audits demonstrating compliance with regulatory requirements, e.g. audits with the aim of providing evidence of implementation of National Institute for Health and Care Excellence (NICE) guidance, National Service Frameworks, and other national guidance such as that generated by the Clinical Outcomes Review Programme (CORP – covering National Confidential Enquiries and Inquiries)*
- *Audits required by external accreditation schemes, e.g. cancer peer review audits etc*
- *Audits that must be undertaken in order to comply with provider policies, particularly those that are subject to external review*
- *Commissioner priorities including national and regional Commissioning for Quality and Innovation (CQUIN) audits*

** See HQIP www.hqip.org.uk/national-programmes/quality-accounts/*

It should also be noted that while most healthcare providers will follow an annual clinical audit programme, many of these projects will need to be undertaken regularly, so a forward plan for future years can be maintained.

2.4 Internal 'must-do' audits

Every healthcare provider will also be able to compile a list of internal 'must-do' clinical audits, based on identified high risk or high profile matters arising locally. Many of these clinical audits will arise from governance issues or high profile local initiatives, and may include national initiatives with local relevance, without penalties for non-participation. They may include:

- Audits undertaken to meet organisational objectives and service developments
- Clinical risk issues
- Audits undertaken in response to serious untoward incidents/adverse incidents/complaints
- Organisational clinical priorities
- Priorities identified via patient and public involvement initiatives

2.5 Registering clinical audit proposals

Once the 'must-do' audits have been identified, stakeholders should be asked to propose projects that they believe would be of benefit to the healthcare provider and its patients and service users.

The most effective way of managing this part of the process is to stipulate that anyone who wants to propose an audit must complete an audit registration form, or proposal document. This form, which could be in hard copy, or electronic, should act as a prompt to ensure that the proposer has considered all of the issues that need to be addressed, in order to decide if the proposal is realistic and relevant to the organisation. In addition to providing the basic information required to enter the project onto the programme database, it should also provide the information that will be required to prioritise the project – see 3.2 overleaf.

3 Review, prioritisation, and formal approval

3.1 Reviewing the draft programme

Each Trust should have a framework to support effective clinical audit that relies on strategic planning and prioritisation. Clinical audits should contribute to the overall priorities of the organisation and should clearly improve patient care. However, resources are finite; both in terms of clinician time and central support function resource and this places a limit on the number of audits that can be carried out over the course of a year. This means that when all the various needs have been considered and a draft programme compiled, the projects that have been proposed need to be reviewed and prioritised in a systematic way. This process of review must be clinically led, and must take into account resource implications.

In smaller organisations the review may be dealt with centrally but in larger providers, the review is likely to require a staged process, with reviews at service unit or directorate/division level, followed by a final review by the clinical audit committee and sign off by the Trust Board.

Issues to be considered during the review include:

- *Is the project a clinical audit? Does it aim to improve patient care by implementing change, where quality of care under review falls short of defined standards and criteria? (Projects that do not meet this definition, e.g. patient surveys, and service reviews with no agreed standards, may still be of value to the provider but there should be a clear statement in the clinical audit policy about whether such projects will be registered as part of the clinical audit programme and how the governance and ethical issues raised by such projects will be addressed)*
- *Is the audit topic of relevance to the organisation?*
- *Are all clinical services represented on the programme?*
- *Are the requirements for clinical audit training for junior doctors and revalidation for more senior staff being met?*
- *What priority should be given to each clinical audit?*

3.2 Prioritising the draft programme

It is important to distinguish between the need to prioritise audits in order to make appropriate plans for the use of resources, and the need to register and monitor clinical audit activity in order to meet external monitoring requirements.

The highest priority must be given to the 'must-do' audits. Once they have been identified, the next priority should be given to projects that are important at the directorate/division/service unit level. Directorate priorities may include:

- Local clinical interest audit agreed by the directorate/division/service as a priority
- National audits where participation is not required to be reported in Quality Accounts
- Participation in regional audits undertaken as part of clinical specialty networks or regional clinical audit networks

Factors that should be taken into account in determining directorate priorities are listed in HQIP's *Best practice in clinical audit*.[3] They include:

- *Is the topic concerned with high cost, high volume or high risk to staff, or to patients/service users?*
- *Is there evidence of a quality problem, e.g. patient complaints, high complication rates, adverse outcomes or poor symptom control?*
- *Is there evidence of wide variation in practice?*
- *Is good evidence available to inform audit standards, e.g. systematic reviews or national clinical guidelines?*
- *Is the problem measurable against relevant standards?*
- *Is auditing the problem likely to improve healthcare outcomes as well as process improvements?*
- *Is auditing the problem likely to have economic and efficiency benefits?*
- *Is the topic a key professional or clinical interest?*
- *Are reliable sources of data readily available for data collection purposes?*
- *Can data be collected within a reasonable time frame?*
- *Is the problem concerned amenable to change?*
- *Is the topic pertinent to national or local initiatives or priorities?*
- *Does the topic lend itself to the process of audit, or is a different process more appropriate e.g. root cause analysis, activity or workload analysis?*
- *How much scope is there for improvement, and what are the potential benefits of undertaking this audit?*

Other factors include the scope for the direct involvement of patients and carers, and whether the project crosses organisational or disciplinary boundaries.

Some of these factors may be applied using a Quality Impact Analysis – *Appendix 2* provides an example.

The lowest priority for use of resources must be given to those audits that are proposed by individual clinicians or clinical teams. This might include audits undertaken by junior doctors for training purposes or by more senior staff as part of the revalidation process. While staff should not be discouraged from undertaking projects that can bring about real improvements in patient care, it must be made clear to all staff that the need for training or revalidation can be met by undertaking projects that also meet directorate, division or organisational priorities.

It is important to ensure that the views of all stakeholders are taken into account during prioritisation. This means consulting with commissioners, patients and the public.

3.3 Approval of the clinical audit programme

In order to be effective in achieving improvements in the quality of care and patient outcomes, the clinical audit programme must have the support and backing of both the clinical leadership and the senior management. In NHS Trusts the medical director, chief executive and Trust Board all have direct responsibilities for the quality of the services they provide, and therefore must be directly engaged in developing and signing off the clinical audit programme.

3.4 Additions to the clinical audit programme

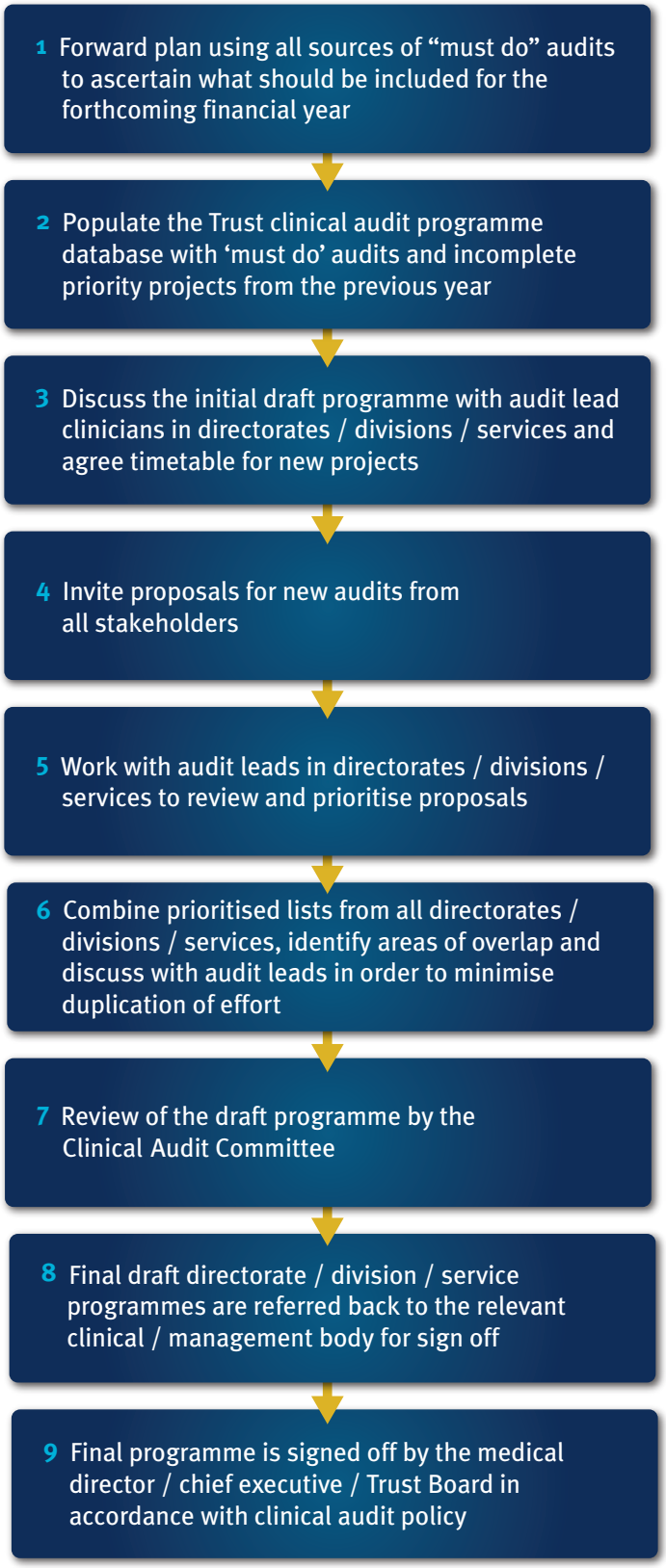
Compiling and prioritising an annual clinical audit programme at the start of the year should not stifle projects that emerge during the year that will contribute to improvements in care.

Some of these projects might be new 'must-do' audits that could not be determined at the outset of the financial year. Others may represent innovative ideas from clinicians, which are just as valid and important as ideas proposed when the programme was originally developed. All this leads to the need for a transparent system for decision-making about whether or not (and to what extent) a project proposed later in the year should attract support from clinical audit resources.

Organisations may wish to update their annual clinical audit programme as part of the regular review of progress, or alternatively record these additional projects on a separate but complementary clinical audit programme. Whichever approach is taken, all clinical audits must be registered so that processes and outcomes can be monitored and the maximum benefit gained for the organisation.

3.5 Practical steps in compiling an annual Trust clinical audit programme

This is a summary of the steps that should be taken in compiling the programme:



4 Monitoring the clinical audit programme

4.1 Responsibilities

Each clinical audit project on the programme should have a clinical lead who is ultimately responsible for the conduct of the audit. However in order to ensure that the organisation as a whole benefits from the programme, it must be monitored, and it is up to each healthcare provider to decide who should be responsible for this process. Responsibility for directorate/division/service unit programmes may be delegated to clinical leads or clinical audit facilitators who work within each of those service levels, while organisation-wide projects may be monitored centrally by the clinical audit manager, or the whole process may be dealt with centrally. These responsibilities must be reflected in the organisational clinical audit policy.

The healthcare provider's clinical audit policy should set out clear lines of reporting for monitoring the clinical audit programme.

4.2 Monitoring progress

Appendix 3 gives an example of a progress report that might be submitted quarterly to the relevant committee. The report gives basic information about all of the projects, and uses a traffic light system/RAG (red-amber-green) rating to indicate progress (or lack of it).

This summary report is based on detailed information held within the clinical audit programme database, and within some databases can be automatically generated as a report.

In order to be able to decide whether a project is progressing satisfactorily, the clinical lead or clinical audit facilitator who maintains the database must receive regular updates on progress from the audit lead. There should be an agreed process for following up on projects that are failing to progress, including provision for escalating concerns to the clinical audit committee.

4.3 Monitoring the implementation of action plans

Once a cycle of data collection has been completed, an action plan will be developed, and the progress in implementing this action plan should also be monitored. All actions should include target dates for completion, and reporting may therefore be by exception. There should be an agreed process for following up any actions that have not been implemented by the target date.

4.4 Identifying risks

If the failure to progress or complete a clinical audit, or the failure to implement an action plan, poses a risk to patients, staff or the healthcare provider as a whole (e.g. a financial risk due to failure to meet standards), appropriate entries must be made on the provider risk register.

5 References

1. Statutory and mandatory requirements in clinical audit (HQIP): *www.hqip.org.uk/resources/hqip-statutory-and-mandatory-requirements-in-clinical-audit-guidance/*
2. Guide for clinical audit leads (HQIP): *www.hqip.org.uk/resources/guide-for-clinical-audit-leads/*
3. Best Practice in Clinical Audit (HQIP, Radcliffe Publishing, 2011): *www.hqip.org.uk/resources/best-practice-in-clinical-audit-hqip-guide/*

Appendix 1. Minimum data set for a clinical audit database

- Unique identifier
- Title of the clinical audit
- Directorate(s)/division(s)/service unit(s) affected
- Audit aims and objectives
- Is the audit an external 'must-do' audit? If so, why?
- Is the audit an internal 'must-do' audit? If so, why?
- Priority level
- Clinician who takes overall responsibility for the audit
- Names of any other clinicians directly involved in carrying out the audit (e.g. junior doctors)
- Name(s) of the clinical audit facilitator(s) who have been involved in the audit
- Key stakeholders and their involvement in the audit
- Involvement of patients or carers – who have been involved and in what way?
- Work plan for carrying out the clinical audit, including expected and actual dates for completion of key stages including re-audit
- Date final report approved and distributed
- Committee/group with responsibility for review of results and ensuring actions are taken, including actual date report received and actions taken and approved

Appendix 2. Quality Impact Analysis

This table can be used to provide a transparent system for deciding whether or not (and to what extent) a locally-conceived clinical audit project should attract clinical audit resources. Each project should be scored against the following criteria.

Criteria	No relevance (0)	Some relevance (1)	Almost met (2)	Fully met (3)	Score
High cost					(x2)
High volume					
High risk					(x2)
Evidence of a quality problem					(x2)
Wide variation in practice					
Good evidence available to inform audit standards					
Likely to improve healthcare outcomes as well as process improvements					
Likely to have economic and efficiency benefits					(x2)
Topic is a key professional or clinical interest					
Reliable sources of data readily available					
Reasonable time frame for completion					
Potential for change					(x2)
Scope for direct involvement of patients and carers					
Multidisciplinary project					
Interface project *					
TOTAL SCORE					

* When projects cross organisational boundaries, consideration should be given to the priority the project has in each organisation.

If the criterion has no relevance, score = 0
If the criterion has some relevance, score = 1
If the criterion is met in part, score = 2
If the criterion is fully met, score = 3
NB Multipliers are used to weight the most important criteria

Appendix: 3 Clinical Audit Progress Report for 'Insert name here' Division/Directorate

Project reference number	Project title	Clinical audit contact	Lead clinician	Project start date	Current Status				Comments	Priority level	Support level
					Q1	Q2	Q3	Q4			

Current Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken.
Amber	Delayed, with evidence of actions to get back on track.
Green	Progressing on schedule, evidence of progress.
Blue	Completed, evidence of compliance with standards or action plans to achieve compliance.
White	Audit not planned to start this quarter.

Priority level		Support level	
1	External 'Must-do'	I	Minimal support – registration and advice only
2	Internal 'Must-do'	II	Moderate support – review design, practical assistance
3	High local priority	III	Full facilitation
4	Medium local priority		
5	Low local priority		

Further information is available at: www.hqip.org.uk

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November 2016. Next review date: November 2019

2.032

Belfast Health and Social Care Trust

Reference No: SG 44/13

Title:	Health and Social Care Audit Policy		
Author(s)	Christine Murphy, Senior Manager, SQA Fintan McErlean, Audit Manager, SQA		
Ownership:	Dr Tony Stevens, Medical Director		
Approval by:	Standards and Guidelines Policy Committee Executive team Meeting	**Approval date:**	6/11/13 18/11/13 20/11/13
Operational Date:	December 2013	**Next Review:**	December 2016
Version No.	V1	**Supercedes**	
Key words:	Clinical Audit Policy		
Links to other policies			

Date	Version	Author	Comments
Nov 13	0.1	F McErlean	Initial Draft

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Clinical Audit is defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change."
"Clinical audit is the component of clinical governance that offers the greatest potential to assess the quality of care routinely provided for NHS users – audit should therefore be at the very heart of clinical governance systems".
(Principles for Best Practice in Clinical Audit (2002, NICE/CHI)

When audit is used as a means of measuring practice against defined standards, it can:

- Provide reassurance that compliance with standards is good
- Highlight poor compliance to reduce risk and inefficiencies
- Lead to improved patient care and outcomes

The title of this policy refers to Clinical Audit which also includes the terms, *Multi-professional Audit* and *Clinical & Social Care Audit.*

1.2 Purpose

The purpose of this policy is to provide guidance to ensure that there is a standardised approach to audit within the Belfast Trust. It will include the Trust process for carrying out an audit covering issues such as:

- Approval
- Registration
- Support
- Action

2.0 DEFINITIONS/SCOPE OF THE POLICY

The policy applies to all healthcare professionals participating in clinical audit or service evaluation projects within the Belfast Trust. The policy does not apply to individuals conducting research projects.
Important distinctions are outlined below:

- **Clinical Audit:** Determines if a pre-determined standard is achieved.
- **Service Evaluation:** Determines what standard is achieved
- **Research:** Generates new knowledge and aims to establish what best practice is.

3.0 ROLES/RESPONSIBILITIES

3.1 Medical Director

3.2 Standards, Quality & Audit Department
The Senior Manager of the Standards, Quality & Audit Department is supported by the Clinical Audit Managers to:

- Register, provide support and guidance *(Appendix 1)* for audit throughout the Trust
- Provide opportunities for training in the concepts and basic skills required to undertake audit
- Produce activity reports of audits registered within the Trust.

4.0 KEY POLICY PRINCIPLES

4.1 Trust Audit Process

When approval has been signed off by a Consultant or Senior Manager, all audits will be registered with the Standards, Quality and Audit Department. When charts are required for audit, the chart request process should be followed *(Appendix 5)*. Audits should be presented at audit meetings following the rolling audit calendar (Appendix 6) which is released on a regional basis by the DHSSPSNI via the Guidelines Audit and Implementation Network (GAIN). A summary of ongoing audits and agreed actions will be circulated to the relevant Audit Leads and Service Area Governance groups for review and monitoring.

The main steps in the Trust audit process are: *(Appendix 2)*

- Need for audit identified by group within or across service areas.
- Audit team identified, to include Consultant or Senior Manager.
- Proposal form completed *(Appendix 3)*
- Proposal assured and registered with Standards, Quality and Audit Department
- Lead person contacted to agree time frame and any resources
- Audit carried out
- Development of action plan *(Appendix 4)*
- Re-audit identified for that Service Areas audit plan.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

List the groups of staff for whom this policy has relevance.
Provide a realistic time scale for implementation and highlight any potential barriers.
Indicate who should be notified (usually the author) if there are significant barriers and timescales are not being met.

5.2 Exceptions

The scope should detail all areas where the policy is to apply - this is to note any area that has been noted as exempt because it is currently unable to comply with or implement the policy.

6.0 MONITORING

Provide detail of any inherent key performance indicators (KPI) relevant to the successful implementation of this policy.
Describe the process for monitoring the effectiveness of all of the above and who and how this will be done. This monitoring should include any section 75 implications of implementing the policy.

7.0 EVIDENCE BASE / REFERENCES

Identified guidance around best practice in Audit

8.0 CONSULTATION PROCESS

Standards, Quality & Audit Department. Standards & Guidelines Committee,

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Guidance on conducting and audit
Appendix 2 - BHSCT Audit Process
Appendix 3 – Multi Professional Audit Proposal Form
Appendix 4 - Process For Ordering Patient Charts For Audit
Appendix 5 – Clinical Audit Training
Appendix 6 – Rolling Audit Calendar 2013 – 2017
Appendix 7 - Multi-Professional Audit Summary Form
Appendix 8 – Action Plan

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Christine Murphy

_____ **Date: ___December 2013__**
Author

_____ **Date: ___December 2013__**
Director

Appendix 1 **Guidance on conducting an audit**

1. Choose Topic

Audit topics should be chosen and prioritised based on their importance in addressing an identified issue **or** their potential to improve the quality and care provided. Topics should be agreed by teams of staff / be fully supported by a Senior colleague (Consultant / 5th Level Manager)

Important topics should:

- Address an identified problem (e.g. from complaints or adverse incidents)
- Support the implementation of quality standards (e.g. auditing new NICE guidance)
- Address issues in: High volume, High risk or High Cost areas of practice

2. Identify a team

It is important that your project is supported by colleagues who will have the authority and commitment to see any necessary changes (as indicated by the audit results) put into practice.

If your audit has implications for professions other than your own, make sure they are consulted at the planning stage.

3. Set Objectives and Standards

Projects should have a specific focus on measuring adherence to an identified standard or guideline. Identify and get agreement on the standards which represent best practice. The key points which you plan to measure performance against should be outlined in the audit proposal form.

4. Data Protection Principles

(i) Personal details (name, date of birth) should **never** be recorded on the audit form

(ii) Record only an "audit ID" on the data collection form and have a separate sheet of paper linking the "Audit ID" to the hospital number. Alternatively if it is necessary to have an identifier on the data collection form, only the hospital number should be used.

(iii) Data collection should be limited to the data relevant to identified standards used in the audit.

(iv) Both paper and electronic data should be kept securely.

(v) Data collection forms should not be destroyed once the project is complete.

5. Analyse your data

Pull your data together in a meaningful way and compare your results with your standards. How well have the standards been met? What were the reasons for failure to meet standards?

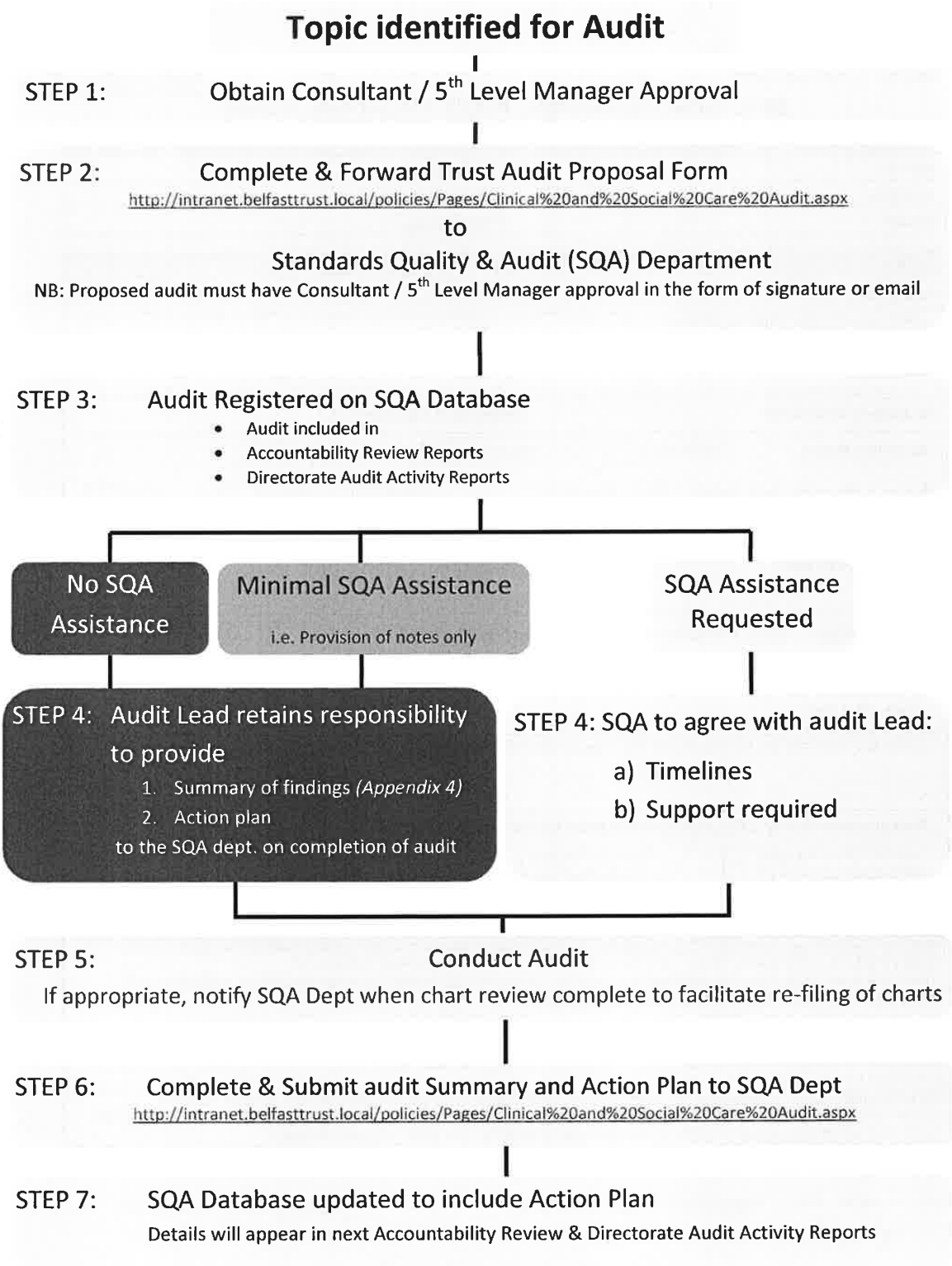
6. Report your findings back to the relevant area/s.

Decide the most appropriate way to report your findings. Consider who needs to be involved in implementing any improvement or actions.

7. Agree and complete a Summary Report and Action Plan (Appendix 2) and send a copy to Standards, Quality and Audit Department.

It is important that a record of results and planned activity is kept as so we can improve service as a result of audit. All improvements made as a result of audit will be reported to each service areas governance meeting.

Appendix 2- **BHSCT Audit Process**



Appendix 3

Belfast Health and Social Care Trust

ID No: (office use only)

MULTI-PROFESSIONAL AUDIT PROPOSAL FORM

DETAILS of PERSON LEADING AUDIT (i.e. Key Contact)	
Name:	Band/Grade:
Job title:	Base Location:
Email:	Tel / Bleep:

AUDIT DETAILS
Audit Title:
Lead Directorate *(Service Group)*:
Specialties Involved:
Proposed Start Date: Estimated End Date:
Remit of Audit: National ☐ Regional ☐ Local ☐
Please Specify Care Areas / Site(s) Involved: RGH ☐ KHCP ☐ S&E ☐ MPH ☐ BCH ☐ Mater ☐ N&W ☐ *(MPH = Musgrave Park / KHCP = Knockbracken)*
Aims / Objectives:
Methodology: *Data Collection* - Retrospective ☐ Concurrent ☐ Prospective ☐ **Chart Review** ☐ Questionnaire ☐ Other (please specify) _____ **Sample Size:** _____
Criteria / Standards being used: *(i.e. Please identify the source of evidence being measured against.)*
Please specify any SQA support required to carry out this audit? Audit Plan/Design ☐ Provision of notes ☐ Data Collection ☐ Data Analysis ☐ Presentation ☐ Report Writing ☐ None ☐

APPROVAL / REGISTRATION DETAILS	
Any Audit carried out within BHSCT should be supervised by a senior member of staff within that area and be registered by the Standards Quality and Audit Dept prior to commencement of the Audit. To ensure that this is done as efficiently as possible, electronic signatures / e-mails forwarding application with endorsement of approval should be used where possible: (i) Supervising/ Approving Consultant or Senior Manager (5th level or above)	
Name:	
Position / Job Title:	
By signing this form I confirm that this project is an appropriate audit for this area of care and the relevant stakeholders have been identified in the application. I will support the dissemination of results and implementation of action plan (if necessary) in order to obtain improvements in the quality of care provided.	
Signature:	

Email completed form to: fintan.mcaleanj@belfasttrust.hscni.net or verdi.jarvis@belfasttrust.hscni.net

Forms can also be posted to: Standards Quality & Audit Dept., 4th Floor, Bostock House, RVH

(Please retain a copy for your own records)

Appendix 4 **PROCESS FOR ORDERING PATIENT CHARTS FOR AUDIT**

Appendix 5

Clinical Audit Training

Training sessions lasting 1½ - 2 hours are available for all health & social care staff within the Belfast Trust. These sessions are usually held every other month (not during July or August).

The aim of this introductory course is to provide guidance on how to carry out an audit of current practice. Topics covered include:

- Definition of audit
- History and benefits of audit
- Different stages of audit
- Audit process within the Belfast HSC Trust

Sessions can be booked on the Trust Intranet (the hub).

If you have any enquiries, please contact by email or phone (details below)

[redacted]. ([redacted])

Appendix 6

Rolling Audit Calendar 2013 - 2017				
Month	Date	Year	Time	Day
SEPTEMBER	17th	2013	PM	TUESDAY
OCTOBER	16th	2013	AM	WEDNESDAY
NOVEMBER	20th	2013	PM	WEDNESDAY
DECEMBER	19th	2013	AM	THURSDAY
JANUARY	16th	2014	PM	THURSDAY
FEBRUARY	21st	2014	AM	FRIDAY
MARCH	21st	2014	PM	FRIDAY
APRIL	15th	2014	AM	TUESDAY
MAY	20th	2014	PM	TUESDAY
JUNE	18th	2014	AM	WEDNESDAY
JULY	16th	2014	PM	WEDNESDAY
AUGUST	21st	2014	AM	THURSDAY
SEPTEMBER	18th	2014	PM	THURSDAY
OCTOBER	17th	2014	AM	FRIDAY
NOVEMBER	21st	2014	PM	FRIDAY
DECEMBER	16th	2014	AM	TUESDAY
JANUARY	20th	2015	PM	TUESDAY
FEBRUARY	18th	2015	AM	WEDNESDAY
MARCH	18th	2015	PM	WEDNESDAY
APRIL	16th	2015	AM	THURSDAY
MAY	21st	2015	PM	THURSDAY
JUNE	19th	2015	AM	FRIDAY
JULY	17th	2015	PM	FRIDAY
AUGUST	18th	2015	AM	TUESDAY
SEPTEMBER	15th	2015	PM	TUESDAY
OCTOBER	21st	2015	AM	WEDNESDAY
NOVEMBER	18th	2015	PM	WEDNESDAY
DECEMBER	17th	2015	AM	THURSDAY
JANUARY	21st	2016	PM	THURSDAY
FEBRUARY	19th	2016	AM	FRIDAY
MARCH	18th	2016	PM	FRIDAY
APRIL	19th	2016	AM	TUESDAY
MAY	17th	2016	PM	TUESDAY
JUNE	15th	2016	AM	WEDNESDAY
JULY	20th	2016	PM	WEDNESDAY
AUGUST	18th	2016	AM	THURSDAY
SEPTEMBER	15th	2016	PM	THURSDAY
OCTOBER	21st	2016	AM	FRIDAY
NOVEMBER	18th	2016	PM	FRIDAY
DECEMBER	20th	2016	AM	TUESDAY
JANUARY	17th	2017	PM	TUESDAY
FEBRUARY	15th	2017	AM	WEDNESDAY
MARCH	15th	2017	PM	WEDNESDAY

Appendix 7

MULTI-PROFESSIONAL AUDIT SUMMARY FORM

Your Details: Audit Lead

Name:	Service Group:	
Position / Job Title:	Specialty:	
Email:	**Tel:**	**Bleep:**

Title:

Brief summary of results:
Areas of good practice (good results against standards):
Areas where improvement is needed (poor results against standards):
How and when were the results of this audit disseminated:
Proposals for change: Did the audit confirm good practice? Yes / No Did the audit identify areas where there is need for improvement? Yes / No **If YES, please complete the action plan overleaf** If an action plan has not yet been produced, please state the reason why: Have protocols or guidelines been written as a result of this audit? Yes / No If yes, protocol/ guideline details:

Appendix 8

ACTION PLAN

Audit Title: _____

	Action *(i.e. How Recommendation will be implemented)*	'Implement By' Date	Staff Member Responsible	Responsible Manager	Change Stage (see key)	Change Stage Key
1						1. Agreed but not yet actioned 2. Action in progress 3. Made – partial implementation 4. Full implementation completed
2						
3						
4						

Date for Re-Audit: _____

Project Lead:

Signature:	Name (printed)	Date:

Senior Clinician / Manager: In signing this, I agree the above action plan recommendations and, if necessary, will take a lead in ensuring that changes are made in order to obtain improvements in the quality of care

Signature:	Name (printed)	Date:

Belfast Health and Social Care Trust

Reference No: TP 88/13

Title:	**Quality Improvement and Audit policy**			
Author(s)	Colin McMullan, Quality Improvement & Patient Safety Senior Manager Fintan McErlean, Quality Improvement / Audit Manager Julie McGrady, Quality Improvement / Audit Manager			
Ownership:	Dr Cathy Jack, Medical Director			
Approval by:	Policy Committee Executive Team Meeting		**Approval date:**	04/10/2018 10/10/2018
Operational Date:	August 2018		**Next Review:**	March 2019
Version No.	3	**Supercedes**	V2 February 2015 – February 2018	
Key words:	Quality Improvement, Clinical Audit, Service Evaluation, project			
Links to other policies				

Date	Version	Author	Comments
November 2013	0.1	F McErlean	Initial Draft
December 2014	1.1	J McGrady	Title change and changes in policy to include Quality Improvement/Service Evaluation initiatives
July 2018	2.1	F McErlean	Removed audit training section. Updated rolling audit calendar and added QI section

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Clinical Audit

Clinical Audit is defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change."
“Clinical audit is the component of clinical governance that offers the greatest potential to assess the quality of care routinely provided for NHS users – audit should therefore be at the very heart of clinical governance systems”.
(Principles for Best Practice in Clinical Audit (2002, NICE/CHI)

When audit is used as a means of measuring practice against defined standards, it can:

- Provide reassurance that compliance with standards is good
- Highlight poor compliance to reduce risk and inefficiencies
- Lead to improved patient care and outcomes

The title of this policy refers to Clinical Audit which also includes the terms, *Multi-professional Audit* and *Clinical & Social Care Audit.*

1.2 Continuous Quality Improvement

“Quality Improvement (QI) is a sequential, dynamic process involving cycles that measure clinical practice compared with evidence based benchmarks of best practice” (Healthcare Quality Improvement Partnership, 2011).
Quality Improvement initiatives incorporate various strategies to improve implementation of best practice and measure the impact of the strategies until the intended improvement is achieved. It involves testing change on a small scale with rapid measurement to determine the effects of change and sustain improvements. The defining element of QI is the use of measurement and feedback aimed at changing care practices, there is a deliberate aim to improve and the effects of change are measured.

1.3 Service Evaluation

Service Evaluation is designed to answer the question “what standard does this service achieve?”
Service/practice evaluation evaluates the ***effectiveness*** or ***efficiency*** of an existing or new service/practice that is evidence based, with the intention of generating information to inform local decision-making. This type of activity is sometimes referred to as a clinical effectiveness study, baseline audit, activity analysis, organisational audit and ***benchmarking.***
(A Guide for Clinical Audit, Research and Service Review, Healthcare Quality Improvement Partnership)

1.4 Purpose

The purpose of this policy is to provide guidance to ensure that there is a standardised approach to carrying out quality improvement and audit initiatives within the Belfast Trust. It will cover issues such as:

- Approval
- Registration
- Support
- Action

From this point onwards the term “project” relates to continuous quality improvement, audit and service evaluation initiatives.

2.0 DEFINITIONS/SCOPE OF THE POLICY

The policy applies to all healthcare professionals participating in clinical audit, service evaluation or continuous quality improvement projects within the Belfast Trust.
Important distinctions are outlined below:

- **Clinical Audit:** Determines if best practice is being achieved.
- **Quality Improvement:** Involves the application of knowledge, tools and techniques from several disciplines for the purpose of making improvements in patient care or service.
- **Service Evaluation:** Determines what standard is achieved

The policy does not apply to individuals conducting research projects.

Research: Generates new knowledge and aims to establish what best practice is. It is also subject to ethical approval.

3.0 ROLES/RESPONSIBILITIES

3.1 Medical Director

The Medical Director has responsibility for ensuring the implementation of the Quality Improvement and Audit process throughout the Organisation.

3.2 Quality Improvement & Patient Safety (QIPS) – Senior Manager

The Senior Manager for QIPS is supported by the QI/Audit Managers to:

- Register, provide support and guidance *(Appendix 1)* for projects carried out within BHSCT
- Provide opportunities for training in the concepts and basic skills required to undertake audit
- Produce Trust activity reports of projects registered with QIPS.

4.0 KEY POLICY PRINCIPLES

4.1 Process for completing projects

When approval has been signed off by a Consultant or Senior Manager, all projects will be registered with the QIPS Department. When charts are required, the chart request process should be followed *(Appendix 4).* Projects should be presented at audit meetings following the rolling audit calendar (Appendix 5) which is released on a regional basis by RQIA/GAIN (Guidelines Audit and Implementation Network). Audit Leads can request a summary of audit for review and monitoring of actions.

The main steps in the Trust project approval process are: *(Appendix 2)*

- Need for project identified by group within or across service areas.
- Project team identified, to include Consultant or Senior Manager.
- Proposal form completed (Appendix 3)
- Proposal assured and registered with QIPS Department
- Lead person contacted to agree time frame and any resources
- Project carried out
- Development of action plan (where appropriate) (Appendix 7)
- Re-audit (where appropriate) identified for that Service Area's audit plan.

5.0 QUALITY IMPROVEMENT

5.1 Quality Improvement Strategy 2017 – 2020

The Belfast Trust Quality Improvement Strategy 2017 – 2020 places the service user at the centre of its work. Delivering safe, high quality and compassionate care is the first order priority for the Trust. We will realise this ambition by developing a culture of excellence in safety and quality by engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those in our care.

The aim of our Quality Improvement Strategy (QIS) is to create the conditions for the Trust to become a leader in providing safe, high quality and compassionate care in the UK;
We will have six shared core objectives with clearly defined targets and goals:

- We will reduce harm from medication errors
- We will reduce harm from Healthcare Associated Infection
- We will reduce harm for the deteriorating patient
- We will keep patients and service users safe in our organisation
- We will ensure that our patients and service users receive the right care in the right place and at the right time
- We will ensure that we have open, transparent and learning culture.

There are a variety of quality improvement approaches that can be used. The Plan, Do Study, Act (PDSA) is an approach to continuous improvement the Trust has adopted in their QI strategy (insert correct title) where changes are tested in small cycles. Therefore the Trust is committed in building quality improvement skills and capability across all levels of staff through the variety of QI programmes/training offered.

5.2 Quality Improvement Strategy Group

This group oversees the quality Improvement Strategy for the Trust and meets at least every other month.

5.3 Quality Improvement Learning & Development Group

This group meets monthly and oversees arrangements in relation to the development of QI training programmes. Other duties include:

- Ensuring that projects initiated through QI Training Programmes are aligned to the Trust QI Plan 2017-2020
- Providing advice and guidance on QI to senior Trust managers or groups within the Assurance Framework as required.

5.4 Quality Improvement Training

The Quality Improvement Faculty within the Trust will provide teaching, support and mentorship to staff via various training programmes:

- Safety Quality Belfast (SQB): The programme consists of online learning, monthly workshops and participation in a quality improvement project with participants drawn from across all Directorates and professions.

- Specialist Trainees Engaged in leadership Programme (STEP): STEP offers basic training in quality improvement with each medical trainee undertaking a quality improvement or patient safety project. There are forty free places offered each year to senior trainees.

- SAS Doctor Training in Improvement and Driving Excellence (STrIDE): A quality improvement and leadership programme exclusively for Staff and Associate Specialty (SAS) Doctors working within the Belfast Trust.

- 'First Steps to Leadership' (First Steps) : A leadership and quality improvement (QI) training programme specifically for Foundation doctors training within Belfast Trust

- Quality 2020 Level 1 Training: The training is essential for all staff and comprises of a 90 minute session designed to raise awareness of the importance of Quality Improvement and ensure all participants can meet the initial level of the Quality Attributes Framework.

- Core Steps: Core STEPs is a quality improvement training programme which aims to equip medical trainees with the basic skills to undertake quality improvement projects and is exclusively for core and junior specialty trainees (CT/ST 1-3).

- Quality Improvement Support for Teams (QIST): QIST is a level 2 QI training programme (as per regional attributes framework) and covers similar content to SQB.

5.5 Quality Improvement Activity

In order to ensure there is a central resource for holding information on all QI activity, staff within the Trust can register their QI projects with the Quality Improvement and Patient Safety Department electronically by means of a QI logging form.

6.0 IMPLEMENTATION OF POLICY

This policy requires dissemination throughout all areas within the Trust.

7.0 MONITORING

Monitoring of this policy should be carried out by comparing the projects presented at the monthly audit meetings with those registered with QIPS.

8.0 EVIDENCE BASE / REFERENCES

Principles for Best Practice in Clinical Audit (2002, NICE/CHI)
A Guide for Clinical Audit, Research and Service Review, Healthcare Quality Improvement Partnership, 2011

9.0 CONSULTATION PROCESS

QIPS Department.
Standards and Guidelines Committee.

10.0 APPENDICES / ATTACHMENTS

Appendix 1 – Guidance on conducting an audit
Appendix 2 - BHSCT Quality & Audit Approval Process
Appendix 3 – Quality & Audit Proposal Form
Appendix 4 - Process for Ordering Patient Charts for Quality & Audit Projects
Appendix 5 – Rolling Audit Calendar 2018 – 2023
Appendix 6 – Audit Summary Form
Appendix 7 – Action Plan

11.0 EQUALITY STATEMENT

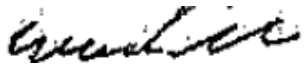
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES



_____ Date: ___July 2018__

Author

_____ Date: ___July 2018__

Director

Appendix 1

Guidance on Conducting an Audit

1. Choose Topic

Audit topics should be chosen and prioritised based on their importance in addressing an identified issue or their potential to improve the quality and care provided. Topics should be agreed by teams of staff / be fully supported by a Senior colleague (Consultant / Service Manager)

Important topics should:

- Address an identified problem (e.g. from complaints or adverse incidents)
- Support the implementation of quality standards (e.g. auditing new NICE guidance)
- Address issues in: High volume, High risk or High Cost areas of practice

2. Identify a team

It is important that your project is supported by colleagues who will have the authority and commitment to see any necessary changes (as indicated by the audit results) put into practice.

If your audit has implications for professions other than your own, make sure they are consulted at the planning stage.

3. Set Objectives and Standards

Projects should have a specific focus on measuring adherence to an identified standard or guideline. Identify and get agreement on the standards which represent best practice. The key points which you plan to measure performance against should be outlined in the audit proposal form.

4. Data Protection Principles

(i) Personal details (name, date of birth) should never be recorded on the audit form

(ii) Record only an “audit ID” on the data collection form and have a separate sheet of paper linking the “Audit ID” to the hospital number. Alternatively if it is necessary to have an identifier on the data collection form, only the hospital number should be used.

(iii) Data collection should be limited to the data relevant to identified standards used in the audit.

(iv) Both paper and electronic data should be kept securely.

(v) Data collection forms should not be destroyed once the project is complete.

5. Analyse your data

Pull your data together in a meaningful way and compare your results with your standards. How well have the standards been met? What were the reasons for failure to meet standards?

6. Report your findings back to the relevant area/s.
Decide the most appropriate way to report your findings. Consider who needs to be involved in implementing any improvement or actions.

7. Agree and complete a Summary Report and Action Plan (Appendix 2) and send a copy to QIPS Department.
It is important that a record of results and planned activity is kept as so we can improve service as a result of audit. All improvements made as a result of audit will be reported to each service areas governance meeting

BHSCT Quality & Audit Approval Process **Appendix 2**

Topic identified for Audit/Project

STEP 1: Obtain Consultant / 5th Level Manager Approval

STEP 2: Complete & Forward Trust Quality & Audit Proposal Form
http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Standards%20Quality%20and%20Audit/Audit.aspx
to
QIPS Department
NB: Proposed project must have Consultant / 5th Level Manager approval in the form of signature or email

STEP 3: Project Registered on Audit Database
All registered projects will be included in:
- Accountability Review Reports
- Requested audit activity Reports

No Audit Assistance

Minimal Audit Assistance
i.e. Provision of notes only

Audit Assistance Requested

STEP 4: Audit Lead retains responsibility to provide:
1. Summary of findings *(Appendix 4)*
2. Action plan sent to the SQA dept. on completion of audit/project

STEP 4: QI/Audit Team to agree with audit Lead:
a) Timelines
b) Support required

STEP 5: Conduct Project
If appropriate, notify QIPS Dept when chart review complete to facilitate re-filing of charts

STEP 6: Complete & Submit Summary and Action Plan to QIPS Dept
http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Standards%20Quality%20and%20Audit/Audit.aspx

STEP 7: Audit Database updated to include Action Plan
Details will appear in next Accountability Review & requested Audit Activity Reports

Appendix 3

Belfast Health and Social Care Trust

Office use only
Date rec'd:
ID No:
Allocated to:

QUALITY & AUDIT PROPOSAL FORM

DETAILS of PERSON LEADING PROJECT (i.e. Key Contact)	
Name:	Band/Grade:
Job title:	Base Location:
Email:	Tel / Bleep:

PROJECT DETAILS

Type of Project: ☐ Audit ☐ Continuous Quality Improvement ☐ Service Evaluation

Project Title:

Specialties Involved:

Proposed Start Date: **Estimated End Date:**

Remit of Project: National ☐ Regional ☐ Local ☐

Please Specify Care Areas / Site(s) Involved: RGH ☐ BCH ☐ Kbracken ☐ Mater ☐ MPH ☐ Community ☐

Aims / Objectives:

Methodology for data collection: Retrospective ☐ Concurrent ☐

Chart Review ☐ Questionnaire ☐ ECR ☐ Other (specify) _____

Sample Size: _____

Criteria / Standards:

Please specify any SQA support required to carry out this project?

Project Plan/Design ☐ Provision of notes ☐ Data Collection ☐ Data Analysis ☐ Presentation ☐ Report Writing ☐ None ☐

APPROVAL / REGISTRATION DETAILS

Any Audit or Quality Improvement Project carried out within BHSCT should be supervised by a senior member of staff within that area and be registered with the Standards Quality & Audit Department prior to commencement. To ensure that this is done as efficiently as possible, electronic signatures can be used OR an e-mail from the approving consultant/Senior Manager is acceptable as signed approval:

(i) Supervising/ Approving Consultant or Senior Manager (5th level or above)

Name:	
Position / Job Title:	

By signing this form I confirm that this project is appropriate for this area of care and the relevant stakeholders have been identified in the application. I will support the dissemination of results and implementation of action plan (if necessary) in order to obtain improvements in the quality of care provided.

Signature:	

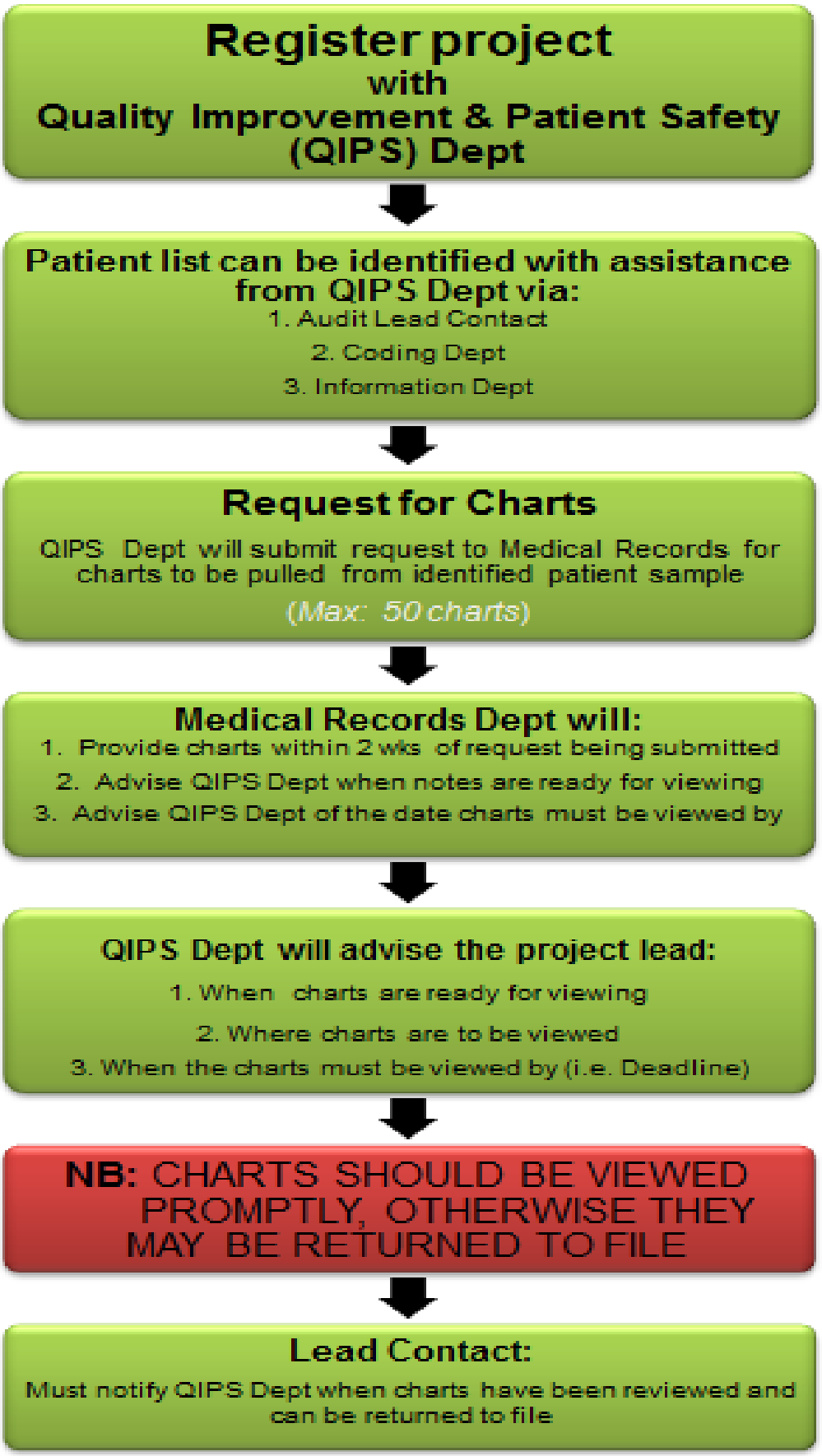
Email completed form to address below:
QualityandAudit@belfasttrust.hscni.net

Forms can also be posted to: Quality Improvement & Patient Safety Dept., 6th Floor, McKinney Hse., Musgrave Pk. Hospital

(Please retain a copy for your own records)

Appendix 4

Process for Ordering Patient Charts for Quality & Audit Projects



Appendix 5

Rolling Audit Calendar 2018 - 2023

Month	Date	Time	Day
2018			
January	18th	PM	Thursday
February	16th	AM	Friday
March	16th	PM	Friday
April	17th	AM	Tuesday
May	15th	PM	Tuesday
June	13th	AM	Wednesday
July	18th	PM	Wednesday
August	16th	AM	Thursday
September	13th	PM	Thursday
October	19th	AM	Friday
November	16th	PM	Friday
December	18th	AM	Tuesday
2019			
January	15th	PM	Tuesday
February	13th	AM	Wednesday
March	13th	PM	Wednesday
April	18th	AM	Thursday
May	16th	PM	Thursday
June	14th	AM	Friday
July	19th	PM	Friday
August	13th	AM	Tuesday
September	17th	PM	Tuesday
October	16th	AM	Wednesday
November	13th	PM	Wednesday
December	12th	AM	Thursday
2020			
January	16th	PM	Thursday
February	14th	AM	Friday
March	13th	PM	Friday
April	21st	AM	Tuesday
May	19th	PM	Tuesday
June	17th	AM	Wednesday
July	15th	PM	Wednesday
August	13th	AM	Thursday
September	17th	PM	Thursday
October	16th	AM	Friday
November	13th	PM	Friday
December	15th	AM	Tuesday
2021			
January	19th	PM	Tuesday
February	17th	AM	Wednesday

Month	Date	Time	Day
March	10th	PM	Wednesday
April	15th	AM	Thursday
May	13th	PM	Thursday
June	18th	AM	Friday
July	16th	PM	Friday
August	17th	AM	Tuesday
September	14th	PM	Tuesday
October	13th	AM	Wednesday
November	17th	PM	Wednesday
December	16th	AM	Thursday
2022			
January	13th	PM	Thursday
February	18th	AM	Friday
March	11th	PM	Friday
April	12th	AM	Tuesday
May	17th	PM	Tuesday
June	15th	AM	Wednesday
July	20th	PM	Wednesday
August	18th	AM	Thursday
September	15th	PM	Thursday
October	14th	AM	Friday
November	18th	PM	Friday
December	13th	AM	Tuesday
2023			
January	17th	PM	Tuesday
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Appendix 6

Audit Summary Form

Your Details: Audit Lead

Name:	Service Group:	
Position / Job Title:	Specialty:	
Email:	**Tel:**	**Bleep:**

Title:

Brief summary of results:
Areas of good practice (good results against standards):
Areas where improvement is needed (poor results against standards):
How and when were the results of this audit disseminated:
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Audit Title: _____

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4						4. Full implementation completed

Date for Re-Audit: _____

Project Lead:

Signature:	Name (printed)	Date:

Senior Clinician / Manager: In signing this, I agree the above action plan recommendations and, if necessary, will take a lead in ensuring that changes are made in order to obtain improvements in the quality of care

Signature:	Name (printed)	Date:

Action plans can be returned to: QualityandAudit@belfasttrust.hscni.net

2.033

Belfast Health and Social Care Trust

Reference No: SG 44/13

Title:	Quality Improvement & Audit Policy		
Author(s)	Christine Murphy, Senior Manager, SQA Fintan McErlean, Audit Manager, SQA Julie McGrady, Audit Manager, SQA		
Ownership:	Dr Cathy Jack, Medical Director		
Approval by:	Standards and Guidelines Policy Committee Executive team Meeting	**Approval date:**	28/01/2015 04/02/2015 06/02/2015
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- Action

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3.2 Standards, Quality & Audit Department
The Senior Manager of the Standards, Quality & Audit Department is supported by the Clinical Audit Managers to:

- Register, provide support and guidance *(Appendix 1)* for projects carried out within BHSCT
- Provide opportunities for training in the concepts and basic skills required to undertake audit
- Produce Trust activity reports of projects registered with SQA.

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When approval has been signed off by a Consultant or Senior Manager, all projects will be registered with the Standards, Quality and Audit Department. When charts are required, the chart request process should be followed *(Appendix 4)*. Projects should be presented at audit meetings following the rolling audit calendar (Appendix 6) which is released on a regional basis by the DHSSPSNI via the Guidelines Audit and Implementation Network (GAIN). A summary of ongoing projects and agreed

actions will be circulated to the relevant Audit Leads and Service Area Governance groups for review and monitoring.

The main steps in the Trust project approval process are: *(Appendix 2)*

- Need for project identified by group within or across service areas.
- Project team identified, to include Consultant or Senior Manager.
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- Lead person contacted to agree time frame and any resources
- Project carried out
- Development of action plan (where appropriate) *(Appendix 8)*
- Re-audit (where appropriate) identified for that Service Area's audit plan.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy requires dissemination throughout all areas within the Trust.

6.0 MONITORING

Monitoring of this policy should be carried out by comparing the projects presented at the monthly audit meetings with those registered with SQA (reported in the Directorate project activity reports).

7.0 EVIDENCE BASE / REFERENCES

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Standards, Quality & Audit Department. Standards & Guidelines Committee.

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Minor impact ☐

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SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Christine Murphy

_____ **Date: ___February 2015__**
Author

Cathy Jack

_____ **Date: ___February 2015__**
Director

Appendix 1 **Guidance on conducting an audit**

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Audit topics should be chosen and prioritised based on their importance in addressing an identified issue **or** their potential to improve the quality and care provided. Topics should be agreed by teams of staff / be fully supported by a Senior colleague (Consultant / 5th Level Manager)

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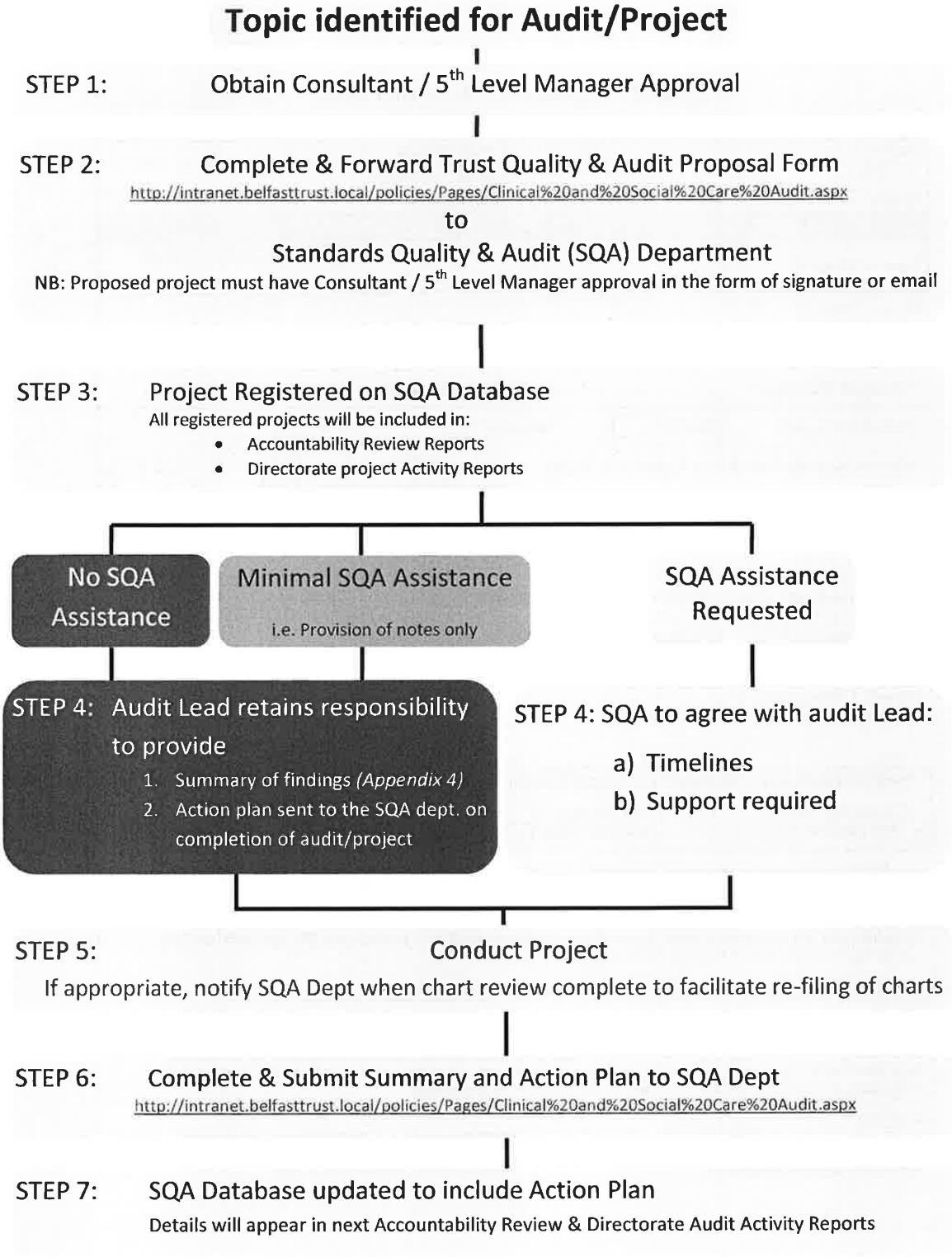
6. Report your findings back to the relevant area/s.

Decide the most appropriate way to report your findings. Consider who needs to be involved in implementing any improvement or actions.

7. Agree and complete a Summary Report and Action Plan (Appendix 2) and send a copy to Standards, Quality and Audit Department.

It is important that a record of results and planned activity is kept as so we can improve service as a result of audit. All improvements made as a result of audit will be reported to each service areas governance meeting.

Appendix 2- **BHSCT Quality & Audit Approval Process**



Appendix 3

Belfast Health and Social Care Trust

Office use only
Date rec'd:
ID No:
Allocated to:

QUALITY & AUDIT PROPOSAL FORM

DETAILS of PERSON LEADING PROJECT (i.e. Key Contact)	
Name:	Band/Grade:
Job title:	Base Location:
Email:	Tel / Bleep:

PROJECT DETAILS

Type of Project: ☐ Audit ☐ Continuous Quality Improvement ☐ Service Evaluation

Project Title:

Specialties Involved:

Proposed Start Date: Estimated End Date:

Remit of Project: National ☐ Regional ☐ Local ☐

Please Specify Care Areas / Site(s) Involved: RGH ☐ BCH ☐ Craigavon ☐ Mater ☐ MPH ☐ Community ☐

Aims / Objectives:

Methodology for data collection: Retrospective ☐ Concurrent ☐

Chart Review ☐ Questionnaire ☐ Other (please specify) _____

Sample Size: _____

Criteria / Standards:

Please specify any SQA support required to carry out this project?

Project Plan/Design Provision of notes ☐ Data Collection Data Analysis ☐ Presentation Report Writing ☐ None ☐

APPROVAL / REGISTRATION DETAILS

Any Audit or Quality Improvement Project carried out within BHSCT should be supervised by a senior member of staff within that area and be registered with the Standards Quality & Audit Department prior to commencement. To ensure that this is done as efficiently as possible, electronic signatures can be used OR an e-mail from the approving consultant/Senior Manager is acceptable as signed approval:

(i) Supervising/ Approving Consultant or Senior Manager (5th level or above)

Name:	
Position / Job Title:	

By signing this form I confirm that this project is appropriate for this area of care and the relevant stakeholders have been identified in the application. I will support the dissemination of results and implementation of action plan (if necessary) in order to obtain improvements in the quality of care provided.

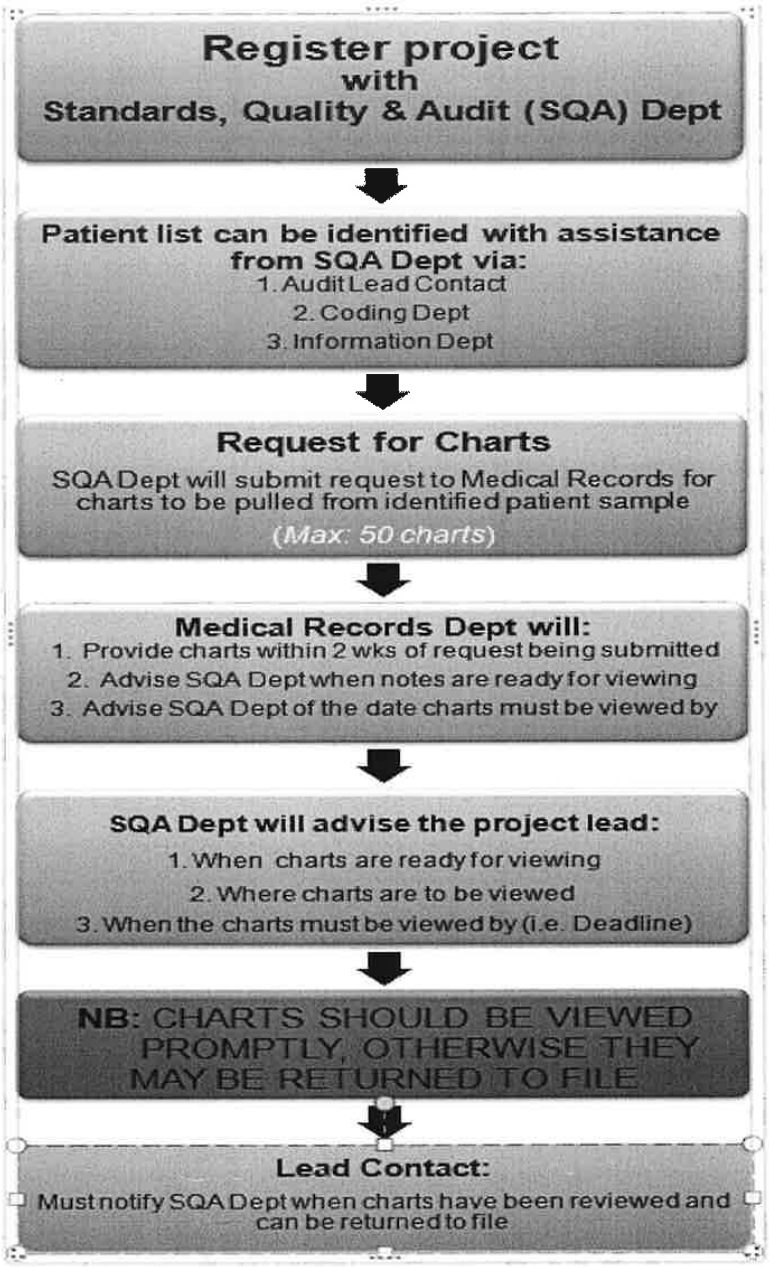
Signature:	

Email completed form to address below:
Quality&Audit@belfasttrust.hscni.net

Forms can also be posted to: Standards Quality & Audit Dept., 4th Floor, Bostock House, RVH

(Please retain a copy for your own records)

Appendix 4 **PROCESS FOR ORDERING PATIENT CHARTS FOR QUALITY & AUDIT PROJECTS**



Appendix 5

Clinical Audit Training

Training sessions lasting 1½ - 2 hours are available for all health & social care staff within the Belfast Trust. These sessions are usually held every other month (not during July or August).

The aim of this introductory course is to provide guidance on how to carry out an audit of current practice. Topics covered include:

- Definition of audit
- History and benefits of audit
- Different stages of audit
- Audit process within the Belfast HSC Trust

Sessions can be booked on the Trust Intranet (the hub).

If you have any enquiries, please contact by email or phone (details below)

[redacted]. ([redacted])

Appendix 6

Rolling Audit Calendar 2013 - 2017				
Month	Date	Year	Time	Day
JANUARY	20th	2015	PM	TUESDAY
FEBRUARY	18th	2015	AM	WEDNESDAY
MARCH	18th	2015	PM	WEDNESDAY
APRIL	16th	2015	AM	THURSDAY
MAY	21st	2015	PM	THURSDAY
JUNE	19th	2015	AM	FRIDAY
JULY	17th	2015	PM	FRIDAY
AUGUST	18th	2015	AM	TUESDAY
SEPTEMBER	15th	2015	PM	TUESDAY
OCTOBER	21st	2015	AM	WEDNESDAY
NOVEMBER	18th	2015	PM	WEDNESDAY
DECEMBER	17th	2015	AM	THURSDAY
JANUARY	21st	2016	PM	THURSDAY
FEBRUARY	19th	2016	AM	FRIDAY
MARCH	18th	2016	PM	FRIDAY
APRIL	19th	2016	AM	TUESDAY
MAY	17th	2016	PM	TUESDAY
JUNE	15th	2016	AM	WEDNESDAY
JULY	20th	2016	PM	WEDNESDAY
AUGUST	18th	2016	AM	THURSDAY
SEPTEMBER	15th	2016	PM	THURSDAY
OCTOBER	21st	2016	AM	FRIDAY
NOVEMBER	18th	2016	PM	FRIDAY
DECEMBER	20th	2016	AM	TUESDAY
JANUARY	17th	2017	PM	TUESDAY
FEBRUARY	15th	2017	AM	WEDNESDAY
MARCH	15th	2017	PM	WEDNESDAY

Appendix 7
AUDIT SUMMARY FORM

Your Details: Audit Lead

Name:	Service Group:
Position / Job Title:	Specialty:
Email:	**Tel:** **Bleep:**

Title:

Brief summary of results:
Areas of good practice (good results against standards):
Areas where improvement is needed (poor results against standards):
How and when were the results of this audit disseminated:
Proposals for change: Did the audit confirm good practice? Yes / No Did the audit identify areas where there is need for improvement? Yes / No **If YES, please complete the action plan overleaf** If an action plan has not yet been produced, please state the reason why: Have protocols or guidelines been written as a result of this audit? Yes / No If yes, protocol/ guideline details:

Appendix 8

ACTION PLAN

Audit Title: _____

	Action *(i.e. How Recommendation will be implemented)*	'Implement By' Date	Staff Member Responsible	Responsible Manager	Change Stage (see key)	Change Stage Key
1						1. Agreed but not yet actioned 2. Action in progress 3. Made – partial implementation 4. Full implementation completed
2						
3						
4						

Date for Re-Audit: _____

Project Lead:

Signature:	Name (printed)	Date:

Senior Clinician / Manager: In signing this, I agree the above action plan recommendations and, if necessary, will take a lead in ensuring that changes are made in order to obtain improvements in the quality of care

Signature:	Name (printed)	Date:

IHRD Implementation Plan

Workstream Brief

Workstream 3: Duty of Quality

WORKSTREAM BRIEF

Programme Workstream: IHRD Implementation Workstream
3 Duty of Quality

Document Information

Author:	Patricia Donnelly / Fergal Bradley
Owner:	Richard Pengelly, SRO
Document Ref:	HE1/18/50264

Document Location This document is available in HPRM at HE1-18-469

Revision History Date of next revision: This document will be updated throughout the lifecycle of the programme.

Revision date	Version No	Summary of Changes	Changes marked
2018-02-27	0.0	First draft	
2018-03-07	0.1	Proof & new structure	E.D
2018-03-09	0.2	New structure	E.D
2018-03-14	0.3	Appendices 1-3	P.D
2018-06-07	0.4	New Structure	F.B.
2018-11-30	0.5	Final proof and edit	P.D.

Approvals

Name	Signature	Title	Date	Version
Fergal Bradley	F.B	Implementation Programme Manager	2018-10-24	0.4

Distribution

Version 0.4 of this document has been distributed to all workstream and sub-group members.

IHRD Implementation Plan - Workstream Brief
DUTY OF QUALITY

Contents

1. Introduction

1.1 Background

On 31 January 2018 the Inquiry into Hyponatraemia Related Deaths (IHRD) was published following an extensive investigation into the deaths of five children in hospitals in Northern Ireland. After hearing evidence from a wide range of individuals and organisations it concluded that the five 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.

In the report Justice O'Hara acknowledged that progress had been made in hyponatraemia practice and guidance but that a more comprehensive approach for learning from error was needed for further unnecessary harm to be avoided. He set out 96 recommendations across 10 themes where he had identified failings in "competency in fluid management, honesty in reporting, professionalism in investigation, focus in leadership and respect for parental involvement".[1]

In receiving the report the Permanent Secretary, Richard Pengelly apologised for the distress, hurt and loss suffered by the families and stated a commitment to the vital work needed to address serious past failings and provide safe and accountable care in future[2]. He further stated that it was "essential that those of us with leadership responsibilities now take concerted and prompt action to address the issues raised in the Report, and reassert the primacy of patient safety and work diligently to rebuild public confidence in the care provided, whether in hospitals, the community or primary care".

"We owe this to the families first and foremost, as well as to patients and other people who use our services across the province and the great many HSC staff who strive to do the right thing, often in very challenging circumstances…(and that)… a critical element in the success of this work will be engagement with the public we serve, particularly those affected"

[1] IHRD Report: Vol3 Chapter 8 Section 8.3-8.4
[2] DoH Press Release 31 January 2018

1.2 Summary of IHRD Recommendations

The Inquiry report made 96 recommendations across a number of themes reflecting the findings made during the investigation[3]. These are referenced in Appendix 5.1 and summarised below:

Themes	Number of Recommendations/ Actions
• Candour	8
• Leadership	1
• Paediatric-clinical	21
• Serious Adverse incidents	24
o SAI reporting	2
o SAI investigation	10
o SAI related to a death	12
• Training and learning	14
• Trust governance	16
• Department	9
• Culture and litigation	3

In developing the recommendations the IHRD report had been guided by five key principles[4]:

1 That healthcare services exist to serve the patient

2 That the quality of healthcare is dependent upon both clinical and non-clinical services

3 That the particular needs of children must be addressed

4 That leadership and candour must be accorded the utmost priority if the fullest learning is to be gained from error

5 That progress should be subject to regular external review

1.3 Objectives

This programme brief sets out the arrangements for the implementation of the 96 recommendations to improve the system and practice in Northern Ireland. It acknowledges that in effecting change, in so large and complex a system, changes

[3] IHRD Report Vol 3 Chapter 9 Pages 84-97
[4] IHRD Report January 2018: Vol 3 Chapter 9 Section 9.1

in the culture that operates around Health and Social Care and into the wider system is needed for the quality of services to be assured and public confidence restored. With that must come greater transparency and accountability both in the planning and delivery of services and in the implementation of the 96 recommendations from the IHRD report.

It is recognised that implementing these recommendations is about the steps necessary beyond the initial implementation to make sure that the change becomes embedded to ensure the delivery of safe accountable care in the future. As the Permanent Secretary stated "the Report also warned of 'a remnant culture of clinical defensiveness' and we must do all in our power to ensure a culture of openness and integrity throughout HSC."

To achieve that will require us to:

- Build capacity in terms of trying to achieve a shared understanding of what underpins the changes and what the positive benefits are;
- Develop a shared understanding of what the change is and how it impacts on day to working of staff;
- Promote how service users engage with staff and other service users;
- Take the opportunity from the changes as the basis for knowledge transfer and building capacity within the HSC around quality improvement methodology, governance etc.;
- Take the opportunity to set an example in how we engage with and involve stakeholders.

In effect how the implementation of the IHRD recommendations is undertaken, through the programme workstreams, is as important as the content of the workstreams. This should be held as an important principle, kept in mind from the outset, as it is as important as the implementation of the recommendations themselves.

1.3 Authority for the Programme

The Authority for the Programme is provided by the Permanent Secretary of the Department of Health as the Senior Responsible Officer (SRO) for the Programme.

2 Programme Structure

The IHRD Programme will ensure the effective implementation of the 120 actions arising from the 96 recommendations of the Inquiry Report. The programme structure is set out in Appendix 5.2 and responsibilities summarised in the following sections and in Diagram 1.

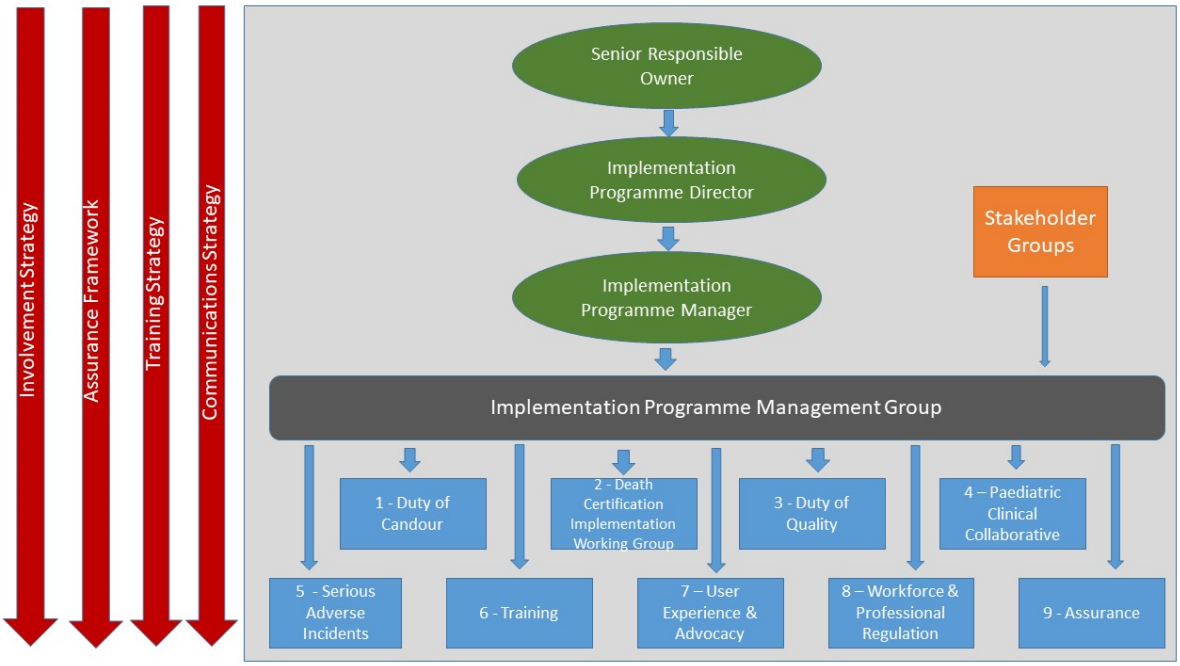


Diagram 1: IHRD Implementation Programme Structure

2.1 Senior Responsible Officer (SRO)

The Permanent Secretary is the SRO for the programme and, in the absence of a Minister, holds the overarching responsibility for the implementation of the recommendations from the IHRD Report.

2.2 The Implementation Programme Director (IPD)

The Deputy Chief Medical Officer (DCMO) will act as Implementation Programme Director. As IPD he will liaise with the HSC Liaison Group, a group of senior healthcare clinicians and managers. The IPD will receive reports from the Implementation Programme Manager and the individual workstreams.

2.3 The Implementation Programme Manager (IPM)

The IPM manager will be in overall day to day operational control of the implementation plan and chair the Implementation Programme Management Group, reporting to the Implementation Programme Director. He will oversee and support the individual workstreams, receiving and analysing progress reports; collating the Issue Log from the working groups and developing the Risk Register for the programme. The IPM will be supported by a deputy and team drawn from the HSC and Department of Health and designate resources as required.

2.4 The Implementation Programme Management Group (IPMG)

Chaired by the Programme Manager the IPMG will comprise the individual Workstream Chairs and Subgroup Chairs as well as representatives from key organisations such as: RQIA; NIPEC; etc

The IPMG is responsible for ensuring that issues such as training needs identified through the work undertaken by workstreams are allocated to the appropriate workstream.

It will undertake the implementation of unallocated recommendations and be responsible for the sign off of strategies and frameworks that cross all workstreams, such as:

- Involvement strategy
- Communication strategy
- Training strategy
- Assurance Framework

The IPMG will also ensure that appropriate links are maintained between relevant workstreams and with existing initiatives. It will be responsible for the implementation of recommendations not delegated to a workstream.

The IPMG will provide an opportunity for Workstream Chairs to share knowledge and experience, support each others work and act as a leadership forum for the Programme.

2.5 Workstreams

Of the 120 individual actions arising from the 96 recommendations, 117 of these have been delegated to 9 workstreams that report to the Implementation Programme Management Group; 3 actions remain the responsibility of the Department. These are set out in detail across the programme in Appendix 5.1 Action Plan Matrix and include:

	Workstream	Actions
1	Duty of Candour	11
2	Death Certification and Bereavement	22
3	Duty of Quality	28
4	Paediatric-clinical - collaborative	21
5	Serious Adverse Incidents	18
6	Training	6
7	User Experience and Advocacy	3
8	Workforce and professional regulation	7
9	Assurance	1

Inevitably there will be cross over between individual workstreams and with existing work outside the programme, where possible this has been identified in the Action Plan Matrix (Appendix 5.1) for each workstream and arrangements put in place to link to or subsume such work into the workstream.

The Department is responsible for implementing specific recommendations[5]:

- Recommendation 85 - Deputy Chief Medical Officer for children's healthcare;
- Recommendation 88 - Child Death Overview Panel; and
- Recommendation 94 - Clinical negligence litigation.

The IPMG is responsible for ensuring the implementation of unallocated recommendations.

[5] Appendix 5.2: IHRD Action Plan Matrix

2.6 Role of Workstream Chair

It is expected that the Workstream Chair will act in a leadership role to provide the vision, delegation, monitoring and challenge to ensure the achievement of the allocated work. In particular it is expected that the Chair will:

- Set out clearly the **objectives** of the workstream for the group
- **Allocate** individual tasks or responsibilities
- Oversee the development of a **Work Plan** for the implementation of delegated Inquiry Report Recommendations
- Develop an **Assurance Plan** for how individual actions can be assured through the development of policies, procedures, training, information and measurement metrics, audit etc and in doing so contribute to the Programme Assurance Framework and Training Strategy
- Identify the key stakeholders and develop an **Involvement and Communication Plan** consistent with the Programme Involvement Strategy and Communication Strategy
- **Engage** with other workstream members in taking actions forward
- Provide **regular reports** to the Programme Manager
- Identify **issues** which impede the progress of the workstream which should be escalated to the Programme Manager for inclusion in the Programme Issue Log and Risk Register
- Participate as a member of the **Implementation Programme Management Group** in taking forward the IHRD recommendations

2.7 Workstream task

The task of Workstream 3 Duty of Quality is to implement 28 actions from 23 IHRD recommendations as set out below:

Table 1: IHRD Recommendation delegated to Workstream 3 – Duty of Quality

IHRD Number	Workstream Action	Recommendation
8[6]	1	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance (with the Duty of Candour) and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.
9	2	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.
34[6]	3	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses
40	4	Learning and trends identified in SAI investigations should inform programmes of clinical audit
41	5	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.
55	6	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.
56	7	All Trust Board Members should receive induction training in their statutory duties.
		Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the

[6] Delegated to workstream Sub-group: RQIA Remit

IHRD Number	Workstream Action	Recommendation
67	8	relevant teaching authority should be informed
68	9	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.
69 (i)	10	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour
69 (ii)	11	(ii) Child Healthcare.
69 (iii)	12	(iii) Learning from SAI related patient deaths.
70	13	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.
71	14	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.
72	15	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director
76	16	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.
77	17	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.
78	18	Implementation of clinical guidelines should be documented and routinely audited
79	19	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.
80	20	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.

IHRD Number	Workstream Action	Recommendation
81	21	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.
84	22	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.
86 (i) [6]	23	The Department should expand both the remit and resources of the RQIA in order that it might (i) Maintain oversight of the SAI process
86 (ii) [6]	24	(ii) Be strengthened in its capacity to investigate and review individual cases or groups of cases, and
86 (iii) [6]	25	(iii) Scrutinise adherence to duty of candour.
90 (i)	26	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability.
90 (ii)	27	(ii) The identification of specific training requirements necessary for effective implementation.
92	28	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.

3.1 Terms of reference:

The terms of reference, membership and administrative arrangements are set out in the following sections for individual IHRD Programme Workstreams

1. To work within the principles set out in the recommendations from the IHRD report[7]

[7] IHRD Report: Volume 3 Chapter 9 Section 9.1

2. To lead or commission work to benchmark the current position within the HSC system against each recommendation as a precursor to developing a workstream implementation and benchmarking framework.

3. To be responsible for developing the implementation plan for 28 specific actions (as set out in section 2.7) arising from 23 recommendations from the IHRD report and to report to the Implementation Programme Management Group and the Programme Manger in doing so.

4. To link with other workstreams as necessary under the direction of the Implementation Programme Manager

5. Working with key stakeholders, to set out a detailed plan for the implementation of the recommendations of the IHRD report as delegated, including the development of an Involvement and Communications Plan

6. To take cognisance of and contribute to the cross cutting plans, strategies and frameworks

7. To maintain an Issue Log, as these arise, for report to the Implementation Programme Manager and inclusion as necessary in the Risk register for the programme

3.2 Membership

Workstream and Sub-group Chairs will participate as members of the Implementation Programme Management Group

Members of each workstream have been included to bring their individual perspective and expertise to the discussion of the recommendations delegated to the workstream. They are not there to represent the organisation or population of which they are members, except for HSC and DoH staff who are there to work on behalf of their organisations.

The Programme Board has a structured plan of involvement and communication with stakeholders so that this is not the responsibility of individual workstream members. However, there may be times when developing the action plan for the recommendations when workstream members are asked to take a wider view from their organisations/ constituencies to inform the work of the group.

Workstream 1: Duty of Quality

Chair: Dr Eddie Rooney

Members: Appendix 5.3

3.3 Sub-Groups:

Three subgroups will take forward 27 of the Workstream actions with 1 recommendation (recommendation 9 Leadership) remaining the direct responsibility of the main workstream.

A ALB Board Effectiveness Sub-Group

The sub-group is responsible for taking forward the delegated actions as set out In Table 2.

Sub-group Chair: Jim Moore

Sub-group Members: Appendix 5.3 (i)

Table 2: IHRD Recommendation delegated to ALB Board Effectiveness Sub-group

IHRD Number	Workstream Action	Recommendation
55	6	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.
56	7	All Trust Board Members should receive induction training in their statutory duties.
69 (i)	10	Trusts should appoint and train Executive Directors with specific responsibility for Issues of Candour
69 (ii)	11	Trusts should appoint and train Executive Directors with specific responsibility for Child Healthcare.
69 (iii)	12	Trusts should appoint and train Executive Directors with specific responsibility for Learning from SAI related patient deaths.
70	13	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.
72	15	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director

IHRD Number	Workstream Action	Recommendation
84	22	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.

B RQIA Remit Sub-Group

The sub-group is responsible for taking forward the delegated actions as set out In Table 3.

Sub-group Chair: Linda Greenlees

Sub-group Members: Appendix 5.3 (ii)

Table 3: IHRD Recommendation delegated to RQIA Remit Sub-group

IHRD Number	Workstream Action	Recommendation
8[8]	1	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance (with the Duty of Candour) and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.
34[6]	3	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses
86 (i) [6]	23	The Department should expand both the remit and resources of the RQIA in order that it might (iv) Maintain oversight of the SAI process
86 (ii) [6]	24	(v) Be strengthened in its capacity to investigate and review individual cases or groups of cases, and
86 (iii) [6]	25	(vi) Scrutinise adherence to duty of candour.

[8] Delegated to workstream Sub-group: RQIA Remit

3.4 C Clinical & Social Care Governance Sub-Group

The sub-group is responsible for taking forward the delegated actions as set out In Table 4.

Sub-group Chair: Lynne Charlton

Sub-group Members: Appendix 5.3 (iii)

Table 4: IHRD Recommendations delegated to the C&SCG sub-group

IHRD Number	Workstream Action	Recommendation
40	4	Learning and trends identified in SAI investigations should inform programmes of clinical audit
41	5	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.
67	8	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed
68	9	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.
71	14	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.
76	16	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.
77	17	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.
78	18	Implementation of clinical guidelines should be documented and routinely audited

IHRD Number	Workstream Action	Recommendation
79	19	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.
80	20	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.
81	21	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.
90 (i)	26	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability.
90 (ii)	27	(ii) The identification of specific training requirements necessary for effective implementation.
92	28	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.

3.5 Administrative Arrangements

The workstream will be supported by professional and administrative support. A standard set of guidance will be provided and links identified to key information and resources.

Risk Register

There will be a single programme risk register covering the entire programme. Workstreams will use their Issues Logs to highlight risks, control issues and mitigating measures relevant to the delivery of their Terms of reference. This includes risks etc. that may be beyond the ability of an individual Workstream to manage or mitigate. These will be considered by the IPMG as part of developing and maintaining a programme risk register.

There are a number of plans and frameworks that need to be developed to support workstreams in delivering against their Terms of Reference. These are as follows:

1. Workstream Work Plans
2. A Programme Training Plan
3. Workstream Involvement and Communication plans
4. Workstream Assurance Framework
5. Workstream Implementation and Benchmarking Frameworks

Each of these plans and frameworks should be considered as living documents subject to change and development over time. There will therefore be a need for version control around each document. There will be an ongoing interplay between these plans and frameworks with workstream documentation, particularly Action and Issues Logs.

Work Plans

Each Workstream will develop its own Work Plan. A standard template will be provided to assist workstreams in setting out actions, milestones, deliverables, interdependencies, resources and timeframes.

A Programme Training Plan (to be developed by Training Workstream)

To avoid duplication, ensure standardisation and ensure the most efficient use of resources to provide Value for Money as well as to maximise the use of available and pre-existing opportunities for Training, the Programme will maintain a single Training Plan under the leadership of the Training workstream. This will ensure that we have strategic engagement with regional bodies such as NIPEC, NIMDTA, the two NI Universities, the Leadership centre etc. This ‘programme’ plan will hold details of training needs arising from individual workstreams. The routine process through which workstreams should highlight training needs will be through the workstream Issues Log.

There will be a need for good quality and regular communication between the Training Workstream that will develop the Training Plan and other Workstreams.

Involvement and Communication Plans

Each workstream will maintain its own Involvement and Communication Plan. They will be assisted and supported through a dedicated engagement resource working as part of the Programme Team. This resource will both assist in the development of individual workstream involvement and engagement plans and also in the organisation and delivery of engagements with different stakeholders. This will ensure that workstreams will have access to programme resources for facilitation and administration in undertaking larger scale engagements.

A Programme Assurance Framework (developed by the Assurance Workstream)

Some level of independent Assurance is essential to ensuring public confidence that IHRD recommendations have been implemented on a sustained basis. A Programme Assurance Strategy and Assurance Framework has been developed under the leadership of the Assurance Workstream. The Framework will set out the tests to be met and evidence to be provided by the HSC/Department in order to provide assurance that each recommendation has been implemented. The work of individual workstreams will both inform and be informed by the strategy and Framework. The 'programme' Assurance Framework will hold details of how each individual recommendation is to be signed off, what evidence should be provided and which recommendations will require some additional form of independent Assurance. Independent assurance work will be undertaken or commissioned under the leadership of the Assurance Workstream

The routine process through which workstreams should highlight Assurance issues will be through the workstream Issues Log. There will be a need for good quality and regular communication between the Assurance Workstream and other Workstreams.

Implementation and Benchmarking Frameworks

Each workstream will develop its own Implementation and benchmarking Framework. The purpose of these Frameworks is to identify the stakeholders and steps necessary to achieve implementation. This should include identification of:

a) What systems (Including IT) need to be changed or updated or where new systems may be needed;

b) What guidance, guidelines, standards, policies and procedures need to be changed or updated or where new guidance, guidelines, standards, policies and procedures systems may be needed;
c) Where Departmental Top Management sign off is required;
d) Where Ministerial/Executive approval is required;
e) Where legislative change is necessary;
f) Where other products and resources need to be developed to be used within the HSC;
g) Which parts of the workforce need to be involved in implementation;
h) Which external partner organisations need to be involved in implementation;
i) Where equality impact assessments and/or rural proofing are indicated;
j) Where a requirement for public consultation is indicated;
k) Key stakeholders whose views will inform the implementation process; and
l) Extant resources and systems already in place in HSC Trusts or elsewhere which might lend themselves as the basis for solutions to meet IHRD recommendations.

An Implementation and Benchmarking Framework is one of the first and key deliverables for each workstream. The basic requirement is for an initial benchmarking exercise to identify the baseline position and specific elements that will need to be addressed when changes necessary to implement recommendations are being actioned. This framework will interplay with and inform the content of work plans, involvement and communication plans, the identification of training needs to be included in the Programme Training plan and work on a Programme Assurance Framework.

3.6 Reporting

The IPMG will regularly receive a Workstream report with exception reporting used at any time to highlight issues with potential to impact on the implementation of the programme plan. A template for reporting will be provided with report frequency dependent on the work plan requirements and timescales for delivery

A workstream Issue Log will be collated to identify those issues likely to have an impact on the implementation of the recommendations.

Each workstream will be provided with a standard suite of documentation to facilitate its programme management and reporting to the Implementation Programme Management Group. These will include:

- Action Log
- Agenda
- Chair's Meeting Brief
- Engagement Activity Tracker
- Exception Report
- Implementation and Benchmarking Framework
- Involvement & Communication Plan (will be provided later)
- Issue Log
- Note of a meeting
- Meeting checklist
- Work Plan
- Workstream Update

This documentation should be held in the document management system of the team providing secretariat services to the workstream (TRIM in the case of Departmental staff.)

Progress on the programme of work will be reported to the SRO through the Programme Director.

Wider communication issues will be determined by the Communication Strategy

4 Governance

Without prejudice to the return of Assembly structures and appointment of a Minister progress will be reported to the SRO, who will remain the accountable officer for the implementation of the recommendations of the IHRD Report.

All existing Executive and Departmental governance systems will apply to the processes in the implementation of the IHRD Programme, including existing financial controls.

5 Appendices:

5.1 IHRD Action Plan Matrix

5.2 Workstreams and delegated tasks

5.3 Workstream membership

APPENDIX 5.1 IHRD: RECOMMENDATIONS
Action Plan Matrix

	Ref	RECOMMENDATION	Report Reference	Workstream
CANDOUR	1	A statutory duty of candour should now be enacted in Northern Ireland so that:	Vol 3, Chapter 8: Section 8.47 Page 55 Section 8.103-106 Page 73-74	**1-Duty of Candour**
		(i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public	Vol 3, Chapter 8: Section 8.101 page 72 Section 8.103 page 74	**1-Duty of Candour** *Linked to:* *6-Training* *8 Workforce and professional regulation*
		(ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.	Vol 2, Chapter 4: Section 4.150 –152 Pages 47 – 48 Section 4.157 Page 49	**1-Duty of Candour** *Linked to:* *5-SAI* *6-Training* *7-User experience* *8 Workforce and professional regulation*
		(iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).	Vol 1, Chapter 3: Section 3.178 Page 181 Section 3.242-244 Page 203-204 Section 3.245-248 Page 204 – 206	**1-Duty of Candour**

	Ref	RECOMMENDATION	Report Reference	Workstream
			Vol 2, Chapter 4: Section 4.86 -88 Page 29 Section 4.310 (ii) Page 92 Section 4.330 Page 98 Vol 2: Chapter 5 Section 5.253-5.254 Page 181	*Linked to:* *6-Training* *7-User experience* *8 Workforce and professional regulation*
		(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.	Vol 1, Chapter 3: Section 3.179 -180 Pages 181-182 Section 3.195-196 Page 186	**1-Duty of Candour** *Linked to:* *6-Training* *8-Workforce and professional regulation*
		(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	Vol 1, Chapter 3: Section 3.200 Page 188 Section 3.202 Page 188	**1-Duty of Candour** *Linked to:* *6-Training*
		(vi) Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.	Vol 1, Chapter 3: Section 3.178 Page Vol 2: Chapter 5: Section 5.253 Page 81	**1-Duty of Candour** *Linked to:* *5-SAI*

	Ref	RECOMMENDATION	Report Reference	Workstream
		(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.	Vol 2, Chapter 4: Section 4.47-53 page 17-19 Section 4.54-55 Page 19-20 Section 4.130 Page 41 Section 4.145 Page 46 Section 4.217 Page 66 Section 4.241 Page 72-73 Section 4.301 Page 89 Section 4.306 Page 98	**1-Duty of Candour** *Linked to:* *5-SAI* *8-Workforce and professional regulation*
	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.	Vol 3, Chapter 8: Section 8.103 Page 73 Section 8.106 Page 74	**1-Duty of Candour** *Linked to:* *8-Workforce and professional regulation*
	3	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty	Vol 3, Chapter 8: Section 8.104 page 74	**1-Duty of Candour** *Linked to:* *6-Training*
	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.		**1-Duty of Candour** *Linked to:* *6-Training*
	5	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.		**8-Workforce & Professional Regulation** *Linked to:*

	Ref	RECOMMENDATION	Report Reference	Workstream
				1-Duty of Candour
	6	Support and protection should be given to those who properly fulfil their duty of candour.	Vol 3: Section 8: Section 8.108 Page 75	**1 - Duty of Candour** *Linked to:* *6-Training*
	7	Trusts should monitor compliance and take disciplinary action against breach.		**8-Workforce & Professional Regulation** *Linked to:* *1-Duty of Candour* *3-Duty of Quality*
	8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.	Vol 3, Chapter 8: Section 8.71 page 63	**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *8-Workforce & professional regulation* *9-Assurance*

	Ref	RECOMMENDATION	Report Reference	Workstream
LEADERSHIP	9	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.	Vol 1, Chapter 3: Section 3.92- 93 Page 223 Section 3.303- 311 Page 227- 230 Vol 2 Chapter 4: Section 4.201 Page 61 Vol 2, Chapter 5: Section 5.122(ix) – 123 Page 142 Section 5.258 Page 183 Section 5.347 Page 210 Section 5.367 Page 216 Vol 2, Chapter 6: Section 6.56-57 Page 237-238 Vol 3, Chapter 8: Section 8.111-115 Pages 76-77	**3-Duty of Quality** *Linked to:* *6-Training*
PAEDIATRIC - CLINICAL	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings	Vol 2: Chapter 6 Section 6.60-61 Page 240-241 Vol 3: Chapter 8; Section 8.30-34 Pages 50-52	**4-Paediatric/Clinical Collaborative** *Linked to:* *2-Death certification* *3-Duty of Quality*
	11	There should be a protocol to specify the information accompanying a patient transfer from one hospital to another	Vol 2 Chapter 4: Section 4.32- 34 Page 13	**4-Paediatric/Clinical Collaborative**
	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Vol 2, Chapter 5 Section 5.75-5.78 Page 126-127 Section 5.233 Page 175	**4-Paediatric/Clinical Collaborative**

	Ref	RECOMMENDATION	Report Reference	Workstream
				Linked to: *3-Duty of Quality*
	13	Foundation doctors should not be employed in children's wards.	Vol 2, Chapter 5 Section 5.104-113 Page 134-137 Section 5.114-121 Page 137- 139 Section 5.214 Page 168	**4-Paediatric/Clinical Collaborative** *Linked to:* *8-Workforce & professional regulation*
	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.		**4-Paediatric/Clinical Collaborative** *Linked to:* *6-Training* *8-Workforce & professional regulation*
	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Vol 1, Chapter 3: Section 3.24 Page Section 3.29 Page Section 3.126 Page 166 Vol 2 Chapter 4 Section 4.202 – 203 Page 61-62 Section 4.205-206 Page 62 Vol 3, Chapter 8: Section 8.29 Page 50	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can	Vol 2, Chapter 5: Section 5.122 (ii) Page 140	**4-Paediatric/Clinical Collaborative**

	Ref	RECOMMENDATION	Report Reference	Workstream
		know who is in charge and responsible.		*Linked to:* *3-Duty of Quality*
	17	Any change in clinical accountability should be recorded in the notes.	Vol 1, Chapter 3 Section 3.199-121 Page 164-165	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	18	The names of all on-call consultants should be prominently displayed in children's wards.		**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Vol 3, Chapter 8: Section 8. Page 45-46	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	20	Children's ward rounds should be led by a consultant and occur every morning and evening	Vol 1, Chapter 3: Section 3.61 Page 143	**4-Paediatric/Clinical Collaborative** *Linked to:*

	Ref	RECOMMENDATION	Report Reference	Workstream
				3-Duty of Quality *8-Workforce & professional regulation*
	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.		**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality* *8-Workforce & professional regulation*
	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Vol 1 Chapter 3: Section 3.61 Page 143 Vol 3, Chapter 8: Section 8.84 page 62	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality* *7-User experience*
	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Vol 1 Chapter 3: Section 3.122- 124 Page 165	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	24	All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart.	Vol 1 Chapter 3: Section 3.34 Page 136 Section 3.45-46 Page 139 Section 3.88-89 Page 153	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*

	Ref	RECOMMENDATION	Report Reference	Workstream
	25	All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician.	Vol 1 Chapter 3: Section 3.95 Page 136 Section 3.104-107 Page 158-159	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Vol 1 Chapter 3: Section 3.52 Page 141 Section 3.76-77 Page 149 Section 3125 Page 166	**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	27	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.		**4-Paediatric/Clinical Collaborative** *Linked to:* *3-Duty of Quality*
	28	Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent.	Vol 1 Chapter 2 Section 2.38 Page 44	**4-Paediatric/Clinical Collaborative**
	29	Record keeping should be subject to rigorous, routine and regular audit.	Vol 3, Chapter 8: Section 8.25-29 Pages 48-50	**4-Paediatric/Clinical Collaborative**

	Ref	RECOMMENDATION	Report Reference	Workstream
				Linked to: *3-Duty of Quality*
	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.	Vol 3, Chapter 8: Section 8.108 Page 75	**4-Paediatric/Clinical Collaborative** *Linked to:* *1-Duty of Candour*
SAI - REPORTING	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').	Vol 2, Chapter 6 Section 6.67-69 Page 242-243 Vol 3: Chapter 8; Section 8.41-42 Page 54 Section 8.46-47 Page 55-56	**5-SAIs** *Linked to:* *1-Duty of Candour* *6-Training*
	32	Failure to report an SAI should be a disciplinary offence.	Vol 2, Chapter 4: Section 4.232 Page 78 Vol 3, Chapter 8: Section 8.65 - 8.66 Page 61	**8-Workforce & Professional Regulation** *Linked to:* *5-SAI*
SAI - INVESTIGA	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.	Vol 3, Chapter 8: Section 8.48 – 8.49 Page 56	**9-Assurance** Linked to: 3-Duty of Quality 5-SAI

	Ref	RECOMMENDATION	Report Reference	Workstream
	34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses	Vol 1 Chapter 3: Section 3.266 (iii – iv) Page 214 Vol 2, Chapter 5: Section 5.313 Page 200 Vol 3, Chapter 8: Section 8.47 page 55 Section 8.133 page 82	**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*
	35	Failure to co-operate with investigation should be a disciplinary offence.	Vol 2, Chapter 4: Section 4.128 Page 41 Section 4.130 Page 141	**8-Workforce & Professional Regulation** *Linked to:* *5-SAI*
	36	Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.	Vol 2, Chapter 5: Section 5.300-301 Page 195-196	**2-Death Certification Implementation Working group**
	37	Trusts should seek to maximise the involvement of families in SAI investigations and in particular:	Vol 3, Chapter 8: Section 8.72 – 8.73 Pages 63 – 64 Section 8.89 Page 68	**5-SAI**
		(i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.	Vol 3, Chapter 8: Sections 8.56 – 8.57 Page 58-59	**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*
		(ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.	Vol 3, Chapter 8: Section 8.74 Page 64	**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*

	Ref	RECOMMENDATION	Report Reference	Workstream
		(iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.	Vol 2, Chapter 4: Section 4.159-161 Page 49-50	**5-SAIs** *Linked to:* *3-Duty of Quality* *7-User experience*
		(iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.	Vol 3, Chapter 8: Section 8.95-100 Page 70-72	**7-User experience & advocacy** *Linked to:* *5-SAI*
		(v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.	Vol 2, Chapter 4: Section 4.174 Page 54 Section 4.177-178 Page 55 Vol 3, Chapter 8: Section 8.74 Page 64	**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*
		(vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.		**5-SAI** *Linked to:* *1-Duty of Candour* *2-Death certification* *3-Duty of Quality* *7-User experience*
		(vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.		**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*

	Ref	RECOMMENDATION	Report Reference	Workstream
		(viii) Family GPs should, with family consent, receive copies of feedback provided.		**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*
		(ix) Families should be formally advised of the lessons learned and the changes effected		**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*
		(x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation	Vol 2, Chapter 4: Section 4.179 Page 55	**5-SAI**
SAI - INVESTIGATION	38	Investigations should be subject to multi-disciplinary peer review.	Vol 3, Chapter 8: Section 8.73 page 64	**5-SAI** *Linked to:* *3-Duty of Quality* *6-Training*
	39	Investigation teams should reconvene after an agreed period to assess both investigation and response.		**5-SAI** *Linked to:*
	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit	Vol 3, Chapter 8: Section 8.49 -50 Page	**3-Duty of Quality** Linked to: 5-SAI
	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.		**3-Duty of Quality**

	Ref	RECOMMENDATION	Report Reference	Workstream
	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.	Vol 2, Chapter 4 Section 4.173-176 Page 54 Vol 3, Chapter 8: Section 8.73 – 8.74 pages 64-65	**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*
SAI – WHERE DEATH OCCURS	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Vol 2, Chapter 4 Section 4.232-238 Page 70-72 Vol 2, Chapter 5 Section 5.162-165 Page 153	**2-Death Certification Implementation Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*
	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family	Vol 1 Chapter 3: Section 3.206-210 Page 190-191	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training*
	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem	Vol 2, Chapter 4 Section 4.284 Page 84	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training*
	46	Where possible, treating clinicians should attend for clinico-pathological discussions at the time of post-mortem examination and thereafter upon request.	Vol 2, Chapter 4 Section 4.286 Page 84-85	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training*

	Ref	RECOMMENDATION	Report Reference	Workstream
	47	In providing post-mortem reports pathologists should be under a duty to: (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them. (ii) Work in liaison with the clinicians involved. (iii) Provide preliminary and final reports with expedition. (iv) Sign the post-mortem report. (v) Forward a copy of the post-mortem report to the family GP	Vol 1, Chapter 2: Section 2.33 Page 199-200 Vol 1, Chapter 3: Section 3.212 Page 191 Section 3.229-230 Page 197-198 Section 3.235-238 page 200-201 Vol 2, Chapter 4: Section 4.291 Page 86 Vol 1, Chapter 3: Section 3.232 Page 98	**2-Death Certification Implementation Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*
	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.	Vol 3, Chapter 8: Section 8.61 Page 59-60	**2-Death Certification Implementation Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*
	49	Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.		**2-Death Certification Implementation Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*

	Ref	RECOMMENDATION	Report Reference	Workstream
	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved	Vol 2, Chapter 4: Section 5.282-291 Page 189-192 Vol 3, Chapter 7: Section 7.57 Pages 21- 22	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality*
	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.	Vol 1, Chapter 2: Section 2.148 Page 85 Section 2.199 Page 101 Vol 1, Chapter 3: Section 3.267 -273 Page 214-217	**2-Death Certification Implementation Working group**
	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.	Vol 1, Chapter 3: Section 3.279-280 Page 218-219	**2-Death Certification Implementation Working group**
	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.	Vol 3, Chapter 8: Section 8.129 Page 81	**2-Death Certification Implementation Working group**
	54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.	Vol 3, Chapter 8: Section 8.57 Page 58-59	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training* *7-User experience*

	Ref	RECOMMENDATION	Report Reference	Workstream
TRAINING & LEARNING	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.		**3-Duty of Quality** *Linked to:* *5-SAI* *6-Training*
	56	All Trust Board Members should receive induction training in their statutory duties.		**3-Duty of Quality** *Linked to:* *6-Training*
	57	Specific clinical training should always accompany the implementation of important clinical guidelines.		**6-Training**
	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and Hyponatraemia.	Vol 3, Chapter 8: Section 8. 17-24Pages 46-48	**6-Training**
	59	There should be training in the completion of the post-mortem examination request form.		**2-Death Certification Implementation Working group** *Linked to:* *6-Training*
	60	There should be training in the communication of appropriate information and documentation to the Coroner's office.	Vol 2, Chapter 4: Section 4.258 Page 77 Section 4.270 Page 80	**2-Death Certification Implementation Working group** *Linked to:* *6-Training*

	Ref	RECOMMENDATION	Report Reference	Workstream
	61	Clinicians caring for children should be trained in effective communication with both parents and children.	Vol 3, Chapter 8: Section 8.86 Page 67	**6-Training** *Linked to:* *1-Duty of Candour* *4-Paediatric/Clinical* *7-User experience*
	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.	Vol 3, Chapter 8: Section 8.87-88 Page 68	**6-Training** *Linked to:* *1-Duty of Candour* *2-Death certification* *4-Paediatric/Clinical* *5-SAI* *7-User experience*
	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.	Vol 3, Chapter 8: Section 8.74-75 Page 64-65	**6-Training** *Linked to:* *1-Duty of Candour*
	64	Parents should be involved in the preparation and provision of any such training programme.		**6-Training** *Linked to:* *7-User experience*
	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.	Vol 2, Chapter 4: Section 4.112-113 Page 36-37 Vol 2, Chapter 5: Section 5.215 -217 Page 167-170	**6-Training** *Linked to:* *5-SAI*

	Ref	RECOMMENDATION	Report Reference	Workstream
	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	Vol 3, Chapter 8: Section 8.81 Page 66	**6-Training**
	67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed		**3-Duty of Quality** *Linked to:* *6-Training*
	68	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.	Vol 3, Chapter 8: Section 8.76 Pages 65-66	**3-Duty of Quality** *Linked to:* *5-SAI* *6-Training* *8-Workforce & professional regulation*
TRUST GVERNANCE	69	(i) Trusts should appoint and train Executive Directors with specific responsibility for: (iii) Issues of Candour	Vol 3, Chapter 8: Section 8.107 Page 74	**3-Duty of Quality** *Linked to:* *1-Duty of Candour* *6-Training* *8-Workforce & professional regulation*
		(iv) Child Healthcare.		**3-Duty of Quality** *Linked to:* *4-Paediatric/ Clinical* *6-Training* *8-Workforce & professional regulation*

	Ref	RECOMMENDATION	Report Reference	Workstream
		(iii) Learning from SAI related patient deaths.		**3-Duty of Quality** *Linked to:* *4-Paediatric/ Clinical* *6-Training* *8-Workforce & professional regulation*
	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.	Vol 2, Chapter 5: Section 5.226 Page 173	**3-Duty of Quality**
	71	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.	Vol 1, Chapter 3: Section 3.292 Page 223 Vol 3, Chapter 8: Section 8.56 Page 58 Section 8.58- 8.59 Page 59	**3-Duty of Quality** *Linked to:* *4-Paediatric/Clinical*
	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.	Vol 2, Chapter 5: Section 5340-344 Page 209-209 Vol 3, Chapter 8: Section 8.83 Page 67 Section 8.107 Page 74	**3-Duty of Quality** *Linked to:* *1-Duty of Candour*
	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.	Vol 3, Chapter 8: Section 8.105 Page 74	**8-Workforce & professional regulation**
	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.		**8-Workforce & professional regulation**

	Ref	RECOMMENDATION	Report Reference	Workstream
	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies	Vol 1, Chapter 3: Section 3.299-301 Page 225-226 Vol 3, Chapter 8: Section 8.109 Page 75 Section 8.110 Page 76	**8-Workforce & professional regulation** *Linked to:* *1-Duty of Candour*
	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.		**3-Duty of Quality** *Linked to:* *9-Assurance*
	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.		**3-Duty of Quality**
	78	Implementation of clinical guidelines should be documented and routinely audited		
	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.		**3-Duty of Quality** *Linked to:* *4-Paediatric/ Clinical*
	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.	Vol 3, Chapter 8: Section 8.109 Page 75	**3-Duty of Quality**
	81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.	Vol 2, Chapter 4: Section 4.187-189 Page 57-58	**3-Duty of Quality** *Linked to:* *5-SAI*

	Ref	RECOMMENDATION	Report Reference	Workstream
	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.	Vol 2, Chapter 4: Section 4.93 Page 30 Vol 3, Chapter 8: Section 8.59 Page 59	**5-SAI** *Linked to:* *3-Duty of Quality*
	83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.		**5-SAI** *Linked to:* *3-Duty of Quality*
	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.		**3-Duty of Quality**
DEPARTMENT	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.		**Department** *Linked to:* *4-Paediatric/ Clinical* *8-Workforce & professional regulation*
	86	The Department should expand both the remit and resources of the RQIA in order that it might (vii) Maintain oversight of the SAI process	Vol 3, Chapter 8: Section 8. Page 54-55 Section 8.71 Page 63 Section 8.107 Page 74	**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*
		(viii) Be strengthened in its capacity to investigate and review individual cases or groups of cases, and		**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*

	Ref	RECOMMENDATION	Report Reference	Workstream
		(ix) Scrutinise adherence to duty of candour.		**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*
	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.	Vol 3, Chapter 8: Section 8.124 Page 80	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training* *7-User experience*
	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel.	Vol 3, Chapter 8: Section 8.82 Page 66 Section 8.118 Page 78 Section 8.119 Page 78 Section 8.127 Page 81	**Department**
	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.	Vol 3, Chapter 8: Section 8.90 Page 69 Sections 8.95-8.97 Pages71	**7-User experience & Advocacy**

	Ref	RECOMMENDATION	Report Reference	Workstream
	90	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (iii) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability.	Vol 3, Chapter 8: Section 8. Pages 52 -53	**3-Duty of Quality** *Linked to:* *8-Workforce & professional regulation*
		(iv) The identification of specific training requirements necessary for effective implementation.		**3-Duty of Quality** *Linked to:* *6-Training*
	91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.	Vol 3, Chapter 8: Section 8.62- 8.64 Pages 60	**5-SAI** *Linked to:* *3-Duty of Quality*
	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.	Vol 3: Chapter 8:	**3-Duty of Quality**
	93	The Department should review Trust responses to the findings and recommendations of this Report.		**9-Assurance** *Linked to:* *All other workstreams*
CULTURE & LITIGATION	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.	Vol 2, Chapter 5: Section 5.355-362 Page 213-215 Vol 3, Chapter 7: Section 7.35 Pages 13-14	*Linked to:* *1-Duty of Candour*

	Ref	RECOMMENDATION	Report Reference	Workstream
	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.	Vol 2, Chapter 5: Section 5.316-320 Page 201-202 Vol 3, Chapter 8: Section 8.129 Page 81	**2-Death Certification Implementation Working group**
	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.	Vol 3, Chapter 8: Section 8.130 Page 82	**2-Death Certification Implementation Working group**

APPENDIX 5.2 IHRD Workstreams and Delegated tasks from IHRD Report Recommendations

Workstream Number	Workstream Name	Actions	Recommendations for implementation Category and Number
1	Duty of Candour	11 Actions from 5 Recommendations	Candour: 1 (i), 1 (ii), 1 (iii), 1 (iv), 1 (v), 1 (vi), 1 (vii), 2,3,4,6,
2	Death Certification Implementation Working Group	22 Actions from 18 Recommendations	SAI Investigation: 36, SAI Death: 43, 44, 45, 46, 47 (i), 47 (ii), 47 (iii), 47 (iv), 47 (v), 48, 49, 50, 51, 52, 53, 54, Training: 59,60, Department: 87, Culture and Litigation: 95, 96
3	Duty of Quality	28 Actions from 23 Recommendations	Candour: 8 Leadership: 9, SAI Investigation: 34, 40, 41, Training: 55, 56, 67, 68, Trust Governance: 69 (i), 69 (ii), 69 (iii), 70, 71, 72, 76, 77, 78, 79, 80, 81, 84, Department: 86 (i), 86 (ii), 86 (ii), 90 (i), 90 (ii), 92
4	Paediatric – Clinical	21 Actions from 21 Recommendations	Paediatric – Clinical: 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30
5	Serious Adverse Incidents	18 Actions from 10 Recommendations	SAI Reporting: 31,33 SAI Investigation 37 (i), 37 (ii), 37 (iii), 37 (v), 37 (vi), 37 (vii), 37 (viii), 37 (ix), 37 (x), 38, 39, 42, Training: 66

			Trust Governance: 82, 83, Department: 91,
6	Training	6 Actions from 6 Recommendations	Training: 57, 58, 61, 62, 64, 65,
7	User Experience and Advocacy	3 Actions from 3 Recommendations	SAI Investigation: 37 (iv), Training: 63, Department: 89
8	Workforce and Professional Regulation	7 Actions from 7 Recommendations	Candour: 5, 7, SAI Reporting: 32, SAI Investigation: 35, Trust Governance: 73, 74, 75,
9	Assurance	1 Actions from 1 Recommendation	Department: 93

APPENDIX 5.3 WORKSTREAM MEMBERSHIP

Chair: Eddie Rooney

Members

Name	Organisation
Linda Greenlees	Department of Health
Jim Moore	Translink
Lynne Charlton	Northern Ireland Ambulance Service (NIAS)
Joanne Stuart	Catalyst

Appendix 5.3 (i)

ALB Board Effectiveness Sub-Group

Chair:

Jim Moore Translink

Members

Name	**Organisation**
Gordon Smyth	Northern Ireland Fire and Rescue Service (NIFRS)
Dale Ashford	Northern Ireland Ambulance Service (NIAS)
Peter McNaney	Belfast Health and Social Care Trust
Martin McDonald	Southern Health and Social Care Trust
Mary McColgan	RQIA
Billy Graham	Northern Health and Social Care Trust
Irene Low	South Eastern Health and Social Care Trust
Myra Weir	South Eastern Health and Social Care Trust
Bob Brown	Western Health and Social Care Trust
Elizabeth Brownlees	Northern Health and Social Care Trust
Vivienne Toal	Southern Health and Social Care Trust
Deborah Reynolds	Northern Ireland Fire and Rescue Service (NIFRS)
Catherine McKeown	BSO
Colin Reid	NSPCC
Brendan O'Hara	AIIHPC
Fiona Greene	NICHS
Maria Somerville	Service User / Carer
Ignatius Maguire	Service User / Carer
Johnny Graham	Service User / Carer
Stephen Galway	Department of Health
Gillian Seeds	Department of Health
Hilda Hagan	Department of Health

Appendix 5.3 (ii)

RQIA Remit Sub-Group

Chair:

Linda Greenlees	Department of Health

Members

Name	**Organisation**
Mary McColgan	RQIA
Suzanne Pullins	Northern Health and Social Care Trust
Colin Reid	NSPCC
Carol McCullough	Service User / Carer
Laura Collins	Service User / Carer
Dale Ashford	Northern Ireland Ambulance Service (NIAS)

Appendix 5.3 (iii)

Clinical and Social Care Governance Sub-Group

Chair:

Lynne Charlton	Northern Ireland Ambulance Service (NIAS)

Members

Name	**Organisation**
Jonathan Patton	Southern Health and Social Care Trust
Peter McNaney	Belfast Health and Social Care Trust
Billy Graham	Northern Health and Social Care Trust
Sally O'Kane	Western Health and Social Care Trust
Mark Roberts	Health and Social Care
Suzanne Pullins	Northern Health and Social Care Trust
Niall Herity	Belfast Health and Social Care Trust
Margaret Marshall	Southern Health and Social Care Trust
Dermot Hughes	Western Health and Social Care Trust
Lesley Edgar	NICE
Celine McStravick	Third Sector
Jenny Irvine	Third Sector
Carol McCullough	Service User / Carer
Laura Collins	Service User / Carer
Maria Somerville	Service User / Carer
Pat Cullen	
John McKeown	Department of Health

id	audittitle	name	jobtitle	Specialty	ecialty_20	baselocation	email	vice_area2	sites	servicegrp
2005	Audit of Standards for Risk Assessment and Risk Management within Adult Protection across Programmes	D Hegarty	Senior Social W		Muckamo	KHCP	deirdre.he	Learning D	Muckamo	Adult Soci
3147	Referrals to single point of access service against proposed assessment criteria for early psychosis intervention team	A Turkington	Specialist	Mental	Acute	Windsor	aidant@d	Mental	BCH,	Adult
3181	Antipsychotic Prescribing in People with Learning Disabilities	Stephen Guy	Clinical	Pharmacy	Pharmacy	Knockbracken	stephen.g	Therapy	Knockbra	Adult
3183	Rapid Tranquilisation for Patients with Learning Disabilities	Arun Subramanian	SpR	Mental He	Muckamo	Muckamore Al	arunmed@	Learning D	Muckamo	Adult Soci
3186	Psychiatry Discharge Documentation (Aug 09)	Pat Flynn	Nurse	Mental	Acute	Knockbracken	patricia.fl	Mental	BCH,	Adult
3235	Antipsychotic Monitoring	Dr D Hughes	Consultant Psy	Muckamo	Muckamo	Muckamore Al	Damien.H	Learning D	Muckamo	Adult Soci
3245	Complaints service-User satisfaction survey 2009	Mrs Jeni Rosborough	Project	Governan		Glendinning	jeni.rosb		BCH,	Adult
3458	Dementia in People with Learning Disabilities	Chris Southwell	Dr	Mental He	Acute Serv	Muckamore Al	csouthwel	Learning D	Muckamo	Adult Soci
3495	Audit of the resettlement process (Mallow Ward)	Dr Paula McLorinan	Consultant Psy		Supported	Muckamore Al	paula.mcl	Learning D	Muckamo	Adult Soci
3559	O'Neiil Recommendations Audit	Mairead Mitchell	Senior	Muckam	Muckam	Mater		Learning	BCH,	Adult
3631	Mobility Risk Assessment	Gillian Bingham	Team Leader		Allied Hea	MAH	gillian.bing	Therapy &	SE Commu	Surgery ar
3663	Audit of admission and discharge process in Cranfield	Dr Damien Hughes	Doctor	Muckamo	Primary Ca	Muckamore Al	damien.hu	Learning D	Muckamo	Adult Soci
3760	Physical Examination Equipment Audit	Dr Ronan Kehoe	Doctor	Mental He	Muckamo	Muckamore Al	ronan.keh	Learning D	Muckamo	Adult Soci
3893	Audit of Benzodiazepine use in kilead ward	Janet MacPherson	Consultant			Muckamore Al	janet.mac	Learning D	Muckamo	Adult Soci
4227	Community Integration (LD) How are the family/relative/patient involved	Jenni Armstrong	Resource Nurse		Muckamo	Library Comple	jenniarms	Learning D	Muckamo	Adult Soci
4333	Prescribing high dose & combination antipsychotics in adult wards	Dr Lisa Montgomery	Locum appoint			Muckamore	lisa.montg	Learning D	Muckamo	Adult Soci
4532	Use of Levels of Observation at Muckamore Abbey Hospital	Dr Colin Milliken	Clinical Directo			Muckamore Al	colin.milli	Learning D	Muckamo	Adult Soci
4602	An evaluation of the OT resettlement service at Muckamore- Service User feedback	Shelley Crawford	Lead OT		Occupatio	Muckamore	shelleycra	Therapy &	Muckamo	Adult Soci
4605	Non-staff support available to Forensic patients in Muckamore Abbey / Belfast Community Forensic LD services	Siobhan Keating	Consultant For		Psychologi	Muckamore (9	siobhan.ke	Psycholog	NW Comm	Adult Soci
4623	An evaluation of the OT breakfast club	Katie Carson	Occupational T		Occupatio	Muckamore	kathrynj.c	Learning D	Muckamo	Adult Soci
4703	Service Evaluation of Occupational Therapy in Resettlement of LD Patients from Muckamore (Staff feedback)	Heather McFarlane	Clinical Lead LD		Occupatio	Muckamore		Therapy &	Muckamo	Adult Soci
4708	Healthy lifestyle audit	Kathryn Carson	Occupational T		Communit	Muckamore Al	kathrynj.c	Learning D	Muckamo	Adult Soci
4738	Patient, Carer & Staff Understanding and Implementation of the Adult Safeguarding Process	Michael Creaney	Safeguarding O			Muckamore	michaelcr	Learning D	Muckamo	Adult Soci
5020	Effectiveness of a community partnership healthy living programme for those with learning disabilities	Heather McFarlane	Clinical Lead O		Allied Hea	Muckamore Al	heather.m	Learning D	Muckamo	Adult Soci
5035	Sensory modulation room use audit	Katie Carson	Occupational T		Communit	Muckamore Al	kathrynj.c	Learning D	Muckamo	Adult Soci
5388	Audit of PRN Benzodiazepine	Damien Hughes	Consultant Psy			Muckamore Al	damien.hu	Learning D	Muckamo	Adult Soci
5389	Kardex Audit	Damien Hughes	Consultant Psy			Muckamore Al	damien.hu	Learning D	Muckamo	Adult Soci
5425	Implementation of Safety Briefings in Muckamore Abbey Hospital	Carole Wilson	ST5			Muckamore	carole.wils	Learning D	Muckamo	Adult Soci
6012	Seclusion Record Audit	Joannae Dougherty	Consultant		Psychologi	Muckamore		Mental He	Muckamo	Adult Soci
6247	An audit of the incidence of trauma and adversity in the life experiences of inpatients with an intellectual disability and forensic history.	Siobhan Keating & Fran	Consultant For		Psychologi	Muckamore Al	Siobhan.k		Muckamo	

id	nicalservic	ad & skele	edicaldirec	entalhealt	nursing	opms	ocialservice	cialistservi	auditremit	bch	rgh	mih	mph	ecommunit	wcommuni	nockbracke	nuckamore
2005	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE
3147	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	Trustwide	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
3181	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	National	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	TRUE
3183	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE		FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE
3186	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	Trustwide	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE
3235	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	Regional	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE
3245	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	Trustwide	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
3458	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
3495	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Regional	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
3559	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Trustwide	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
3631	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
3663	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
3760	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
3893	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4227	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4333	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4532	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4602	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Regional	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4605	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4623	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4703	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Regional	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4708	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
4738	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
5020	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
5035	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
5388	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
5389	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
5425	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
6012	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
6247	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	Local	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE

id	reason	objectives	method	standards	proposedstart	proposedend	impact	againstotherarea	ervisorna	ervisorjob
2005	High Risk /	1) To ensu	Retrospec	Local consensus					S O'Brien	Director o
3147	Confirm	Develop	Collect all	Locally	02-Jun-09		To identify a clear	Audit will	S Cooper	Consulta
3181	To	To		National	01-Jun-09	30-Jun-09	Will help identify if	Joint audit	Dr Ita	
3183	Similar au	To audit th	Retrospec	NICE Schiz	03-Aug-09	30-Sep-09	Will help review curre		Dr Damien	Consultant
3186	Ongoing	To		Recomm	12-Aug-09	31-Aug-09			Mairead	Senior
3235	New guide	To ensure	Retrospec	Maudsley Prescribing Guidelines			Any adverse effects sh		Dr D Hugh	Consultant
3245	DOH	To gauge	Question	100%	01-Dec-09	31-Jan-10	Improvement in		Margaret	Senior
3458	Recent gu	To ensure	Review of	The audit	18-Aug-10	30-Sep-10	This audi would help h	No	Dr Colin M	Clinical Dir
3495					01-Jan-10	28-Feb-10			Clare Paul	Consultant
3559		To ensure			22-Nov-10	07-Jan-11			Mairead	Senior
3631	1. To impr	1. To ensu	Audit of cu	BHSCT Risk	01-Feb-11	31-Jan-12			Anne Duff	Assistant F
3663		To improv			01-Apr-11				Damien H	Consultant
3760		To identify			02-May-11	31-May-11			Dr D Hugh	Consultant
3893	to review	Determine	Questionn	BNF Maud	01-Jul-11	21-Jul-12			Janet Mac	Consultant
4227	To audit th	To improv	6 patients	The integr	10-Dec-12	31-Jan-13			Mairead M	Senior Ma
4333	Explore ra	To identify	Retrospec		20-Apr-13	28-Jun-13			Dr Colin M	Clinical Dir
4532		To examin			22-Jan-14	28-Mar-14			Dr Colin M	Clinical Dir
4602		To investig		COT stand	01-Apr-14	30-May-14			Aisling Cu	OT Manag
4605		To measur			31-Mar-14	05-May-14			Dr Philip N	Consultant
4623	To collect	As above	questionn		01-Apr-14	31-May-14			Shelley Cr	Clinical Lea
4703		Audit staff			03-Jul-14	30-Jul-14			Aisling Cu	OT Manag
4708		To be defi	Questionn	Learning disability service framework. I						
4738		To determ			04-Sep-14	19-Dec-14			Esther Raf	Service Ma
5020		To increas		To offer a	28-Sep-15	30-May-16			Aisling Cu	OT Manag
5035		Utilising a	Sample siz	Monitoring against seclusion records fo					Barry Mills	Nursing M
5388	To audit th	To audit th	Chart revi	Dosage of	05-Sep-16	19-Sep-16			Damien H	Consultant
5389	To audit th	To audit th	chart revie	Patient ide	05-Sep-16	19-Oct-16			Damien H	Consultant
5425		To introdu			01-Nov-16	26-Jun-17			Karen Hun	Consultant
6012	Audit com	Audit com			04-Sep-19	31-Mar-20			Joannae D	Consultant
6247			Chart revi		01-Jul-20	31-Jan-21			Siobhan K	Consultant

id	signed	datereceived	dateregistere	dateapprove	etrospectiv	concurrent	rospective	port Provi	datecomplete	planrequeste	nplanreminde	rojectstag	ctionagree	pportedbysqa
2005	TRUE	21-Mar-07	29-Jul-08	21-Mar-07	TRUE	FALSE	FALSE	Design / M	31-Jul-08	01/07/2008		Action imp	The Trust	TRUE
3147	TRUE		02-Jun-09		TRUE	FALSE	FALSE	Follow-	30-Jun-09	03/06/2011	15/06/2011	No	no action	FALSE
3181	FALSE	21-Jul-09	21-Jul-09	21-Jul-09	FALSE	FALSE	FALSE	Follow-	21-Dec-10			No		FALSE
3183	FALSE	28-Jul-09	28-Jul-09	28-Jul-09	FALSE	FALSE	FALSE	Follow-up	11-Aug-10	14/06/2010		No Action	No Action	FALSE
3186	FALSE	31-Jul-09	31-Jul-09	31-Jul-09	FALSE	FALSE	FALSE	Data	15-Jan-10	11/12/2009		Action	-Audits to	TRUE
3235	TRUE	09-Oct-09	30-Oct-09	09-Oct-09	TRUE	FALSE	FALSE	Analysis, R	10-Aug-10	23/07/2010		Action pla	Implemen	TRUE
3245	TRUE	26-Oct-09	05-Nov-09	29-Oct-09	TRUE	FALSE	FALSE	Follow-	25-Mar-10			Action	No action	TRUE
3458	TRUE	13-Jul-10	23-Aug-10	18-Aug-10	TRUE	FALSE	FALSE		04-Oct-11			Abandone	Project Ab	TRUE
3495	TRUE	30-Sep-10	05-Oct-10	01-Oct-10	TRUE	FALSE	FALSE					Data colle		TRUE
3559	FALSE	20-Oct-10	07-Dec-10		FALSE	FALSE	FALSE	Design /				Report/pr		TRUE
3631	TRUE	10-Jan-11	14-Mar-11		TRUE	FALSE	FALSE	Data Colle	18-Oct-12			No Action		TRUE
3663	TRUE	28-Mar-11	05-Apr-11		TRUE	FALSE	FALSE	Follow-up	10-Nov-11	25/07/2011	27/09/2011	No Action		FALSE
3760	TRUE	21-Jul-11	22-Jul-11		FALSE	TRUE	FALSE	Follow-up	10-Jan-12			No Action	No action	FALSE
3893	TRUE	02-Nov-11	12-Jan-12		TRUE	FALSE	FALSE	Follow-up	16-Nov-12	16/11/2012		No Action		FALSE
4227	FALSE	04-Dec-12	07-Dec-12		FALSE	TRUE	FALSE	Follow-up	01-Nov-13	03/12/2013		No Action		TRUE
4333	FALSE	23-Apr-13	08-May-13		TRUE	FALSE	FALSE	Analysis	22-Nov-13			Action pla	Recomme	TRUE
4532	FALSE	21-Jan-14	22-Jan-14		TRUE	FALSE	FALSE	Analysis, Presentation				Report/pr		FALSE
4602	FALSE	13-Mar-14	20-Mar-14		FALSE	FALSE	FALSE	Design / Methodology, Analysis, Presentation				No Action		FALSE
4605	FALSE	18-Mar-14	20-Mar-14		FALSE	FALSE	FALSE	Analysis, Presentation				Report/pr		TRUE
4623	TRUE	28-Mar-14	07-Apr-14		TRUE	FALSE	FALSE	Analysis, P	21-May-14			Action pla	From the r	TRUE
4703	FALSE	02-Jul-14	03-Jul-14		FALSE	FALSE	FALSE	Design / Methodology, Analysis, Presentation				No Action		TRUE
4708	FALSE	23-Jun-14	08-Jul-14		FALSE	FALSE	TRUE	Analysis, R	30-Nov-15	02/06/2015		No Action		TRUE
4738	FALSE	04-Sep-14	04-Sep-14		FALSE	FALSE	FALSE	Design / Methodology, Analysis, Report, Presentatio				Report/pr		TRUE
5020	FALSE	02-Sep-15	02-Sep-15		FALSE	FALSE	FALSE	Analysis				Data colle		FALSE
5035	FALSE	14-Sep-15	22-Sep-15		FALSE	TRUE	FALSE	Analysis, Report, Presentation				Analysis		TRUE
5388	FALSE	16-Sep-16	28-Oct-16		FALSE	TRUE	FALSE	Follow-up				Data colle		FALSE
5389	TRUE	16-Sep-16	28-Oct-16		FALSE	TRUE	FALSE	Follow-up				Data colle		FALSE
5425	FALSE	08-Dec-16	19-Dec-16		FALSE	FALSE	FALSE	Follow-up				Data colle		FALSE
6012	FALSE	04-Sep-19	04-Sep-19		TRUE	FALSE	FALSE	Design / Methodology, Presentation				Design/pla		TRUE
6247	FALSE	05-Oct-20	09-Oct-20		FALSE	FALSE	FALSE	Follow-up				Design/pla		FALSE