2.049

Belfast Health and Social Care Trust

Reference No: TP099/15

Title:	Procedure for Securing evidence when incidents involving Unexpected death or serious untoward harm has occurred in suspicious circumstances		
Author(s)	Claire Cairns, Co-Director, Risk and Governance P Keenan, Senior Manager		
Ownership:	Cathy Jack, Medical Director, Belfast Health and Social care Trust		
Approval by:	Policy Committee Executive Team	**Approval date:**	04.02.15 11.02.15
Operational Date:	March 2015	**Next Review:**	March 2018
Version No.	V1 **Supercedes**		
Key words:	Patient Safety, Client Safety, Unexpected Death, Suspicious Death, Serious Untoward Harm, Response, Preservation of Evidence		
Links to other policies	Emergency Care Protocol: Requests for Information from PSNI Guidance on Action to be Taken after a Patient's Death Clinical Record Keeping RIDDOR Guidance for Managers Sharps Injuries and Blood and Body Fluid Exposure- Prevention and Management of: Control of Substances Hazardous to Health Adverse Incident Procedure for Reporting Serious Adverse Incident		

Version control for drafts			
Date	**Version**	**Author**	**Comments**
25.09.2013	0.1	Claire Cairns	Initial Draft
01.05.2014	0.2	Claire Cairns	Second Draft
05.01.2015	0.3	Claire Cairns	Final Draft
12.03.2015	V1	Claire Cairns	Sent for upload to Hub

1.0 INTRODUCTION / PURPOSE OF PROCEDURE

This procedure has been developed to help staff working within the Belfast Health and Social Care Trust respond to;

- What constitutes a suspicious / unexpected death / serious untoward harm, as defined within the (ref) Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward Harm) (Memorandum of Understanding)
- Safe and secure preservation of evidence / scene
- Completion of appropriate documentation
- Effective communication internally and/or with external agencies

1.1 Background

The Belfast Health and Social Care Trust is committed to staff and service user safety and cooperation with statutory agencies with regard to the response to/and investigation of incidents of suspicious / unexpected death and serious untoward harm.

Following the publication of the Memorandum of Understanding[1] investigating staff / service user safety incidents, the Trust reviewed current associated policies and pre existing practices in order to create a new Trust wide procedure supporting staff in recognising where preservation of evidence is required and the process of effective communication and collaboration with those agencies requesting such evidence

1.2 Purpose

The purpose of the procedure is to outline the process that Trust staff will be required to follow in the event of a suspicious / unexpected death and serious untoward harm.

This procedure does not apply where the death of a staff member or service user is not regarded as suspicious or linked to an unexpected event that may give rise to investigation whether internally by the Trust or by other external agencies. In these circumstances the normal Trust procedures for management of a patient / client death will be followed.

It will ensure that there is a consistent approach to the response to such incidents and that staff at all levels are aware of their role and responsibilities in the management and reporting of such events.

This procedure does not replace the existing Trust policy/procedures on Reporting Serious Adverse Incidents or the Guidance to be taken after a patient's death.

[1] Memorandum of Understanding Investigating patient or client safety incidents (Unexpected death or serious untoward harm) Draft November 2014

1.3 Objectives

- To provide guidance for staff in identified key areas
- To comply with existing legislation
- To assist staff in identifying related key policies

2.0 SCOPE OF THE PROCEDURE

The scope of the procedure applies to those staff / service user safety incidents involving unexpected or suspicious death or serious untoward harm requiring investigation by the; PSNI, HSENI, Coroner's Office or by the PSNI and HSENI jointly.

Such events may happen in;

- Trust facilities, such as hospitals, clinics
- Well-being centres and care facilities
- Patients/ clients residence

In cases where any doubt exists as to the nature or circumstances of the event leading to the serious assault / death of a patient / client then staff should seek advice from their line or designated manager as appropriate.

3.0 ROLES/RESPONSIBILITIES

All staff are required to adhere to the procedure

4.0 KEY PROCEDURE PRINCIPLES

Definitions:

For the purposes of this procedure an HSC patient or client is defined as 'A person receiving health and/ or personal social services under the Health and Personal Social Service (Northern Ireland) Order 1972'[2].

Whereas no comprehensive legal definition exists for suspicious death the following examples may assist in differentiating between presenting circumstances leading to the death of a patient / client;

- **Natural:** Natural deaths are the workings of natural life in that death results from a natural disease process. Heart attacks, cancers, pneumonias, and strokes are common natural causes of death.
- **Accidental:** Accidental deaths result from an unplanned and unforeseeable sequence of events. Falls, automobile accidents, and in-home electrocutions are examples of accidental deaths.
- **Suicidal:** Suicides are deaths caused by the dead person's own hand. Intentional, self-inflicted gunshot wounds, drug overdoses, and self-hangings are suicidal deaths.

[2] Memorandum of Understanding (Investigating patient or client safety incidents Unexpected death or serious untoward harm) March 2013(p6 para1.8)

- **Homicidal:** Homicides are deaths that occur by the hand of someone other than the deceased.

Memorandum of understanding also refers to the term 'Serious Untoward Harm': This term describes an incident that has caused serious injury or harm (including those injuries that have resulted from sexual assault) requiring investigation by the PSNI /HSENI separately or jointly. It may be an incident which has arisen from or involved criminal intent, recklessness and /or gross negligence, untoward harm or in the context of Health and Safety a work related death (including where such incidents which involve injury /harm to staff).

Key Procedure Statement(s)

Procedure Principles

4.1 In light of the continuing requirements for the safe and effective care of services users and the legal requirements associated in the preservation of evidence and communication with the various statutory agencies as described in the Memorandum of Understanding, Trust staff should be familiar with those procedures and practices that will assist in such scenarios.

4.2 Staff should endeavour to be able to recognise those service users who present with serious untoward harm or those scenarios where a suspicious or unexpected death occurs.

4.3 Staff should be able to respond to these situations continue to provide the therapeutic / clinical response and be aware of the requirements in keeping a scene or preserving evidence that may be required for forensic or further examination.

4.4 Staff should be familiar with the protocol for communication with external agencies such as HSENI or Coroner's Office. (Data Protection Act 1998) PSNI will complete Form 81 'Personal Data Request Form', (Emergency Care Protocol: Requests for Information from PSNI)

4.5 Staff should be familiar with methods to preserve and maintain evidence including potential evidence in human tissue/ bodily fluids, clothing and or foreign objects recovered from injured person and understand what needs to be done, when, where and on whom;

- Sharps Policy,
- COSHH,
- Management of Unidentified Patients,
- Procedure for Reporting Incidents Involving Medical Devices.

Staff should restrict access to a scene to minimise potential loss / damage of evidence (i.e. closing a room / cubicle) Recovered sharps should be placed into a suitable container and secured. A list of all recovered items should be kept by the designated staff member.

4.6 Staff should refer to the flowcharts (Appendix 1Trust Facilities or Appendix 2 Community / Residential Setting) for guidance in procedure and decision making and if in doubt consult with their line manager / clinical lead.

5.0 IMPLEMENTATION OF PROCEDURE

5.1 Dissemination:

This procedure is applicable to all areas;

- Trust facilities, such as hospitals, clinics
- Well-being centres and care facilities
- Patients/ clients residence

All staff involved in the provision of service user care.
This procedure will be shared in line with the established process following approval by the relevant committee through Directors and cascaded within Service Directorates.

5.2 Resources

This procedure should be incorporated in the 'investigation training' local induction training where in relevant areas and be made available on the Trust intranet as a point of reference for staff. This procedure will be available on the Trust intranet.

6.0 MONITORING

Adherence to this procedure may be monitored as part of the audit of incidents / yearly / systematic review of Serious Adverse Incidents and BRATT

7.0 EVIDENCE BASE / REFERENCES

Memorandum of Understanding Investigating patient or client safety incidents (Unexpected deaths or serious untoward harm)
Other related policies

8.0 CONSULTATION PROCESS:

Coroner's Office N.I Court Service
Health and Safety Committee
PSNI

9.0 APPENDICES / ATTACHMENTS:

Appendix 1 - Flow chart for Trust facilities including theatre
Appendix 2 - Flow chart for staff providing care in community / residential home setting
Memorandum of Understanding Investigating patient or client safety incidents (Unexpected deaths or serious untoward harm)

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. X

SIGNATORIES

Cathy Jack

11 February 2015

Name Dr Cathy Jack
Title Medical Director

Date:

Michael McBride

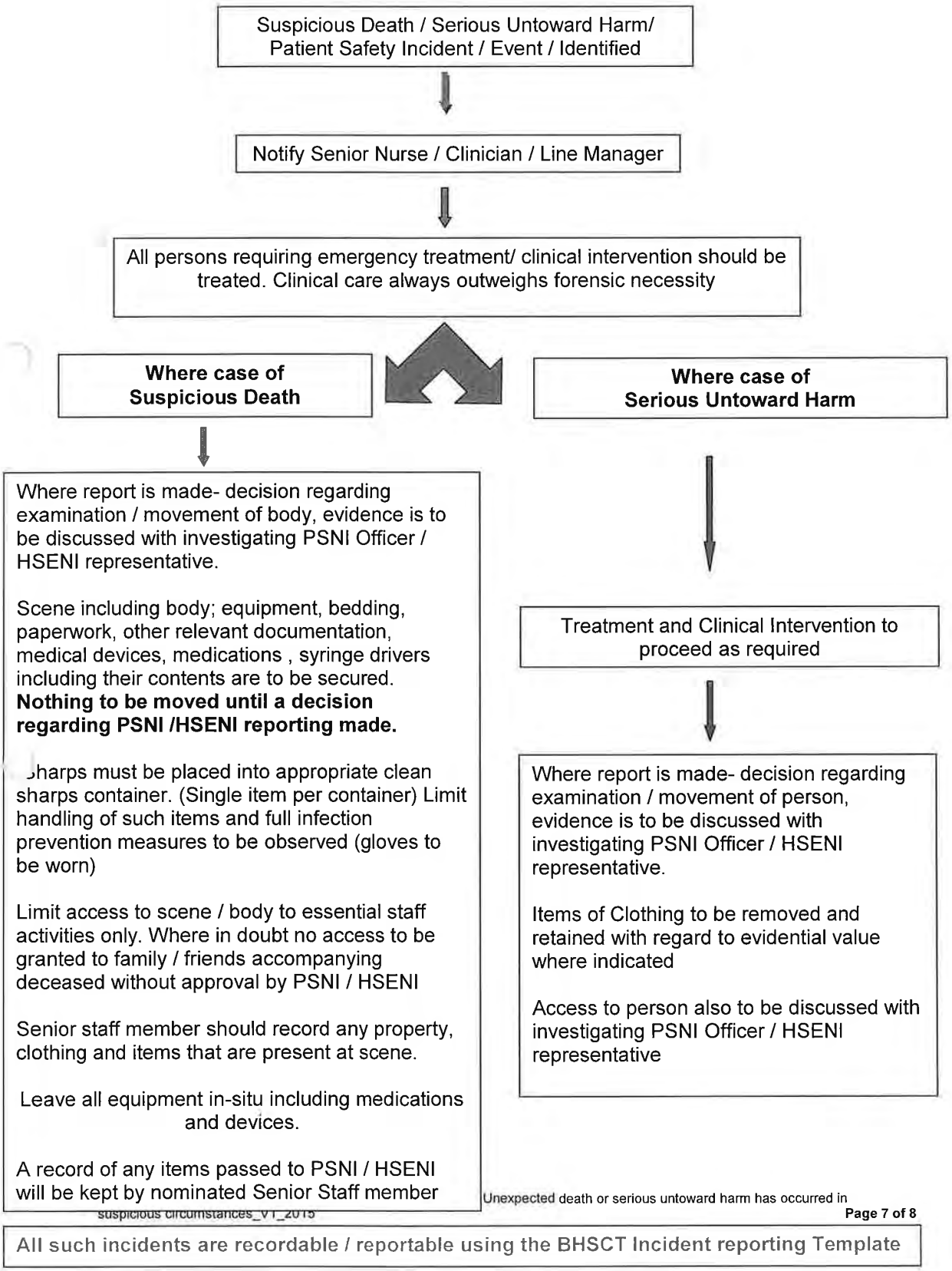
11 February 2015

Name Dr Michael McBride
Title Chief Executive

Date:

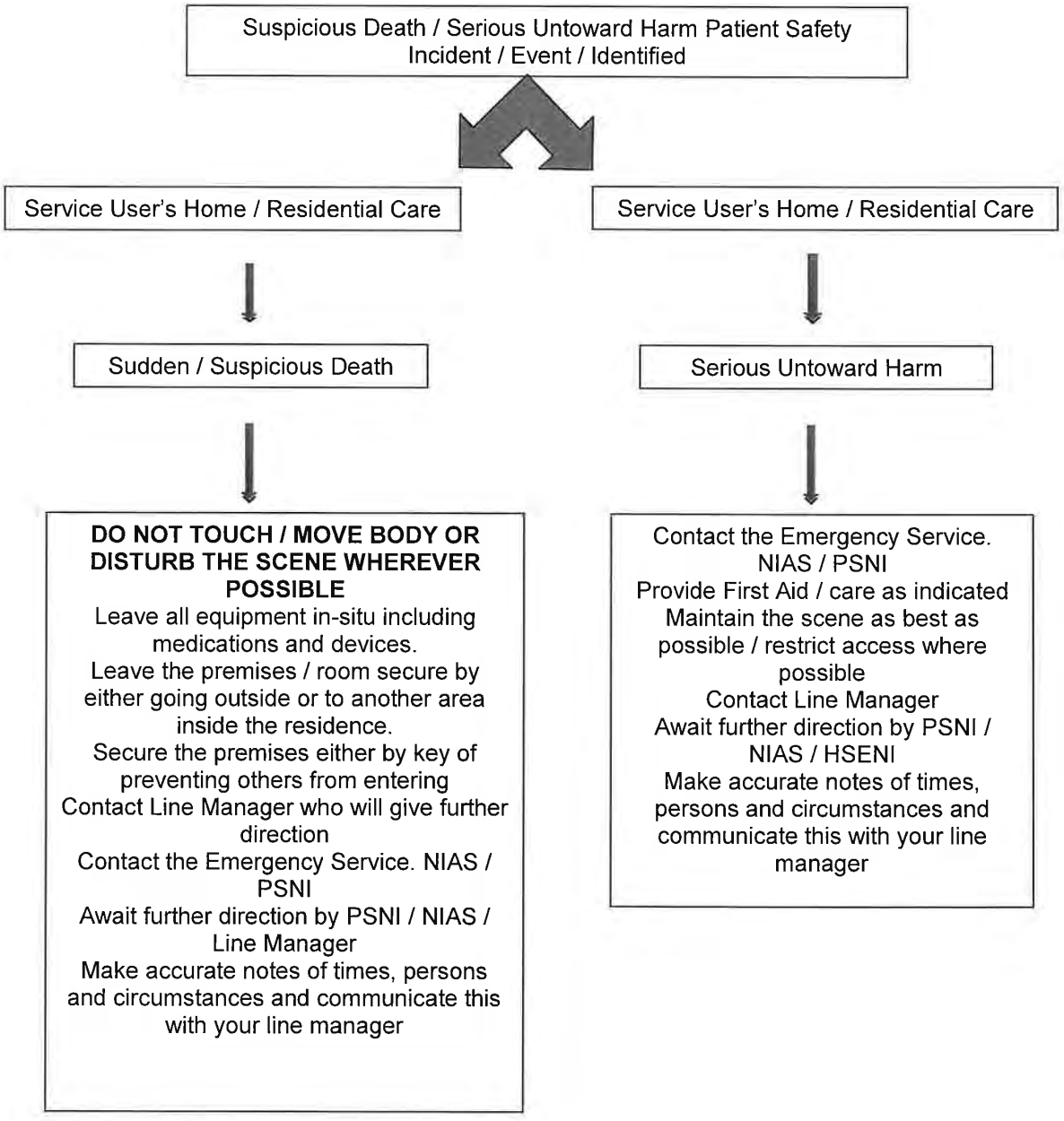
APPENDIX 1

Flow Chart for Response / Management of Unexpected / Suspicious Death / Serious Untoward Harm Occurring In Trust Facilities



APPENDIX 2

Flow Chart for Response / Management of Unexpected / Suspicious Death / Serious Untoward Harm In Community Residential Setting / Service User's Home



All Incidents to be recorded on the Trust Incident Reporting Template

Belfast Health and Social Care Trust

Reference No: SG 04/09

Title:	Guidance on actions to be taken after a patient's death		
Author(s)	Ms Nicki Patterson Co-Director Nursing Workforce Planning and Development [redacted] Dr JR Johnston Dr Ann Harper, RJMH		
Ownership:	Dr AB Stevens, Medical Director		
Approval by:	Standards and Guidelines Committee	**Approval date:**	S+G: 17/5/11 Policy Committee: 21/5/12
Operational Date:	July 2010	**Next Review:**	July 2013
Version No.	2.4 **Supercedes** 2		
Links to other policies			

Version Record

Date	Version	Author	Comments
30/11/2009	V 1.1	JR Johnston	Maternal death amendments
26/04/2010	V 1.2	JR Johnston	Changes after AH's 14/12/2009 email
25/05/2010	V 1.3	JR Johnston	CMACE manager name change 8.10 signature & GMC number on MCCD
02/07/2010	V 1.4	O Macleod M Trimble JRJ	Reviewed verification of death, completion of MCCD, contacting Coroner's office. Added hospital post-mortem examination information & Proforma form. Reviewed updated GMC guidance on *Treatment and care towards the end of life* – no change required.
28/07/2010	V 1.5	JR Johnston	Contents page : HCAI infections
23/08/2010	V 1.6	JR Johnston	Coroner Office changes - Dr Clarke
11/10/2010	V 1.7	JRJ	Flowchart amended and format changed
8/11/2010	V 1.8	JRJ	Remove HM; HCAI wording 8.16 + app 2.
05/08/2011	V2.1	CM	Addition of-responsibility to inform relatives of cause of death, - record coroner referred in patient's notes.
14/12/2011	V2.2	CM	Update of Appendix 2 following comments from a Serious Incident Investigation.

07/03/2012	V2.3	CM	Update Appendix 2 following HSC Board letter (6/02/2012) requesting improved timeliness to GP being informed of deaths
1/5/2012	2.4	JRJ	New format; After S&G on 4/4/12

Guidance on actions to be taken after a patient's death

1.0 INTRODUCTION / PURPOSE OF POLICY

This policy provides guidance on the steps that need to be taken after a patient dies:-

- **confirmation and verification of death, stillbirth.**
- **when and how to liase with the coroner's services.**
- **completion of medical certificates.**
- **cremation certification**

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff on verifying life extinct and to ensure the appropriate steps are then taken.
- ensure that all deaths are reported and recorded in accordance with the Coroner's office.
- ensure that staff deal with the death of a patient in a caring, compassionate and professional manner.
- comply with DHSSPSNI circulars HSS(MD) 3/2008, 8/2008, 10/2008.

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff that have a role in verifying and recording life extinct, death certification and reporting deaths to the coroner's office.

It applies to a variety of settings: wards, ICU/CCU, emergency department and community.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

When a person dies, a number of steps need to be completed to allow confirmation, certification and legal registration of the death. These steps are:

A. Verifying life extinct.
B. Certifying the medical cause of death or
C. Referral to the Coroner.
D. Registering the Death.
E. Obtaining a burial or cremation order.

3.0 ROLES/RESPONSIBILITIES

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Doctors are responsible for completing a Medical Certificate and Cause of Death (MCCD). The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

Those verifying and certifying death must be aware of the roles of Health and Social Care, the Police Service of Northern Ireland and the Coroner's Office in the process of dealing with death.

4.0 KEY POLICY PRINCIPLES

A. Verifying life extinct.

4.1 This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

4.2 In order to verify life extinct, cessation of circulatory & respiratory systems and cerebral function must be confirmed and documented in the patient's notes - appendix 1.

Further details of the process for confirming death are given in appendix 3 and from the "A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008)".

4.3 Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

4.4 Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death (appendix 2).

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death.

4.5 Where there are concerns about the death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct how the death should be handled.

4.6 There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

B. Certifying the medical cause of death, stillbirth.

4.7 Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange disposal of the body and settle their estate.A doctor who had treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).

4.8 All doctors completing medical certificates of cause of death or cremation forms and doctors and midwifes completing stillbirth forms should be aware of when and how to complete the forms and when deaths should be referred to the coroner.

4.9 All staff should refer to the DHSSPSNI guidance on Medical Certification and Cause of Death (MCCD), when completing a death certification / liasing with the Coroner. This can be found at the link below:

http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

An expected death can be defined as: “a death where the patient’s demise is anticipated in the near future”. In such cases the doctor will be able to issue a medical certificate as to the cause of death.

Where there is a death in suspicious circumstances or a sudden /unexpected death nursing and medical staff must be familiar with the necessary steps required to deal with this situation – outlined in appendix 2. These procedures should be handled in a sensitive and knowledgeable way.

4.10 Registered Medical Practitioners have a legal duty to provide, without delay, a certificate of cause of death if, to the best of their knowledge, that person died of natural causes for which they had treated that person in the last 28 days.

4.11 Any alterations to the MCCD must be initialled by the doctor.

4.12 Because Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a

- legible printed name,
- signature
- GMC number beside your signature and
- contact details. Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

4.13 It is good practice to either make a note in the clinical record of the details recorded on the MCCD, or keep a copy of the MCCD in the patient’s records.

4.14 It is ultimately the responsibility of the consultant in charge of the patient’s care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

4.15 If a doctor cannot complete an MCCD, either because the cause of death was not natural or because they were not treated in the final 28 days of life, then the death must be referred to the Coroner. If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

A doctor who had not been directly involved in the patient's care at any time during the illness from which they died cannot certify the cause of death, but should provide the coroner with any information that may help to determine the cause of death.

If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) then the duty doctor may contact the Coroner's office and, after agreement, complete a pro-forma which will allow the death to be registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland*).

If the Coroner agrees this approach, you will be asked to draft a completed but unsigned MCCD giving the cause of death as agreed and a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). These are both to be faxed through to the Coroner's office (both originals should then follow in the post).

It is also good practice to inform the patient's GP if death occurs in hospital.

4.16 **Recording Healthcare Associated Infections (HCAI)**

The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.

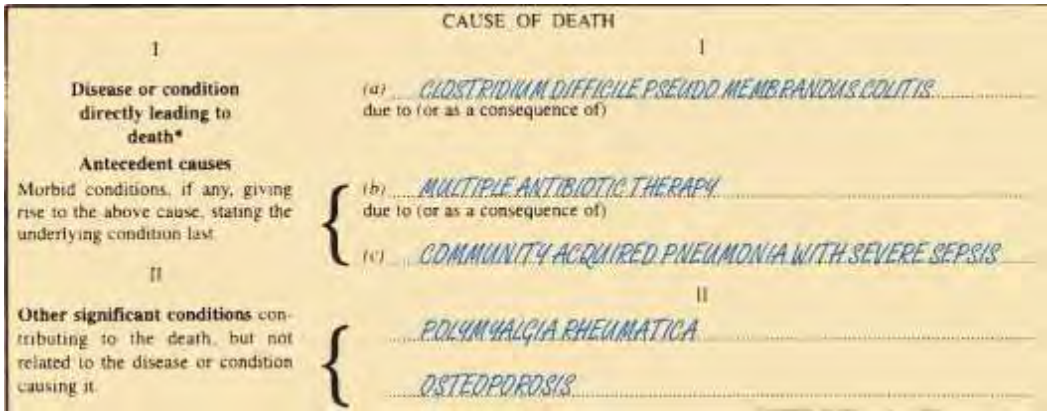
The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.

Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease

i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS

due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) MULTIPLE ANTIBIOTIC THERAPY

due to (or as a consequence of)

(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS

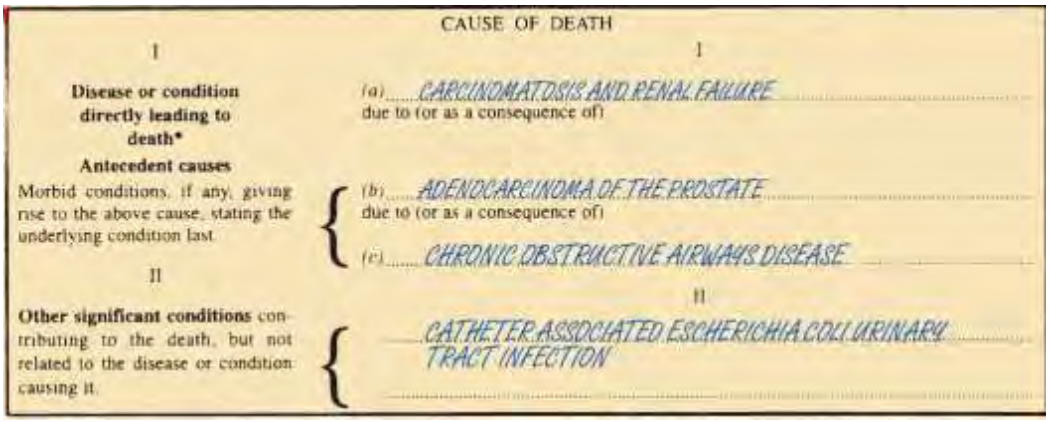
II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

POLYMYALGIA RHEUMATICA

OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CARCINOMATOSIS AND RENAL FAILURE

due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) ADENOCARCINOMA OF THE PROSTATE

due to (or as a consequence of)

(c) CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to be contributory to a patient's death it is important not to record it on the MCCD.

The recommended sequence should be:-

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.

2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)

3. **Inform** ward manager/nurse in charge that MCCD with contributory HCAI has been issued.

4. **Assist** ward manager/nurse in charge in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
- Consultant advice.

C. Referral to the Coroner.

4.17 There is a general requirement under section 7 of the Coroners Act (NI) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

Notification to the coroner and any discussions with the coroner should be recorded in the patient's notes.

For information regarding the Coroner's office refer to
http://www.coronersni.gov.uk/publications/Coroners_Service.pdf

4.18 Therefore, before you proceed with completing a MCCD ask yourself this question – *Does this Death have to be reported to the coroner?*

For help, refer to appendix 4 and/or
Guidance on Death, Stillbirth & Cremation Certification. **DHSSPSNI, 2008.**

4.19 Notification to the Coroner of the death of a child must be done by a Consultant.

4.20 Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed.

If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns. A written record of these concerns should always be made and retained with the medical records.

4.21 A foundation level doctor must consult a more senior colleague before reporting a death to the coroner.

4.22 A death occurring in hospital during the night does not usually need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning. A coroner is always on call and can be reached if necessary out-of-hours. Where there is a need to obtain consent for the transplantation of organs or some other complicating factor arises, the death should be reported to the coroner as soon as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.

4.23 The office of the Coroners Service for Northern Ireland is at:

- May's Chambers, 73 May Street, Belfast BT1 3JL.
- Tel: 028 9044 6800; Fax 028 9044 6801.
- Website: www.coronersni.gov.uk
- E-mail: coronersoffice@courtsni.gov.uk
- the office is staffed weekdays 9.00am – 5.00pm,
- weekends and public holidays 9.30am – 12.30pm (except Christmas Day when the office is closed)
- outside normal office hours a recorded message will provide contact details for the duty coroner or messages may be left on the telephone answering machine.

NB: If a doctor contacts the Coroner's Office out of hours ***they should listen to the full range of options*** on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

4.24 **Hospital Post-Mortem Examinations**

In some cases, where the nature of the terminal illness is unclear, or the cause of death is uncertain, but there are no concerns that the death was not due to natural causes, a hospital post-mortem examination may be requested.

The decision to request a hospital post-mortem examination in an adult should be taken by a senior doctor, e.g. ST3 grade or above. Any request for a hospital post-mortem on a child must be made by a consultant.

In these cases, the next of kin must be counselled and made conversant of the reasons why a post-mortem examination would be desirable and written consent must be obtained. Information books and consent forms are available for neonatal, paediatric and adult examinations - Post Mortem Examinations DHSSPS(NI).

4.25 **Definition of a maternal death – ICD code 9/10.**

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self harm as consequence of postnatal depression.

A **Coincidental (fortuitous**) death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

4.26 For detailed guidance please refer to the BHSCT policy on "management of a maternal death" - http://intranet.belfasttrust.local/Policies%20and%20Procedures/Management%20of%20a%20Maternal%20Death.pdf

4.27 When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

4.28 **Centre for Maternal and Child Enquiries" (CMACE)**
It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that Maternal deaths are reported to the CMACE (Centre for Maternal and Child Enquiries) i.e. the Maternal Mortality Enquiry. It is commissioned and monitored by the National Patient Safety Agency (NPSA).

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the CMACE Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

4.29 CMACE in Northern Ireland is commissioned by the DHSSPS through the Public Health Agency for Northern Ireland and can be contacted through:-
Regional Manager: Dr Jackie McCall

Address:
Public Health Agency (PHA)
Eastern Office (Floor 2)
12 - 22 Linenhall Street
Belfast BT2 8BS
Northern Ireland

Phone:
[redacted] or [redacted]

Fax:
[redacted]

Email: [redacted]

D. Registering the Death.

4.30 The family (or certain other people) will provide the person's details to the local registrar, with either the MCCD or the Coroners form giving the cause of death.

E. Obtaining a burial or cremation order.

4.31 The registrar or coroner can issue a burial or cremation order.

4.32 Cremation

When a body is to be cremated there are a series of special medical forms to be completed by different, independent doctors, to provide reassurance that the death does not require further investigation. If the death has not been referred to the coroner, and a MCCD - certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

4.33 Form B

This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C

The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care;
- not be related to the deceased.

Form F

This is completed by the Medical Referee for the Cremation Authority.

Stillbirth

Stillbirth forms can be completed by a medical practitioner who was present at the birth, or who examined the body.

Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.

A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

5.0 IMPLEMENTATION OF POLICY

6.0 MONITORING

Monitoring of MCCDs will be done by checking the concurrent entry of death certification details onto a new IT system to be introduced in 2012.

7.0 EVIDENCE BASE / REFERENCES

1. DHSSPSNI guidance on death, still birth and cremation certification – 2008.
2. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges. 2008.
3. DHSSPSNI circulars

References, including relevant external guidelines:

1. Guidance on Death, Stillbirth & Cremation Certification. Part A **DHSSPSNI, 2008.**
2. Guidance on Death, Stillbirth & Cremation Certification. Part B **DHSSPSNI, 2008.**
3. A code of practice for the diagnosis and confirmation of death. **Academy of Medical Royal Colleges, 2008.**
4. HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
5. HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.
6. Guidelines for Verifying Life Extinct (PDF 62 KB)
7. HSS(MD) 10/2008. Enhanced monitoring arrangements for deaths where C.DIFFICILE or MRSA infection is mentioned on the death certificate.
8. http://www.coronersni.gov.uk/publications/Coroners_Service.pdf - Coroner's Service, July 2008.
9. *Working with the Coroner's Service for Northern Ireland*

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Verification of Life Extinct
Appendix 2: Protocol for actions to be taken after a death in Hospital
Appendix 3: Diagnosing and confirming death after cardiorespiratory arrest
Appendix 4: Deaths that must be reported to the coroner

10.0 EQUALITY STATEMENT

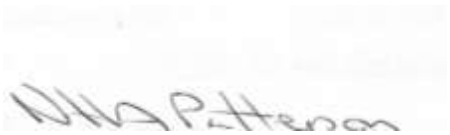
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been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

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES



Date: March 2012

Name: Nicki Patterson
Title:
Co-Director Nursing Workforce Planning and Development

Name: Dr A B Stevens **Date: March 2012**
Title:
Medical Director

Appendix 1

VERIFICATION OF LIFE EXTINCT

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

In order to verify life extinct, cessation of

- circulatory system
- respiratory system
- cerebral function

must be confirmed and documented in the patient's notes with a name and signature.

The documentation recording the examination undertaken and verifying life extinct should be completed and put in the patient's notes.
(**N.B** This applies whether Doctor or Nurse verifies death).

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
   - No pulses on palpation.
   - No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing)

2. Cessation of respiratory system e.g.
   - No respiratory effort observed
   - No breath sounds (verified by listening for one full minute)

3. Cessation of cerebral function e.g.
   - Pupils dilated and not reacting to light
   - No reaction to painful stimuli

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.**

In these situations active resuscitation should continue until an experienced doctor has verified life extinct.

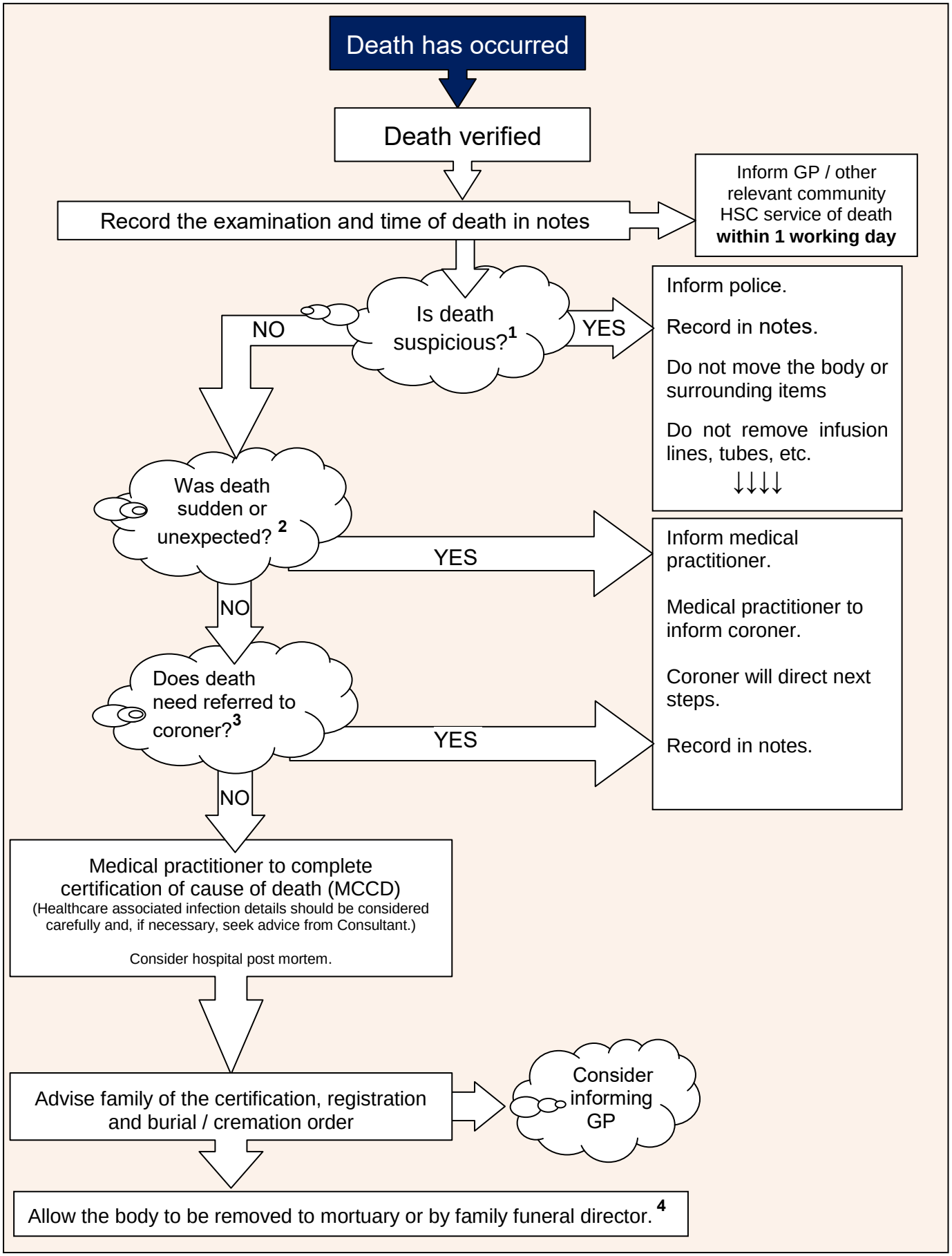
There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. See appendix 3.

From:
HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.

Guidelines for Verifying Life Extinct (PDF 62 KB)

Appendix 2

PROTOCOL FOR ACTIONS TO BE TAKEN AFTER A DEATH IN HOSPITAL



Standards and Guidelines Committee – Guidance on actions to be taken after a patient's death – V2.4 – May 2012

Notes for Appendix 2

1. **Death involving suspicious circumstances** e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle.
   The body must not be moved. Do not disturb the scene.
   There must be immediate contact with the Police and the appropriate medical practitioner (GP, Out-of-Hours Service or hospital medical staff).
   The Police or medical practitioner must contact the Coroner.
   The body will require Post Mortem examination by State Pathology.
   The Police will arrange transfer to a mortuary.

2. **Sudden/unexpected death without suspicious circumstances** e.g. person found dead at home or initial resuscitation is unsuccessful but circumstances do not raise concerns. Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

3. **Death related to specific conditions which need referred to the Coroners Service.** In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

   Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

4. **Paediatric deaths**
   In certain paediatric cases, parents have the opportunity to take the body of their child home prior to the funeral and where appropriate this choice should be offered. The GP must be informed that this is happening.

Appendix 3

DIAGNOSING AND CONFIRMING DEATH AFTER CARDIORESPIRATORY ARREST

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation

- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section [5]

- One of the following is fulfilled:
  - the individual meets the criteria for not attempting cardiopulmonary resuscitation[8]
  - attempts at cardiopulmonary resuscitation have failed
  - treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment

- The individual should be observed by the person responsible for confirming death for a minimum of five minutes [9,10] to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
  - absence of a central pulse on palpation
  - absence of heart sounds on auscultation

  These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:
  - asystole on a continuous ECG display
  - absence of pulsatile flow using direct intra-arterial pressure monitoring
  - absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed

- The time of death is recorded as the time at which these criteria are fulfilled.

A CODE OF PRACTICE FOR THE DIAGNOSIS AND CONFIRMATION OF DEATH

Appendix 4

DEATHS THAT MUST BE REPORTED TO THE CORONER

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   • homicidal deaths or deaths following assault;
   • road traffic accidents or accidents at work;
   • deaths associated with the misuse of drugs (whether accidental or deliberate);
   • any apparently suicidal death;
   • all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

6. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

7. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

   - Industrial diseases or poisoning and other poisonings
     A. Industrial lung diseases
     B. Other industrial diseases
     C. Industrial poisoning
     D. Other poisonings

   - Death resulting from an injury
     A. Injury
     B. Indirect injury
     C. Birth injury
     D. Operation / anaesthetic

For further detail go to:
http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

Belfast Health and Social Care Trust

Reference No: SG 04/09

Title:	**Guidance on actions to be taken after a patient's death**		
Author(s)	**Ms Nicki Patterson** **Co-Director Nursing Workforce Planning and Development** [redacted] **Dr JR Johnston, Co-Chair Standards and Guidelines.** **Dr Ann Harper, RJMH**		
Ownership:	**Dr AB Stevens, Medical Director**		
Approval by:	**Standards and Guidelines Committee**	**Approval date:**	**14/09/2011**
Operational Date:	**July 2010**	**Next Review:**	**July 2013**
Version No.	**3** **Supercedes** **2**		
Links to other policies			

Version Record

Date	Version	Author	Comments
05/08/2011	V2.1	CM	Addition of-responsibility to inform relatives of cause of death, - record coroner referred in patient's notes.
14/12/2011	V2.2	CM	Update of Appendix 2 following comments from a Serious Incident Investigation.
07/03/2012	V2.3	CM	Update Appendix 2 following HSC Board letter (6/02/2012) requesting improved timeliness to GP being informed of deaths
1/5/2012	V2.4	JRJ	New format; After S&G on 4/4/12
14/5/2012	V2.5	JRJ	Hyperlinks updated; update 4.18

Guidance on actions to be taken after a patient's death

1.0 INTRODUCTION / PURPOSE OF POLICY

This policy provides guidance on the steps that need to be taken after a patient dies:-

- **confirmation and verification of death, stillbirth.**
- **when and how to liase with the coroner's services.** **completion of medical certificates.**
- **cremation certification**

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff on verifying life extinct and to ensure the appropriate steps are then taken.
- ensure that all deaths are reported and recorded in accordance with the Coroner's office.
- ensure that staff deal with the death of a patient in a caring, compassionate and professional manner.
- comply with DHSSPSNI circulars HSS(MD) 3/2008, 8/2008, 10/2008.

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff that have a role in verifying and recording life extinct, death certification and reporting deaths to the coroner's office.

It applies to a variety of settings: wards, ICU/CCU, emergency department and community.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

When a person dies, a number of steps need to be completed to allow confirmation, certification and legal registration of the death. These steps are: A. Verifying life extinct.

B. Certifying the medical cause of death or
C. Referral to the Coroner.
D. Registering the Death.
E. Obtaining a burial or cremation order.

3.0 ROLES/RESPONSIBILITIES

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Doctors are responsible for completing a Medical Certificate and Cause of Death (MCCD). The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

Those verifying and certifying death must be aware of the roles of Health and Social Care, the Police Service of Northern Ireland and the Coroner's Office in the process of dealing with death.

4.0 KEY POLICY PRINCIPLES

A. Verifying life extinct.

4.1 This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

4.2 In order to verify life extinct, cessation of circulatory & respiratory systems and cerebral function must be confirmed and documented in the patient's notes - appendix 1.

Further details of the process for confirming death are given in appendix 3 and from the "A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008)".

4.3 Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

4.4 Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death (appendix 2).

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death.

4.5 Where there are concerns about the death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct how the death should be handled.

4.6 There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of

practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

B. Certifying the medical cause of death, stillbirth.

4.7 Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange disposal of the body and settle their estate.

A doctor who had treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).

4.8 All doctors completing medical certificates of cause of death or cremation forms and doctors and midwifes completing stillbirth forms should be aware of when and how to complete the forms and when deaths should be referred to the coroner.

4.9 All staff should refer to the DHSSPSNI guidance on Medical Certification and Cause of Death (MCCD), when completing a death certification / liaising with the Coroner. This can be found at the link below:

http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

An expected death can be defined as: “a death where the patient’s demise is anticipated in the near future”. In such cases the doctor will be able to issue a medical certificate as to the cause of death.

Where there is a death in suspicious circumstances or a sudden /unexpected death nursing and medical staff must be familiar with the necessary steps required to deal with this situation – outlined in appendix 2. These procedures should be handled in a sensitive and knowledgeable way.

4.10 Registered Medical Practitioners have a legal duty to provide, without delay, a certificate of cause of death if, to the best of their knowledge, that person died of natural causes for which they had treated that person in the last 28 days.

4.11 Any alterations to the MCCD must be initialled by the doctor.

4.12 Because Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a

- legible printed name,
- signature
- GMC number beside your signature and
- contact details. Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

4.13 It is good practice to either make a note in the clinical record of the details recorded on the MCCD, or keep a copy of the MCCD in the patient’s records.

4.14 It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

4.15 If a doctor cannot complete an MCCD, either because the cause of death was not natural or because they were not treated in the final 28 days of life, then the death must be referred to the Coroner. If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

A doctor who had not been directly involved in the patient's care at any time during the illness from which they died cannot certify the cause of death, but should provide the coroner with any information that may help to determine the cause of death.

If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) then the duty doctor may contact the Coroner's office and, after agreement, complete a pro-forma which will allow the death to be registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland*).

If the Coroner agrees this approach, you will be asked to draft a completed but unsigned MCCD giving the cause of death as agreed and a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). These are both to be faxed through to the Coroner's office (both originals should then follow in the post).

It is also good practice to inform the patient's GP if death occurs in hospital.

4.16 **Recording Healthcare Associated Infections (HCAI)**

The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.

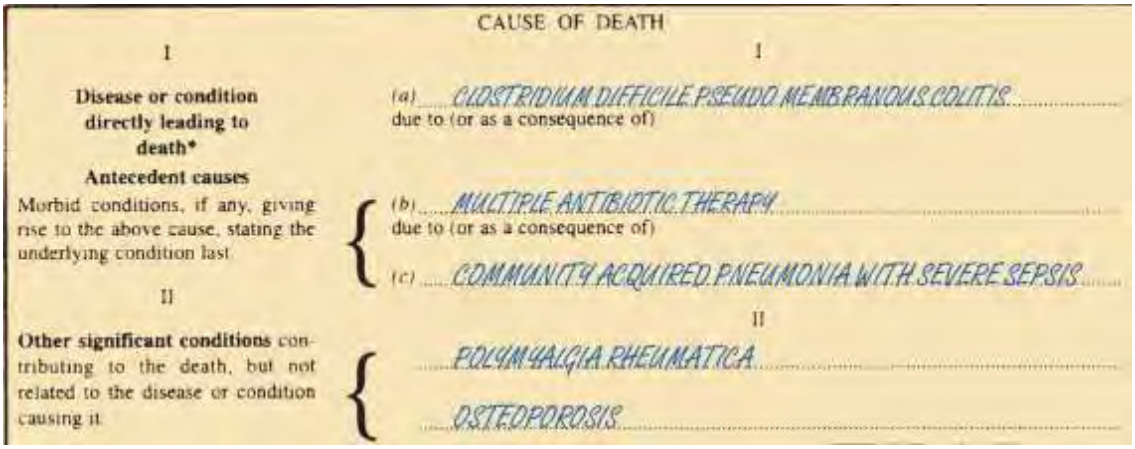
The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.

Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease

i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS

due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) MULTIPLE ANTIBIOTIC THERAPY

due to (or as a consequence of)

(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS

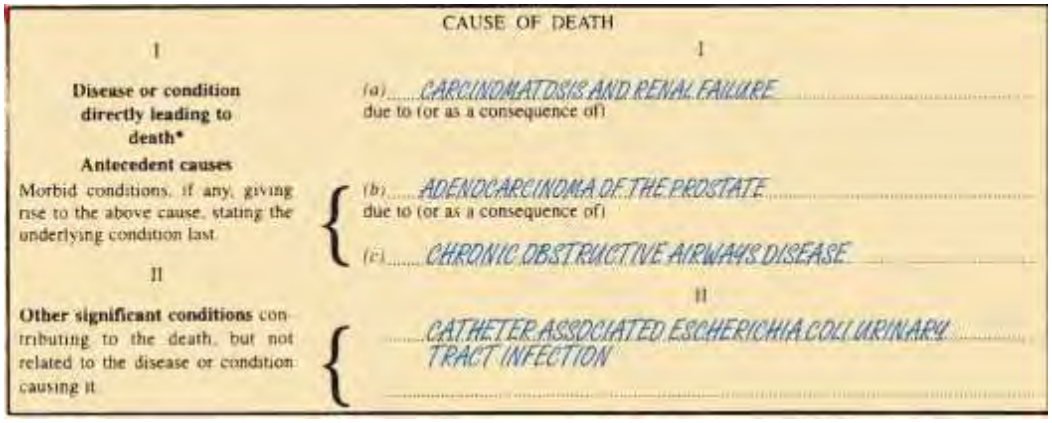
II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

POLYMYALGIA RHEUMATICA

OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CARCINOMATOSIS AND RENAL FAILURE

due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) ADENOCARCINOMA OF THE PROSTATE

due to (or as a consequence of)

(c) CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to be contributory to a patient's death it is important not to record it on the MCCD.

The recommended sequence should be:-

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.
2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)
3. **Inform** ward manager/nurse in charge that MCCD with contributory HCAI has been issued.
4. **Assist** ward manager/nurse in charge in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
- Consultant advice.

C. Referral to the Coroner.

4.17 There is a general requirement under section 7 of the Coroners Act (NI) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

Notification to the coroner and any discussions with the coroner should be recorded in the patient's notes.

For information regarding the Coroner's office refer to the Coroners Service for Northern Ireland – June 2011.

4.18 Therefore, before you proceed with completing a MCCD ask yourself this question – *Does this Death have to be reported to the coroner?*

Death is reported to the Coroner in the following situations:

- a doctor did not treat the person during their last illness;
- a doctor did not see or treat them in the 28 days before they died;
- the cause of death was sudden, violent or unnatural such as an accident, or suicide;
- the cause of death was murder;
- the cause of death was an industrial disease of the lungs such as asbestosis; or
- the death occurred in other circumstances that may require investigation.

A death in hospital should be reported if:

- there is a question of negligence or misadventure about the treatment of the person who died;
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause; or
- the patient died as the result of the administration of an anaesthetic.

From: Coroners service for Northern Ireland – June 2011

For help, refer to appendix 4 and/or

Guidance on Death, Stillbirth & Cremation Certification. **DHSSPSNI, 2008.**

4.19 Notification to the Coroner of the death of a child must be done by a Consultant.

4.20 Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed.

If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns. A written record of these concerns should always be made and retained with the medical records.

4.21 A foundation level doctor must consult a more senior colleague before reporting a death to the coroner.

4.22 A death occurring in hospital during the night does not usually need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning.

A coroner is always on call and can be reached if necessary out-of-hours. Where there is a need to obtain consent for the transplantation of organs or some other complicating factor arises, the death should be reported to the coroner as soon as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.

4.23 The office of the Coroners Service for Northern Ireland is at:

- May's Chambers, 73 May Street, Belfast BT1 3JL. Tel: 028 9044 6800; Fax 028 9044 6801.
- Website: www.coronersni.gov.uk
- E-mail: coronersoffice@courtsni.gov.uk
- the office is staffed weekdays 9.00am – 5.00pm,
- weekends and public holidays 9.30am – 12.30pm
- (except Christmas Day when the office is closed)
- outside normal office hours a recorded message will provide contact details for the duty coroner or messages may be left on the telephone answering machine.

NB: If a doctor contacts the Coroner's Office out of hours ***they should listen to the full range of options*** on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

4.24 **Hospital Post-Mortem Examinations**

In some cases, where the nature of the terminal illness is unclear, or the cause of death is uncertain, but there are no concerns that the death was not due to natural causes, a hospital post-mortem examination may be requested.

The decision to request a hospital post-mortem examination in an adult should be taken by a senior doctor, e.g. ST3 grade or above. Any request for a hospital postmortem on a child must be made by a consultant.

In these cases, the next of kin must be counselled and made conversant of the reasons why a post-mortem examination would be desirable and written consent must be obtained. Information books and consent forms are available for neonatal, paediatric and adult examinations - Post Mortem Examinations DHSSPS(NI).

4.25 **Definition of a maternal death – ICD code 9/10.**

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self harm as consequence of postnatal depression.

A **Coincidental (fortuitous**) death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

4.26 For detailed guidance please refer to the BHSCT policy on “management of a maternal death” - http://intranet.belfasttrust.local/Policies%20and%20Procedures/Management%20of%20a%20Maternal%20Death.pdf

4.27 When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

4.28 **Centre for Maternal and Child Enquiries” (CMACE)**

It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that Maternal deaths are reported to the

CMACE (Centre for Maternal and Child Enquiries) i.e. the Maternal Mortality Enquiry. It is commissioned and monitored by the National Patient Safety Agency (NPSA).

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the CMACE Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

4.29 CMACE in Northern Ireland is commissioned by the DHSSPS through the Public Health Agency for Northern Ireland and can be contacted through:-

Regional Manager: Dr Jackie McCall

Address:
Public Health Agency (PHA)
Eastern Office (Floor 2) 12 - 22 Linenhall Street
Belfast BT2 8BS
Northern Ireland

Phone:
[redacted] or [redacted]

Fax:
[redacted]

Email: [redacted]

D. Registering the Death.

4.30 The family (or certain other people) will provide the person's details to the local registrar, with either the MCCD or the Coroners form giving the cause of death.

E. Obtaining a burial or cremation order.

4.31 The registrar or coroner can issue a burial or cremation order.

4.32 Cremation

When a body is to be cremated there are a series of special medical forms to be completed by different, independent doctors, to provide reassurance that the death does not require further investigation. If the death has not been referred to the coroner,

and a MCCD - certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

4.33 Form B

This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C

The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care; not be related to the deceased.

Form F

This is completed by the Medical Referee for the Cremation Authority.

Stillbirth

Stillbirth forms can be completed by a medical practitioner who was present at the birth, or who examined the body.

Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.

A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

5.0 IMPLEMENTATION OF POLICY

6.0 MONITORING

Monitoring of MCCDs will be done by checking the concurrent entry of death certification details onto a new IT system to be introduced in 2012.

7.0 EVIDENCE BASE / REFERENCES

1. DHSSPSNI guidance on death, still birth and cremation certification – 2008.
2. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges. 2008.
3. DHSSPSNI circulars

References, including relevant external guidelines:

1. Guidance on Death, Stillbirth & Cremation Certification. Part A DHSSPSNI, 2008.
2. Guidance on Death, Stillbirth & Cremation Certification. Part B DHSSPSNI, 2008.
3. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges, 2008.
4. HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
5. HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.
6. Guidelines for Verifying Life Extinct (PDF 62 KB)
7. HSS(MD) 10/2008. Enhanced monitoring arrangements for deaths where C.DIFFICILE or MRSA infection is mentioned on the death certificate.
8. Coroner's Service for Northern Ireland - June 2011.
9. *Working with the Coroner's Service for Northern Ireland*

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Verification of Life Extinct
Appendix 2: Protocol for actions to be taken after a death in Hospital
Appendix 3: Diagnosing and confirming death after cardiorespiratory arrest
Appendix 4: Deaths that must be reported to the coroner

10.0 EQUALITY STATEMENT

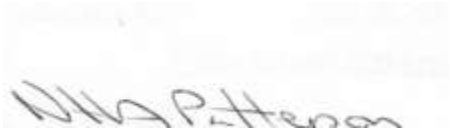
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been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

Major impact ☐

Minor impact ☐

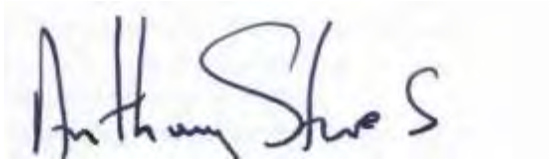
No impact. ☒

SIGNATORIES



Name: Nicki Patterson **Date: March 2012**

Title:
Co-Director Nursing Workforce Planning and Development



Name: Dr A B Stevens **Date: March 2012**
Title:
Medical Director

Appendix

1 VERIFICATION OF LIFE EXTINCT

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

In order to verify life extinct, cessation of

- circulatory system
- respiratory system
- cerebral function must be confirmed and documented in the patient's notes with a name and signature.

The documentation recording the examination undertaken and verifying life extinct should be completed and put in the patient's notes.
(**N.B** This applies whether Doctor or Nurse verifies death).

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
   - No pulses on palpation.
   - No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing)

2. Cessation of respiratory system e.g.
   - No respiratory effort observed
   - No breath sounds (verified by listening for one full minute)

3. Cessation of cerebral function e.g.
   - Pupils dilated and not reacting to light
   - No reaction to painful stimuli

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.**

In these situations active resuscitation should continue until an experienced doctor has verified life extinct.

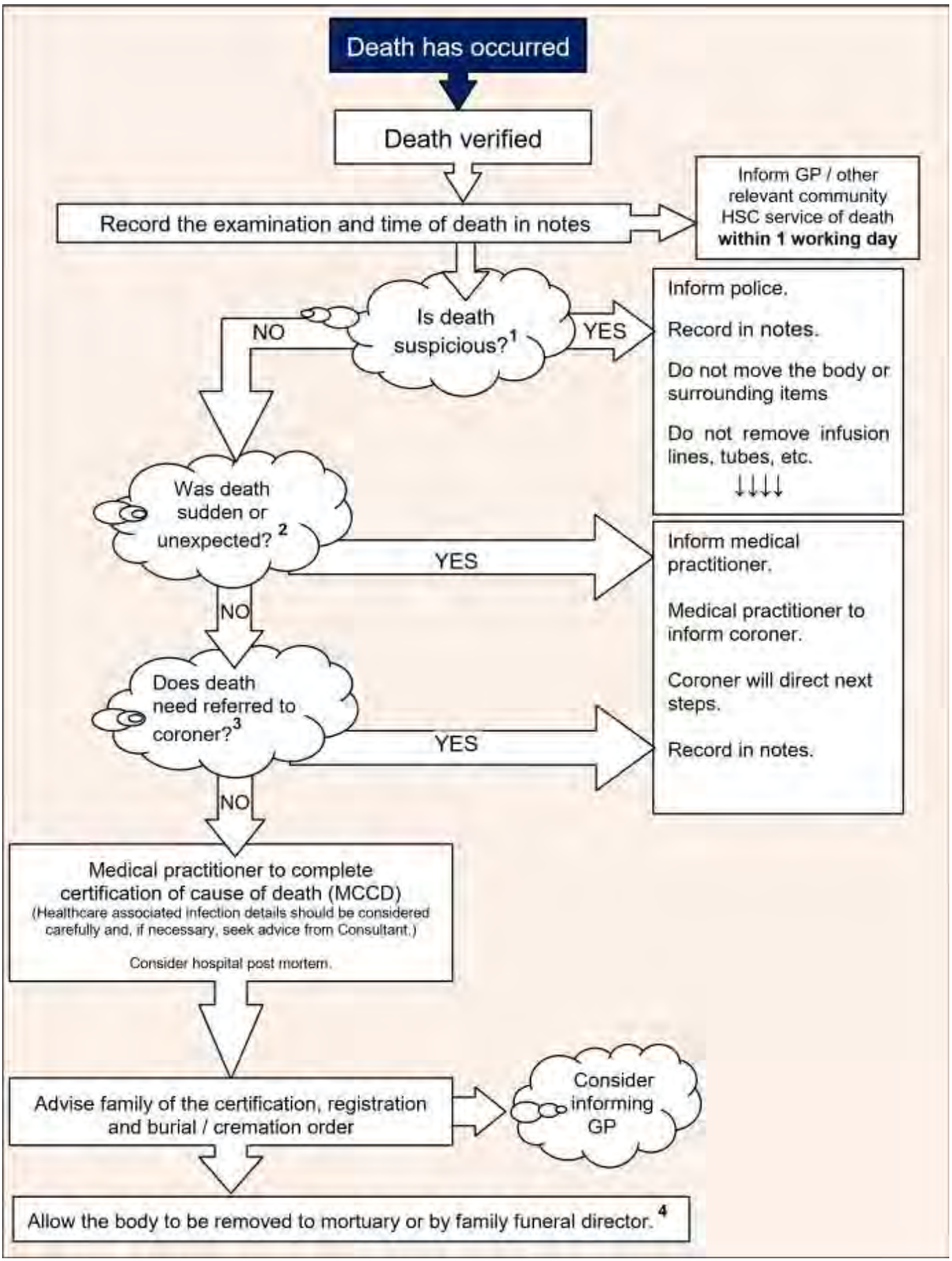
There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. See appendix 3.

From:
HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.

Guidelines for Verifying Life Extinct (PDF 62 KB)

Appendix 2

PROTOCOL FOR ACTIONS TO BE TAKEN AFTER A DEATH IN HOSPITAL



Standards and Guidelines Committee – Guidance on actions to be taken after a patient's death – V3 – May 2012

Notes for Appendix 2

1. **Death involving suspicious circumstances** e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle. *The body must not be moved. Do not disturb the scene.*
   There must be immediate contact with the Police and the appropriate medical practitioner (GP, Out-of-Hours Service or hospital medical staff).
   The Police or medical practitioner must contact the Coroner.
   The body will require Post Mortem examination by State Pathology. The Police will arrange transfer to a mortuary.

2. **Sudden/unexpected death without suspicious circumstances** e.g. person found dead at home or initial resuscitation is unsuccessful but circumstances do not raise concerns. Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a proforma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

3. **Death related to specific conditions which need referred to the Coroners Service.** In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

   Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a proforma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

4. **Paediatric deaths**
   In certain paediatric cases, parents have the opportunity to take the body of their child home prior to the funeral and where appropriate this choice should be offered. The GP must be informed that this is happening.

Appendix 3

DIAGNOSING AND CONFIRMING DEATH AFTER CARDIORESPIRATORY ARREST

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are

pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation

- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section [5]

- One of the following is fulfilled:
  - the individual meets the criteria for not attempting cardiopulmonary resuscitation[8]
  - attempts at cardiopulmonary resuscitation have failed
  - treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment

- The individual should be observed by the person responsible for confirming death for a minimum of five minutes [9,10] to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
  - absence of a central pulse on palpation
  - absence of heart sounds on auscultation

  These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:
  - asystole on a continuous ECG display
  - absence of pulsatile flow using direct intra-arterial pressure monitoring
  - absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed

- The time of death is recorded as the time at which these criteria are fulfilled.

A CODE OF PRACTICE FOR THE DIAGNOSIS AND CONFIRMATION OF DEATH

Appendix 4

DEATHS THAT MUST BE REPORTED TO THE CORONER

Standards and Guidelines Committee – Guidance on actions to be taken after a patient's death – V3 – May 2012

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   • homicidal deaths or deaths following assault;
   • road traffic accidents or accidents at work;
   • deaths associated with the misuse of drugs (whether accidental or deliberate);
   • any apparently suicidal death;
   • all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

6. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

7. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

   • Industrial diseases or poisoning and other poisonings
      A. Industrial lung diseases
      B. Other industrial diseases
      C. Industrial poisoning
      D. Other poisonings

   • Death resulting from an injury
      A. Injury
      B. Indirect injury
      C. Birth injury
      D. Operation / anaesthetic

For further detail go to: http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

Belfast Health and Social Care Trust

Reference No: SG 04/09

Title:	Guidance on actions to be taken after a patient's death		
Author(s)	Dr D Robinson Co-Director Nursing Workforce Planning and Development [redacted] Dr JR Johnston, Co-Chair Standards and Guidelines. Dr Ann Harper, RJMH		
Ownership:	Dr AB Stevens, Medical Director		
Approval by:	Standards and Guidelines Policy Committee Executive Team Meeting	**Approval date:**	
Operational Date:	December 2013	**Next Review:**	December 2016
Version No.	4	**Supercedes**	V 3 July 2010-2013
Key words	Confirming and certifying a death, actions after a death		
Links to other policies			

Version Record

Date	Version	Author	Comments
05/08/2011	V2.1	CM	Addition of-responsibility to inform relatives of cause of death, - record coroner referred in patient's notes.
14/12/2011	V2.2	CM	Update of Appendix 2 following comments from a Serious Incident Investigation.
07/03/2012	V2.3	CM	Update Appendix 2 following HSC Board letter (6/02/2012) requesting improved timeliness to GP being informed of deaths
1/5/2012	V2.4	JRJ	New format; After S&G on 4/4/12
14/5/2012	V2.5	JRJ	Hyperlinks updated; update 4.18
28/08/2013	V3.1	JRJ	Appendix 2 changes
28/11/2013	V3.2	JRJ	Suggested changed by D Robinson made

1.0 INTRODUCTION / PURPOSE OF POLICY

This policy provides guidance on the steps that need to be taken after a patient dies:-

- confirmation and verification of death, stillbirth.
- when and how to liase with the coroner's services.
- completion of medical certificates.
- cremation certification

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff on verifying life extinct and to ensure the appropriate steps are then taken.
- ensure that all deaths are reported and recorded in accordance with the Coroner's office.
- ensure that staff deal with the death of a patient in a caring, compassionate and professional manner.
- comply with DHSSPSNI circulars HSS(MD) 3/2008, 8/2008, 10/2008.

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff that have a role in verifying and recording life extinct, death certification and reporting deaths to the coroner's office.

It applies to a variety of settings: wards, ICU/CCU, emergency department and community.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

When a person dies, a number of steps need to be completed to allow confirmation, certification and legal registration of the death. These steps are:

A. Verifying life extinct.
B. Certifying the medical cause of death or
C. Referral to the Coroner.
D. Registering the Death.
E. Obtaining a burial or cremation order.

3.0 ROLES/RESPONSIBILITIES

Verifying life extinct can be undertaken by all doctors and, where directorates deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Doctors are responsible for completing a Medical Certificate and Cause of Death (MCCD). The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

Those verifying and certifying death must be aware of the roles of Health and Social Care, the Police Service of Northern Ireland and the Coroner's Office in the process of dealing with death.

4.0 KEY POLICY PRINCIPLES

A. Verifying life extinct.

4.1 This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

4.2 In order to verify life extinct, cessation of circulatory & respiratory systems and cerebral function must be confirmed and documented in the patient's notes - appendix 1.

Further details of the process for confirming death are given in appendix 3 and from the "A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008)".

4.3 Verifying life extinct can be undertaken by all doctors and, where directorates deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

4.4 Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death (appendix 2).

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death.

4.5 Where there are concerns about the death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct how the death should be handled.

4.6 There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

B. Certifying the medical cause of death, stillbirth.

4.7 Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange disposal of the body and settle their estate.

A doctor who had treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).

4.8 All doctors completing medical certificates of cause of death or cremation forms and doctors and midwifes completing stillbirth forms should be aware of when and how to complete the forms and when deaths should be referred to the coroner.

4.9 All staff should refer to the DHSSPSNI guidance on Medical Certification and Cause of Death (MCCD), when completing a death certification / liaising with the Coroner. This can be found at the link below:

http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

An expected death can be defined as: "a death where the patient's demise is anticipated in the near future". In such cases the doctor will be able to issue a medical certificate as to the cause of death.

Where there is a death in suspicious circumstances or a sudden /unexpected death nursing and medical staff must be familiar with the necessary steps required to deal with this situation – outlined in appendix 2. These procedures should be handled in a sensitive and knowledgeable way.

4.10 Registered Medical Practitioners have a legal duty to provide, without delay, a certificate of cause of death if, to the best of their knowledge, that person died of natural causes for which they had treated that person in the last 28 days.

4.11 Any alterations to the MCCD must be initialled by the doctor.

4.12 Because Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a

- legible printed name,
- signature
- GMC number beside your signature and
- contact details. Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

4.13 It is good practice to either make a note in the clinical record of the details recorded on the MCCD, or keep a copy of the MCCD in the patient's records.

4.14 It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

4.15 If a doctor cannot complete an MCCD, either because the cause of death was not natural or because they were not treated in the final 28 days of life, then the death must be referred to the Coroner. If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

A doctor who had not been directly involved in the patient's care at any time during the illness from which they died cannot certify the cause of death, but should provide the coroner with any information that may help to determine the cause of death.

If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) then the duty doctor may contact the Coroner's office and, after agreement, complete a pro-forma which will allow the death to be registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland*).

If the Coroner agrees this approach, you will be asked to draft a completed but unsigned MCCD giving the cause of death as agreed and a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). These are both to be faxed through to the Coroner's office (both originals should then follow in the post).

It is the responsibility of the Ward/Department Sister to ensure that the General Practitioner or other relevant Community HSC Service is informed of the patient's death within one working day. The Ward/Department Sister may delegate the task of contacting the GP or other relevant Community HSC Service to other members of the ward team, eg, Nurse in charge of the shift or Ward Clark.

4.16 **Recording Healthcare Associated Infections (HCAI)**

The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.

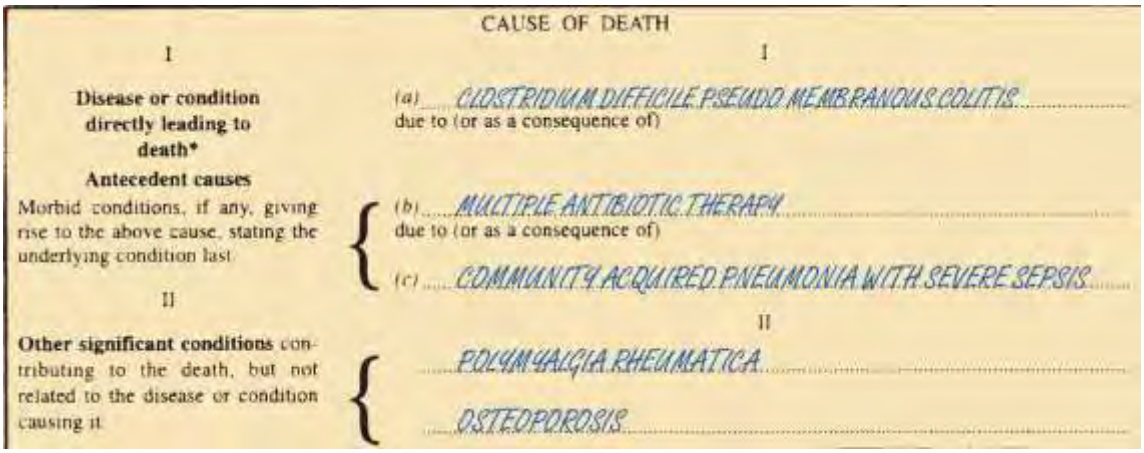
The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.

Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease

i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS

due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) MULTIPLE ANTIBIOTIC THERAPY

due to (or as a consequence of)

(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS

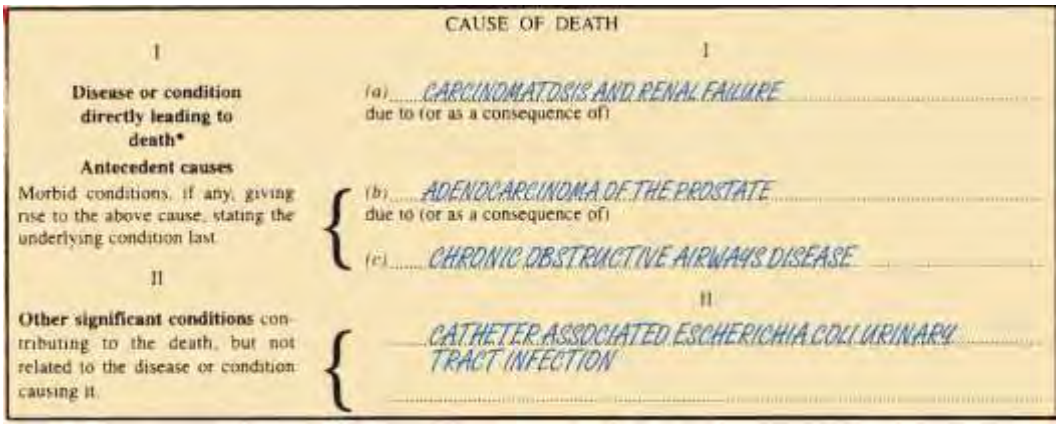
II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

POLYMYALGIA RHEUMATICA

OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CARCINOMATOSIS AND RENAL FAILURE due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.

(b) ADENOCARCINOMA OF THE PROSTATE due to (or as a consequence of)

(c) CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

II

Other significant conditions contributing to the death, but not related to the disease or condition causing it.

CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to be contributory to a patient's death it is important not to record it on the MCCD.

The recommended sequence should be:-

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.
2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)
3. **Inform** Ward sister/ Charge nurse that MCCD with contributory HCAI has been issued.
4. **Assist** Ward sister/ Charge nurse in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
- Consultant advice.

C. Referral to the Coroner.

4.17 There is a general requirement under section 7 of the Coroners Act (NI) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

Notification to the coroner and any discussions with the coroner should be recorded in the patient's notes.

For information regarding the Coroner's office refer to the Coroners Service for Northern Ireland – June 2011.

4.18 Therefore, before you proceed with completing a MCCD ask yourself this question – *Does this Death have to be reported to the coroner?*

Death is reported to the Coroner in the following situations:

- a doctor did not treat the person during their last illness;
- a doctor did not see or treat them in the 28 days before they died;
- the cause of death was sudden, violent or unnatural such as an accident, or suicide;
- the cause of death was murder;
- the cause of death was an industrial disease of the lungs such as asbestosis; or
- the death occurred in other circumstances that may require investigation.

A death in hospital should be reported if:

- there is a question of negligence or misadventure about the treatment of the person who died;
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause; or
- the patient died as the result of the administration of an anaesthetic.

From: Coroners service for Northern Ireland – June 2011

For help, refer to appendix 4 and/or

Guidance on Death, Stillbirth & Cremation Certification. **DHSSPSNI, 2008.**

4.19 Notification to the Coroner of the death of a child must be done by a Consultant.

4.20 Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed.

If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns. A written record of these concerns should always be made and retained with the medical records.

4.21 A foundation level doctor must consult a more senior colleague before reporting a death to the coroner.

4.22 A death occurring in hospital during the night does not usually need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning.

A coroner is always on call and can be reached if necessary out-of-hours. Where there is a need to obtain consent for the transplantation of organs or some other complicating factor arises, the death should be reported to the coroner as soon as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.

4.23 The office of the Coroners Service for Northern Ireland is at:

- May's Chambers, 73 May Street, Belfast BT1 3JL.
- Tel: 028 9044 6800; Fax 028 9044 6801.

- Website: www.coronersni.gov.uk
- E-mail: coronersoffice@courtsni.gov.uk
- the office is staffed weekdays 9.00am – 5.00pm,
- weekends and public holidays 9.30am – 12.30pm
- (except Christmas Day when the office is closed)
- outside normal office hours a recorded message will provide contact details for the duty coroner or messages may be left on the telephone answering machine.

NB: If a doctor contacts the Coroner's Office out of hours ***they should listen to the full range of options*** on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

4.24 **Hospital Post-Mortem Examinations**

In some cases, where the nature of the terminal illness is unclear, or the cause of death is uncertain, but there are no concerns that the death was not due to natural causes, a hospital post-mortem examination may be requested.

The decision to request a hospital post-mortem examination in an adult should be taken by a senior doctor, e.g. ST3 grade or above. Any request for a hospital post-mortem on a child must be made by a consultant.

In these cases, the next of kin must be counselled and made conversant of the reasons why a post-mortem examination would be desirable and written consent must be obtained. Information books and consent forms are available for neonatal, paediatric and adult examinations - Post Mortem Examinations DHSSPS(NI).

4.25 **Definition of a maternal death – ICD code 9/10.**

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self harm as consequence of postnatal depression.

A **Coincidental (fortuitous**) death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

4.26 For detailed guidance please refer to the BHSCT policy on “management of a maternal death” - http://intranet.belfasttrust.local/Policies%20and%20Procedures/Management%20of%20a%20Maternal%20Death.pdf

4.27 When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

4.28 **Centre for Maternal and Child Enquiries” (CMACE)**
It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that Maternal deaths are reported to the CMACE (Centre for Maternal and Child Enquiries) i.e. the Maternal Mortality Enquiry. It is commissioned and monitored by the National Patient Safety Agency (NPSA).

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the CMACE Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

4.29 CMACE in Northern Ireland is commissioned by the DHSSPS through the Public Health Agency for Northern Ireland and can be contacted through:-
Regional Manager: Dr Jackie McCall

Address:
Public Health Agency (PHA)
Eastern Office (Floor 2)
12 - 22 Linenhall Street
Belfast BT2 8BS
Northern Ireland

Phone:
[redacted] or [redacted]

Fax:
[redacted]
Email: [redacted]

D. Registering the Death.

4.30 The family (or certain other people) will provide the person’s details to the local registrar, with either the MCCD or the Coroners form giving the cause of death.

E. Obtaining a burial or cremation order.

4.31 The registrar or coroner can issue a burial or cremation order.

4.32 Cremation
When a body is to be cremated there are a series of special medical forms to be completed by different, independent doctors, to provide reassurance that the death does not require further investigation. If the death has not been referred to the coroner, and a MCCD - certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

4.33 Form B

This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C

The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care;
- not be related to the deceased.

Form F

This is completed by the Medical Referee for the Cremation Authority.

Stillbirth

Stillbirth forms can be completed by a medical practitioner who was present at the birth, or who examined the body.

Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.

A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

5.0 IMPLEMENTATION OF POLICY

6.0 MONITORING

Monitoring of MCCDs will be done by checking the concurrent entry of death certification details onto a new IT system to be introduced in 2012.

7.0 EVIDENCE BASE / REFERENCES

1. DHSSPSNI guidance on death, still birth and cremation certification – 2008.
2. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges. 2008.
3. DHSSPSNI circulars

References, including relevant external guidelines:

1. Guidance on Death, Stillbirth & Cremation Certification. Part A DHSSPSNI, 2008.
2. Guidance on Death, Stillbirth & Cremation Certification. Part B DHSSPSNI, 2008.
3. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges, 2008.
4. HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
5. HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.
6. Guidelines for Verifying Life Extinct (PDF 62 KB)
7. HSS(MD) 10/2008. Enhanced monitoring arrangements for deaths where C.DIFFICILE or MRSA infection is mentioned on the death certificate.
8. Coroner's Service for Northern Ireland - June 2011.
9. *Working with the Coroner's Service for Northern Ireland*

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Verification of Life Extinct
Appendix 2: Protocol for actions to be taken after a death in Hospital
Appendix 3: Diagnosing and confirming death after cardiorespiratory arrest
Appendix 4: Deaths that must be reported to the coroner

10.0 EQUALITY STATEMENT

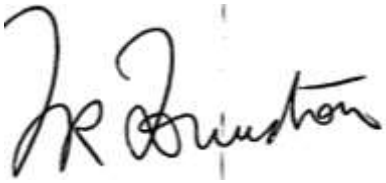
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been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



_____ Date: _____Dec 2013_____
Author

_____ Date: _____Dec 2013_____
Director

Appendix 1

VERIFICATION OF LIFE EXTINCT

Verifying life extinct can be undertaken by all doctors and, where directorates deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

In order to verify life extinct, cessation of

- circulatory system
- respiratory system
- cerebral function

must be confirmed and documented in the patient's notes with a name and signature.

The documentation recording the examination undertaken and verifying life extinct should be completed and put in the patient's notes.
(**N.B** This applies whether Doctor or Nurse verifies death).

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
   - No pulses on palpation.
   - No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing)

2. Cessation of respiratory system e.g.
   - No respiratory effort observed
   - No breath sounds (verified by listening for one full minute)

3. Cessation of cerebral function e.g.
   - Pupils dilated and not reacting to light
   - No reaction to painful stimuli

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.**

In these situations active resuscitation should continue until an experienced doctor has verified life extinct.

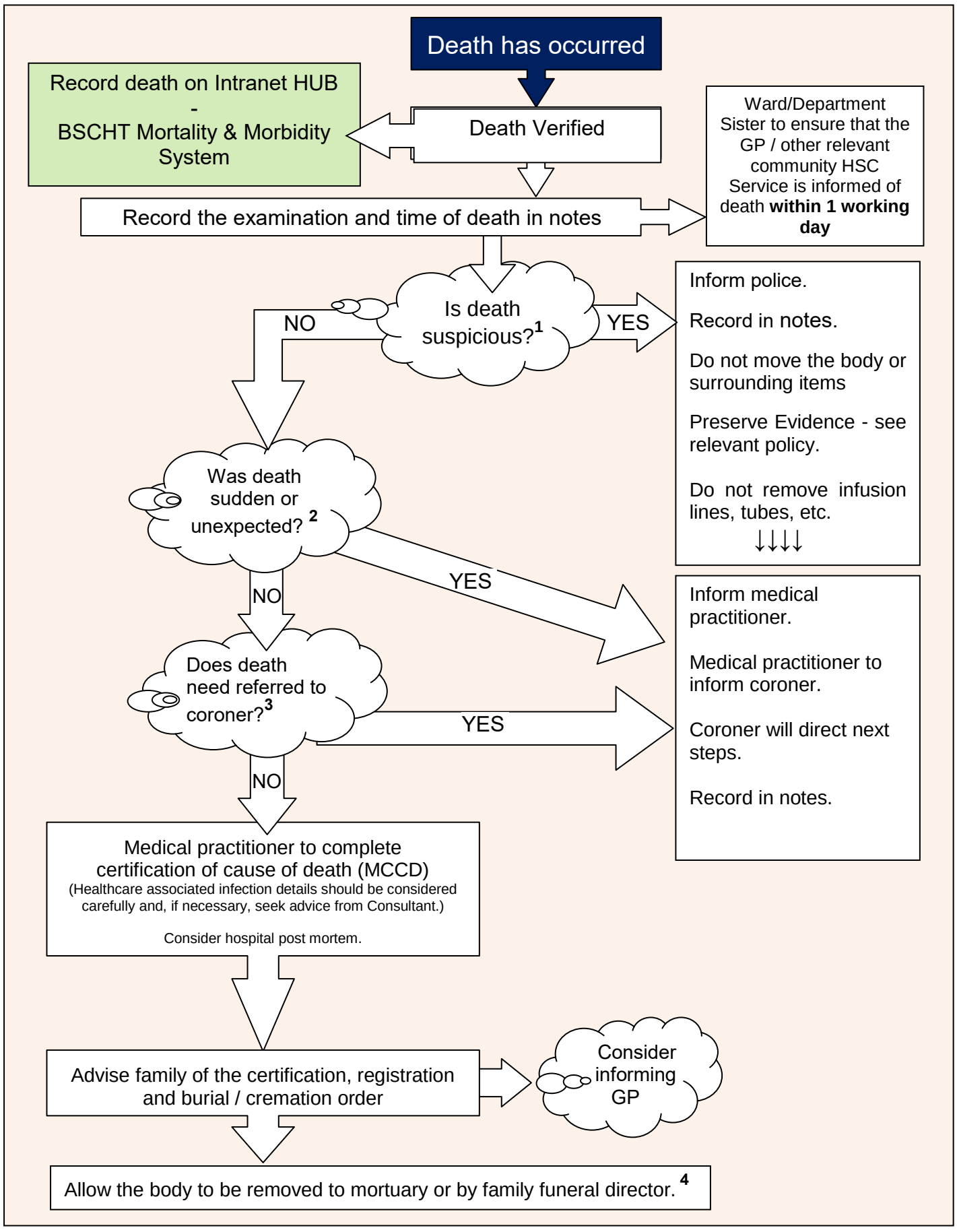
There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. See appendix 3.

From:
HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.

Guidelines for Verifying Life Extinct (PDF 62 KB)

Appendix 2

PROTOCOL FOR ACTIONS TO BE TAKEN AFTER A DEATH IN HOSPITAL



Notes for Appendix 2

1. **Death involving suspicious circumstances** e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle.
   The body must not be moved. Do not disturb the scene.
   There must be immediate contact with the Police and the appropriate medical practitioner (GP, Out-of-Hours Service or hospital medical staff).
   The Police or medical practitioner must contact the Coroner.
   The body will require Post Mortem examination by State Pathology.
   The Police will arrange transfer to a mortuary.

2. **Sudden/unexpected death without suspicious circumstances** e.g. person found dead at home or initial resuscitation is unsuccessful but circumstances do not raise concerns. Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

3. **Death related to specific conditions which need referred to the Coroners Service.** In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

   Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

4. **Paediatric deaths**
   In certain paediatric cases, parents have the opportunity to take the body of their child home prior to the funeral and where appropriate this choice should be offered. The GP must be informed that this is happening.

Appendix 3

DIAGNOSING AND CONFIRMING DEATH AFTER CARDIORESPIRATORY ARREST

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation

- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section [5]

- One of the following is fulfilled:
  - the individual meets the criteria for not attempting cardiopulmonary resuscitation[8]
  - attempts at cardiopulmonary resuscitation have failed
  - treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment

- The individual should be observed by the person responsible for confirming death for a minimum of five minutes [9,10] to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
  - absence of a central pulse on palpation
  - absence of heart sounds on auscultation

  These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:
  - asystole on a continuous ECG display
  - absence of pulsatile flow using direct intra-arterial pressure monitoring
  - absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed

- The time of death is recorded as the time at which these criteria are fulfilled.

A CODE OF PRACTICE FOR THE DIAGNOSIS AND CONFIRMATION OF DEATH

Appendix 4

DEATHS THAT MUST BE REPORTED TO THE CORONER

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   • homicidal deaths or deaths following assault;
   • road traffic accidents or accidents at work;
   • deaths associated with the misuse of drugs (whether accidental or deliberate);
   • any apparently suicidal death;
   • all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

6. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

7. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

   - Industrial diseases or poisoning and other poisonings
     A. Industrial lung diseases
     B. Other industrial diseases
     C. Industrial poisoning
     D. Other poisonings

   - Death resulting from an injury
     A. Injury
     B. Indirect injury
     C. Birth injury
     D. Operation / anaesthetic

For further detail go to:
http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 04/09

Title:	**Guidance on Actions to be Taken after a Patient's Death in Hospital**			
Author(s)	Irene Thompson, Interim Director of Nursing Heather Russell, Bereavement Coordinator Dr Ann Harper, RJMH			
Ownership:	Dr Cathy Jack, Medical Director			
Approval by:	Standards and Guidelines Committee Policy Committee Executive Team Meeting		**Approval date:**	03/10/2018 04/10/2018 10/10/2018
Operational Date:	October 2018		**Next Review:**	October 2023
Version No.	5	**Supercedes**	V4 December 2013-2016	
Key words	Death, Coroner, Death certificate, MCCD, Last Offices, Organ Donation			
Links to other policies	Post-Mortem Examination Regional policy Patient Property Policy Infection Control Manual Organ Donation from heart beating donors Organ Donation from Donors following circulatory death Release of a baby or child from the place of their death Management of Maternal Death Being Open Policy Adverse Incident Reporting and Management policy Multi-Cultural and Beliefs Handbook Bereavement Policy Memorandum of Understanding and Evidential procedures policy			

Date	Version	Author	Comments
28/08/2013	3.1	JRJ	Appendix 2 changes
28/11/2013	3.2	JRJ	Review by D Robinson
28/05/2014	4.1	Heather Russell JRJ	Bereavement additions
09/06/2016	4.2	Heather Russell JRJ	Review-Addition of Appendix 11 - Check List of Nursing Actions required following Death of a Patient
01/12/2017	5	Irene Thompson Heather Russell	RM&MR and resource additions and procedural changes
09/07/2018	5.1	Heather Russell	Revised to incorporate table of Infectious Diseases

1.0 INTRODUCTION

This policy provides the underlying principles, guidance and information required on the actions, care and support to be provided by BHSCT staff, following the death of a patient in hospital.

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff when a patient dies to ensure the appropriate legal and procedural processes are followed
- promote effective interagency working by outlining the roles and responsibilities of relevant professionals and organisations who have a role with deceased patients and their relatives
- ensure that deceased patients, and those important to them, are treated with dignity and respect in a caring, compassionate and professional manner, and that their cultural/spiritual needs are acknowledged and, if possible, addressed
- comply with DoH circulars HSS(MD) 3/2008, 8/2008, 10/2008, 44/2013.

1.2 Objectives

To ensure a consistent approach to all aspects of care of dying, deceased and bereaved people across all BHSCT in-patient areas; and to meet the statutory requirements regarding:

- confirmation and verification of death and stillbirth
- completion of Medical Certificate of Cause of Death
- when and how to report deaths to the Coroner's Service .
- completion of cremation certification
- organ donation and hospital post-mortem examination
- care of the body including religious and cultural considerations, infection control issues, local arrangements for removal from place of death
- reporting of maternal deaths and still births
- supportive bereavement care

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff with responsibility for procedures after death in hospital, e.g. verifying and recording life extinct, completing medical certificate of cause of death, reporting deaths to the Coroner's office, managing or delivering care to deceased patients and providing information to bereaved people and supporting them.

It applies to all inpatient settings: wards, ICU/CCU, theatres, emergency and outpatients departments.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

3.0 ROLES/RESPONSIBILITIES

3.1 All Staff

All staff employed by BHSCT whose duties involve coming into contact with and/or caring for dying people, and those important to them, should perform their duties with professionalism, sensitivity, compassion and respect. They have a responsibility to consider any training or learning required in order to provide the best care and identify this in Personal Development Plans. A range of training is provided across the organisation. Specific responsibilities include those listed below:

3.2 Medical Staff

Medical staff responsibilities include:

- timely verification of life extinct
- verbal communication of fact and cause of death to family, next of kin or carers and explaining coroner's processes if applicable
- timely and accurate electronic completion of medical certificate of cause of death (MCCD) or discussion with coroner using the RM&MRs platform on BHSCT Hub,
- liaising with the coroner's service/PSNI when death is due to unnatural causes or is sudden/unexpected and sharing coroner's/PSNI decisions with nursing colleagues
- completing Form B on cremation documentation when requested
- liaising with Specialist Nurse Organ Donation to identify patients eligible for organ donation
- completing training in post mortem consent, discussing value of hospital post-mortem examination and obtaining consent if applicable
- writing to the patient's GP to inform of the death

Medical Consultants

Consultants responsibilities include:

- reviewing their patients' completed MCCDs and presenting their deaths at the monthly M&M meeting for discussion
- overseeing timely completion of the MCCD to allow release of patient from mortuary, especially at weekends
- being available for a follow up meeting when requested by complaints or service managers or bereavement coordinator on behalf of family

NB The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

3.3 Nursing Staff

Nursing staff responsibilities include:

- encouraging a quiet and respectful environment when a patients through the use of the waterlily symbol
- reporting the death of a patient to medical colleagues and requesting their timely attendance for verification of life extinct
- liaising with medical colleagues regarding family communication and support
- contacting next of kin if not present at time of death and supporting those in attendance

- providing compassionate support that is responsive to the needs of bereaved people
- providing verbal and written information to bereaved people, in a format/language they understand, that explains legal and procedural requirements after death, and includes help with management of grief reactions
- returning personal possessions to the family respectfully or informing mortuary if the deceased patient has no NoK
- appropriately caring for the patient's body after death
- arranging the safe and timely removal of deceased patients from their place of death
- informing and involving other members of the multi-disciplinary team as requested by the family, e.g. chaplains/social worker
- recording all aspects of care provided in patients' health records
- facilitating follow-up for every family i.e. sending sympathy card;
- accessing learning opportunities that promote competence/confidence when caring for deceased and bereaved people

Ward/Department Sister/Charge Nurse

The responsibilities of the Ward/Department Sister/Charge Nurse include:

- providing training opportunities for staff that support and equip them to manage dying patients, bereaved people and themselves
- ensuring that there is an ethos of sensitivity and respect for dying and deceased patients and those important to them
- ensuring that the GP and other relevant Community HSC Services are informed of the patient's death within one working day, this task may be delegated to a member of the ward team, e.g. Nurse in charge of the shift or Ward Clerk:

All nurses must adhere to "The code:Professional Standards of practice and behavior for nurses and midwives" (NMC 2015).

3.4 **Managers**

Healthcare Managers responsibilities include:

- recognising the importance of care before, at the time of and after death; and the impact that care has on bereaved people and staff
- commissioning training for staff who deliver care and support at the time of and after death
- addressing support needs of staff who are affected by bereavement (personal or professional).

4.0 KEY POLICY PRINCIPLES

Awareness and compliance with the policy and procedures detailed below will ensure that:

- statutory and procedural requirements are met
- deceased patients and those important to them are dealt with in a professional, safe, sensitive and supportive way.

5.0 IMPLEMENTATION OF POLICY

The policy will be hosted on the policy and guidelines and bereavement sections of the Trust intranet. Awareness of the procedures contained within it will be raised at staff induction and training opportunities.

6.0 MONITORING

Implementation of the policy will be monitored by:

- Review of MCCD completion on RM&MR database at M&M meetings
- Regular audit of documentation e.g. Completion of Body Transfer and PM examination consent forms, provision of bereavement booklets
- Presentation of organ donation statistics
- Regional audit against the bereavement standards
- The activity of BHSCT bereavement fora

7.0 EVIDENCE BASE / REFERENCES

1. Guidance on Death, Stillbirth & Cremation Certification. Part A DHSSPSNI, 2008.
2. Guidance on Death, Stillbirth & Cremation Certification. Part B DHSSPSNI, 2008.
3. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges, 2008.
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8. Coroner's Service for Northern Ireland - June 2011.
9. Working with the Coroner's Service for Northern Ireland
10. HSC Multicultural and Beliefs Handbook 2012f
11. HSS (MD) 44/2013 Appeal Court Decision on Referral of Stillbirth to Coroner
12. Care of the deceased patient and their family Guideline for Nursing Practice in Northern Ireland - March 2017
13. Care of the deceased patient and their family A Guideline for Nursing Practice in Northern Ireland May 2017

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Topic	Appendix
Verifying life extinct.	1
Protocol for actions to be taken after a death in hospital	2
Certifying the medical cause of death or stillbirth	3
Referral to the Coroner.	4
Hospital post mortem examination	5
Managing maternal death and stillbirth	6
Obtaining a burial or cremation order.	7
Care of the body after death	8
Faith/cultural considerations	9
Body Transfer Forms 1a and 1b	10
Check List of Nursing Actions required following Death of a Patient	11

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

18/09/2018

_____ **Date:** _____

Author

18/09/2018

_____ **Date:** _____

Director

VERIFICATION OF LIFE EXTINCT

Appendix 1

This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

Verifying life extinct can be undertaken by all doctors and, where service groups deem necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

Procedure for verification of death

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
   - No pulses on palpation.
   - No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing).

2. Cessation of respiratory system e.g.
   - No respiratory effort observed.
   - No breath sounds (verified by listening for one full minute).

3. Cessation of cerebral function e.g.
   - Pupils dilated and not reacting to light.
   - No reaction to painful stimuli.

Documentation

An explanation of the examination undertaken and verification of life extinct should be completed in the patient's health record. The date and time of verification should be recorded. (**N.B** This applies whether a doctor or nurse verifies death).

It is important that verification of life extinct is timely as this will influence the actual date and time of death inserted on the MCCD. This is crucially important if the death occurs close to midnight, or if the Coroner will be issuing a Death Certificate to the family after the funeral has taken place.

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.** In these situations active resuscitation should continue until an experienced doctor has confirmed death.

There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. (See appendix 3)

Next steps

Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death. (Appendices 3 & 4)

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death. Where there are major concerns about the cause of death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct next steps. See *Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm)*

There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation.
- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section.
- One of the following is fulfilled:
    - the individual meets the criteria for not attempting cardiopulmonary resuscitation
    - attempts at cardiopulmonary resuscitation have failed
    - treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment
- The individual should be observed by the person responsible for confirming death for a minimum of five minutes to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
    - absence of a central pulse on palpation
    - absence of heart sounds on auscultation

These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:

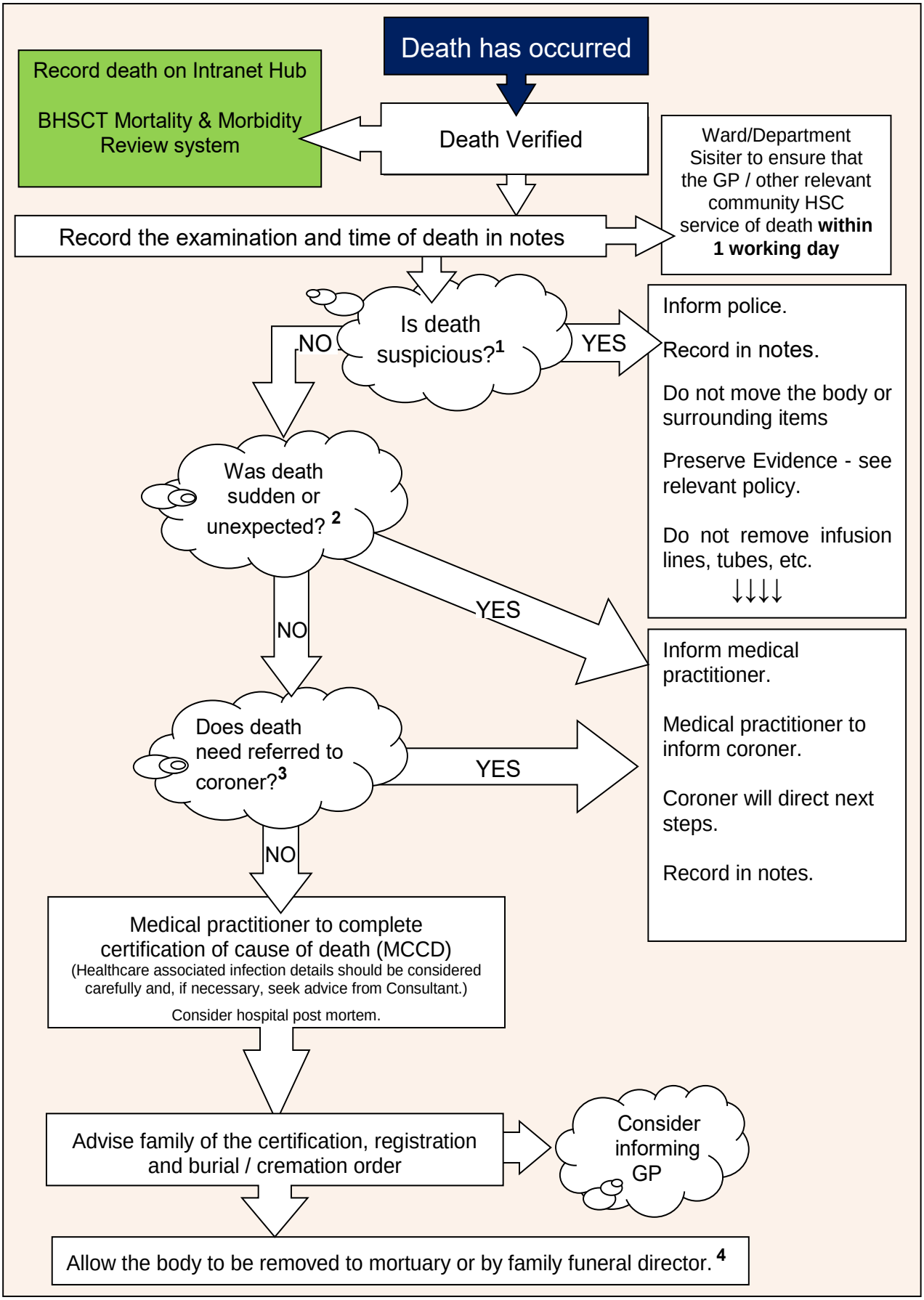
- asystole on a continuous ECG display
- absence of pulsatile flow using direct intra-arterial pressure monitoring
- absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest
- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed
- The time of death is recorded as the time at which these criteria are fulfilled.

A CODE OF PRACTICE FOR THE DIAGNOSIS AND CONFIRMATION OF DEATH

Protocol for actions to be taken after a death in hospital

appendix 2



Notes for Appendix 2

Death involving suspicious circumstances e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle.

- *The body must not be moved. Do not disturb the scene*
- There must be immediate contact with the Police and the appropriate medical practitioner
- The police or medical practitioner must contact the Coroner
- The body will require a forensic post mortem examination by a State Pathologist
- The police will arrange transfer to a mortuary

Sudden/unexpected death without suspicious circumstances e.g. person found dead or initial resuscitation is unsuccessful but circumstances do not raise concerns.

- The appropriate medical practitioner must contact the coroner
- The coroner may direct a coroner's post mortem examination
- If the coroner is content that a post mortem examination is not required the doctor should complete a pro-forma letter (unsigned MCCD) and clinical summary for the coroner on the RM&MRS
- If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the person's GP is available to discuss the case) the body should be taken to the hospital mortuary
- The trust contracted funeral director will transfer the deceased patient to BHSCT mortuary on behalf of the coroner, they will then be moved to State Pathologist's Department if a post mortem examination is to take place

Death related to specific conditions that need to be referred to the Coroners Service. In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

- The appropriate medical practitioner must contact the coroner
- The coroner may direct a coroners post mortem examination
- If the coroner is content that post mortem examination is not required the doctor should complete a pro-forma letter and clinical summary for the coroner on RM&MRS, print off and fax them to the coroners office
- If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the person's GP is available to discuss the case) the body should be taken to the designated hospital mortuary
- The trust contracted funeral director will transfer the deceased patient to BHSCT mortuary on behalf of the coroner, they will then be moved to State Pathologist's Department if a post mortem examination is to take place

Paediatric deaths

Parents may wish to take their child directly home following death and where appropriate this choice should be supported. In this event BHSCT mortuary, the child's GP and a family funeral director must be informed prior to the family leaving the ward. See BHSCT policy Removal of a baby or child from the place of their death.

Certifying the medical cause of death, stillbirth. Appendix 3

1. Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange a funeral and settle their estate.
2. A doctor who has treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).
3. All doctors completing MCCDs or cremation forms, and doctors and midwifes completing stillbirth certificates, should be aware of when and how to complete them and which deaths should be referred to the coroner.
4. All staff should refer to the DHSSPSNI Guidance on Death, Stillbirth and Cremation Certification, when completing death certification / liaising with the coroner.

Expected Deaths

5. An expected death can be defined as: "a death where the patient's demise is anticipated in the near future". In such cases the treating doctor will be able to issue a medical certificate as to the cause of death.
6. Registered Medical Practitioners have a legal duty to provide, without delay, a MCCD if, to the best of their knowledge, the person died of natural causes for which they had treated that person in the last 28 days.
7. **Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed. If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns**. A written record of these concerns should always be made and retained with the patient's health record. The MCCD should be completed electronically on RM &MRS. This will enable the patient's consultant to review/revise the cause of death and provide information for discussion at Mortality and Morbidity Review meeting.
8. Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a:
    - legible printed name
    - signature
    - GMC number
    - doctor's contact details.

    Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

9. If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) the duty doctor should contact the patient's consultant to avoid delay of release. It is also permissible to discuss the death with the coroner's office and, after agreement, complete a pro-forma which will allow the death to be registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland*).
10. If the coroner agrees this approach, the doctor will be asked to complete a MCCD giving the cause of death as agreed, leave it unsigned and fax it to the coroner's office along with a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). Printed originals should then be sent to coroner's office by post.

11. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

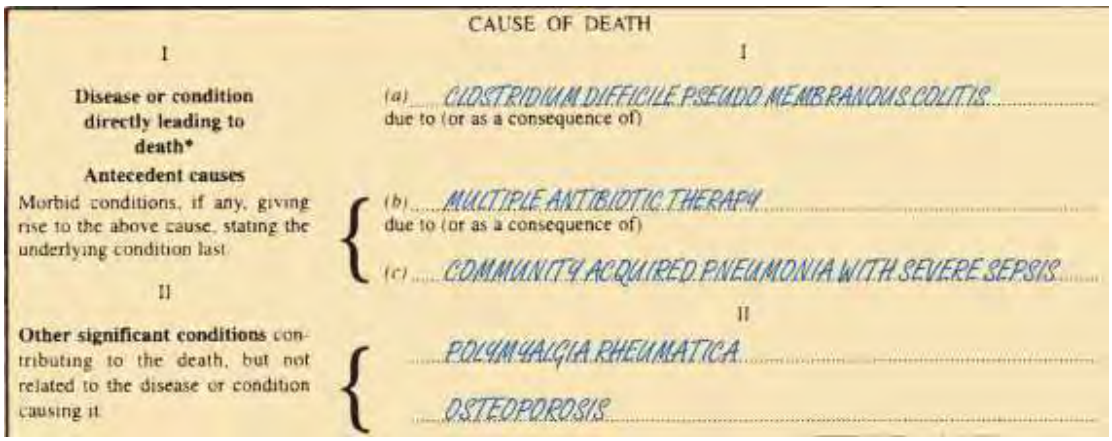
Recording Healthcare Associated Infections (HCAI)

12. The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.
13. The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.
14. Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease:

i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS
due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) MULTIPLE ANTIBIOTIC THERAPY
due to (or as a consequence of)

(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS

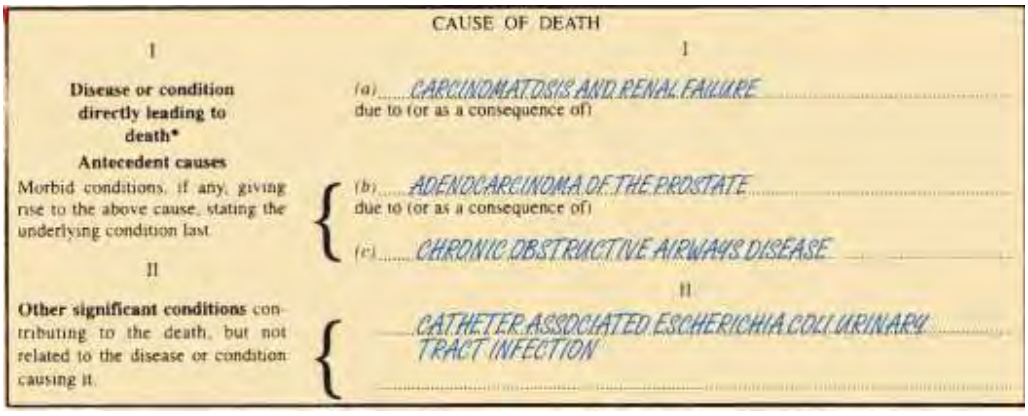
II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

POLYMYALGIA RHEUMATICA

OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CARCINOMATOSIS AND RENAL FAILURE
due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) ADENOCARCINOMA OF THE PROSTATE
due to (or as a consequence of)

(c) CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

II

Other significant conditions contributing to the death, but not related to the disease or condition causing it

CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to have contributed to a patient's death it is important **not** to record it on the MCCD.

The recommended sequence should be:

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.
2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)
3. **Inform** Ward sister/ Charge nurse that MCCD with contributory HCAI has been issued.
4. **Assist** Ward sister/ Charge nurse in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to:

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- Consultant advice

Reporting a death to the Coroner. Appendix 4

Doctors should be aware of the criteria for referring death to the coroner and also the Registrar General's Extra-statutory list of Causes of Death that should be referred to the Coroner. Before proceeding to MCCD completion doctors should ask themselves:
Does this death have to be reported to the Coroner?

Causes of death that must be reported to the Coroner

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   • homicidal deaths or deaths following assault;
   • road traffic accidents or accidents at work;
   • deaths associated with the misuse of drugs (whether accidental or deliberate);
   • any apparently suicidal death;
   • all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Stillbirth:
   - Since the Appeal Court Decision on Reporting Stillbirths to the Coroner (November 2013) all babies stillborn, deemed by obstetricians to be capable of being born alive, are to be reported to the coroner for a decision on post mortem examination. If the coroner doesn't direct a post mortem examination the parents should be approached about a hospital post mortem examination.
   - Stillbirth forms can be completed for a baby delivered at or beyond 24-week gestation, by a medical practitioner who was present at the birth or who examined the baby's body.
   - Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.
   - A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

6. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

7. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

8. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

    - Industrial diseases or poisoning and other poisonings
        A. Industrial lung diseases
        B. Other industrial diseases
        C. Industrial poisoning
        D. Other poisonings

    - Death resulting from an injury
        - Injury
        - Indirect injury
        - Birth injury
        - Operation / anaesthetic

    - Family Concerns
      In the event of a family expressing concern about treatment and care received by the deceased patient it is advisable to report the death to the coroner outlining the family's concerns. A written record of the concerns should always be made and retained in the medical records.

For further detail go to:
Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.

When reporting a patient's death to the Coroner:

- A child's death should be reported to the coroner by a consultant.
- Notification to the coroner and any discussions with the coroner should be recorded in the child's health record.
- A foundation level doctor must consult a more senior colleague before reporting a death to the coroner
- A coroner is always on call and can be reached if necessary out-of-hours to discuss a need to obtain consent for the transplantation of organs, the death of a child or a complicating factor that requires the death to be reported as soon after death as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.
- Most deaths occurring in hospital during the night do not need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning. If parents do not want their child to be taken to the mortuary the coroner can be contacted out of hours.
- The office of the Coroners Service for Northern Ireland:
  Address: Laganside House,
  23-27 Oxford Street
  BT1 3LA

  Tel: 0300 200 7811

Website: www.coronersni.gov.uk
E-mail: coronersoffice@courtsni.gov.uk
Office Hours: Weekdays 9.00am – 5.00pm,
Weekends and public holidays 9.30am – 12.30pm
Christmas Day the office is closed

- When a doctor needs to contact the coroner's office outside office hours for immediate direction they will hear a recorded message. ***It is important that they listen to the full range of options presented before selecting one as the most appropriate option may not be clear until the message is completed. The on-call coroner's mobile telephone number is only given at the very end of the recording.***

For information regarding the Coroner's office refer to the Coroners Service for Northern Ireland – June 2011.

Coroner's direction to doctors
Following report of a death the coroner will direct one of three courses:

1. Advise doctor to complete a MCCD

2. Direct that a death be processed under the 'pro-forma' system
   - When the Coroner directs that the death can be processed using the 'pro-forma' system, a clinical summary, along with an unsigned MCCD, should be printed and faxed/ e-mailed to the Coroner's Service as soon as possible and the hard copy of both documents posted to them (see contact details in section 8)
   - The new Regional Mortality and Morbidity Review System will generate a 'Coroners Clinical Summary' when the 'Coroner notified – Coroner Requested Proforma' option is selected along with a MCCD for this purpose.
   - NB. In this situation the MCCD **is not** given to the family. They should be given an explanation about this process and that the coroner, on receipt of the clinical summary and unsigned MCCD, will notify the Registrar about the death who will then issue a death certificate to them at the Registrar's Office.

3. Direct a post mortem examination to establish cause of death
   - When the coroner directs that a coroner's post mortem examination is required it is particularly distressing for families.
   - Doctors must give information to families that will help them understand the coroner's process and what will happen next i.e. that police will attend as coroner's agents and complete staff and family statements regarding the deceased's last few minutes/hours.
   - Requests for formal statements or medical records are usually requested through the Trust Coroner Liaison Officer

Families should be informed of any contact with the coroner's office as part of the Trust's obligation of duty of candour.

Care of the patient's body:

- In a case of suspicious death or homicide all medical devices including ET tube should remain in position.

- When there are no suspicious circumstances and where the endotracheal tube has been clinically confirmed to have been in the appropriate position and there are no questions regarding intubation or anaesthesia having played a role in the death, the ET tube can be removed.

- Any medical device which is removed should be documented in the medical notes and in the clinical summary provided to the pathologist, along with any supporting evidence with regard to its correct positioning and function prior to removal. If there are any doubts, the device should be left in-situ, again any supporting evidence regarding correct position and function should be documented in the medical records and clinical summary, as it is possible that the device could become dislodged in transfer.

Post-mortem (PM) examination is important for informing relatives, healthcare professionals and other interested parties about the cause of death. Following a death due to natural causes the treating clinician may wish to request a hospital PM examination to investigate further the cause of death, to improve knowledge of the disease or effectiveness of the treatment given. Occasionally relatives may request that a hospital PM examination is performed.

Who may seek consent?
It is usually the responsibility of the deceased person's clinician to raise the possibility of a PM examination however others in the team may be involved in the consent process.

The need for a hospital PM examination of a child must be discussed and agreed with the child's consultant, and consent must be obtained by an experienced clinician.

The Human Tissue Authority (HTA) requires that anyone approaching relatives to seek consent for hospital post-mortem examination:

> *"should have relevant experience and a good understanding of the consent procedure. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations. Ideally, they should also have witnessed a post-mortem examination." HTA Code B, Para 82*

The DoH has developed a 2-part training programme for those obtaining consent or supporting families who have consented to a post mortem examination.

Part 1, an e-learning module can be accessed at
http://www.hsclearning.com/belfasttrust/

Part 2, a face to face session on "grief, bereavement and communicating with grieving families" can be booked by contacting Heather Russell, Trust Bereavement Coordinator. [redacted]

For detailed guidance please refer to the policy:
HSC Consent for Hospital Post-Mortem Examination Regional Policy

Definition of a maternal death – ICD code 9/10. Appendix 6

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self-harm as consequence of postnatal depression.

A **Coincidental (fortuitous**) death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

For detailed guidance please refer to the BHSCT policy on "Management of a Maternal Death"

When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

Northern Ireland Maternal and Child Health (NIMACH)
It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that maternal deaths are reported to:

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the NIMACH Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

NIMACH is commissioned by the DoH through the Public Health Agency for Northern Ireland and can be contacted through:

Regional Manager: Dr Heather Reid

Address:
NIMACH Regional Office
Public Health Agency (PHA) (Floor 2)
12 - 22 Linenhall Street
Belfast BT2 8BS
Northern Ireland

Phone:
028 9536 3481

Fax:
028 9536 3947

Obtaining a burial or cremation order. Appendix 7

The registrar or coroner can issue a burial or cremation order.

Cremation
When a body is to be cremated there are a series of special medical forms to be completed by 2 independent doctors, to provide assurance that the death does not require further investigation. If the death has not been referred to the coroner, and a MCCD – medical certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

Form B
This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C
The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care;
- not be related to the deceased.

Form F
This is completed by the Medical Referee for the Cremation Authority.

Care and removal of the body after death (Last Offices) Appendix 8

Preparing the body of deceased patients for removal is the final, important clinical role of staff who cared for them during their last hospital admission. Many patients, due to the nature of their illness, will die in hospital after a lengthy stay; others are admitted and die soon after. It is important that safe and effective care continues for patients after death and that their bodies are treated with dignity, their wishes are respected and any cultural or religious requirements are met.
The Trust has adopted the Royal Marsden clinical nursing procedure guidelines Chapter 22 and "Care of the deceased patient and their family" HSC Bereavement Network
The procedure should not commence until after death has been verified and the patient's immediate family has had an opportunity to attend the ward/department and spend some time with them following death, should they so wish. However, Last Offices should usually be carried out and the body removed within two to four hours of death. In exceptional circumstances e.g. after arriving from overseas, additional relatives may view the deceased patient in the Trust Mortuary Viewing Room on the Royal Hospitals site. This can be arranged by contacting mortuary staff.
Before relatives see their loved one, items of medical/nursing equipment should be removed from the room/bed space.
The procedure describes steps to be taken following most deaths in hospital however:

- In the event of the death falling under the jurisdiction of the coroner the body should not be unduly handled, to preserve evidence especially if the death occurs after assault
- In the event of the death of a child or baby their parents may wish to be involved in the care after death and removal arrangements (see BHSCT policy "Release of a baby or child from the place of their death")

Two members of staff, at least one qualified, should conduct the last offices procedure at the bedside. The senior member of staff is responsible for overseeing the procedure and completing the documentation.
Before commencing, it is important to assess the patient for any risks:

- If there is an infection risk the infection prevention precautions, taken when the patient was alive, should be continued after death
- If there is a manual handling risk the number of staff required to undertake Last Offices procedure may need to be increased from 2 to a number that ensures safe manual handling

Last Offices Equipment

- Disposable plastic gloves and aprons (additional PPE if patient has an infection)
- Towels, bowl of warm water, soap, disposable wash cloths, comb, items for mouth care/teeth cleaning
- Gauze, waterproof tape, dressings and bandages to cover wounds or intravenous/arterial lines or cannulae

- Receptacle for collecting urine/uribag if appropriate, plastic bags for clinical waste
- Laundry skip and appropriate bag for soiled linen
- Clean sheet or purple woven body sheet (MIH), shroud (or patient's personal clothing if requested by family)
- Two identity bands: one on each wrist or other limb if applying to second wrist is not possible
- Body bag if:
    - Patient's medical history is unknown
    - Actual or potential leakage of body fluids
    - Infection (with labels to indicate nature of infection)
- Purple woven bag for return of patient's personal possessions
- Record book for property and valuables
- Body Transfer Form book

Last Offices Procedure and notification of GP

Two members of staff (unless more are required) will conduct the procedure. Senior staff member is responsible for completing required documentation. All equipment should be gathered before entering the room/bedspace.

- If family is present ask if patient had any wishes or cultural/religious requirements for care after death; a member of the family may want to assist
- Explain that after completion of Last Offices they will not be able to view their loved one until the family funeral director has taken them to his premises.
- If family is waiting for the patient's property find them somewhere to sit and ask if they would like a cup of tea
- Wash hands and put on disposable gloves and apron.
- If the patient is on a pressure relieving mattress follow manufacturer's instructions
- Lay the patient on their back. Remove all but one pillow. Support the jaw by placing a pillow or rolled up towel on the chest underneath the jaw.
- Remove any subcutaneous infusions and apply gauze to the site firmly with tape, remove ET tubes and infusions. Securely close all devices e.g. venflons, drains, catheters and leave in situ.
  NB. If a death is referred to the coroner leave all devices, tubes and dressings in situ, unless advised otherwise by medical colleagues (see Page 17)
- Straighten limbs and close eyes with pressure or moistened cotton wool, not tape.
- Pad any leaking areas e.g. vagina or bowel. If leaking continues the patient should be placed in a body bag before removal.
- Cover exuding wounds or unhealed surgical scars with clean, absorbent dressing and secure with an occlusive dressing. Cover stomas with a clean bag.
- Wash patient, do not shave male patients.

- Clean mouth, removing debris and secretions. Clean dentures and replace in mouth if possible. If not replaced they should be returned to the family or recorded on the Body Transfer Form and sent to the Mortuary with the patient.
- Remove all jewellery unless requested by the family not to do so. Jewellery remaining on the patient should be recorded on the Body Transfer Form, rings should be taped. Record removed jewellery and other valuables in the Patient Property Book and store according to Trust policy.
- Dress the patient in a shroud (or personal clothing documented on Body Transfer Form).
- Ensure there are 2 identical armbands which detail patient name, H&C number, DOB and ward/dept.
- Senior staff member completes **every part** of Section 1 of Body Transfer Form, adding their name and the time of completion.
- Wrap the patient in white or purple sheet, ensuring that limbs and face are covered but leaving armband near opening and accessible so that the name can be checked at time of removal.
- Place the wrapped body in a body bag if any of the criteria apply i.e. infection, actual or potential leakage, history unknown.
- Remove gloves and apron, dispose of equipment and wash hands.
- Return patient's property in purple property bag and give family a bereavement booklet, telling them it contains helpful information on what they need to do next.
- If there is patient property in the Trust Cash Office, tell the family how to access it.
- Record all details and actions in the patient's nursing record. Complete Checklist following the Death of a Patient (appendix 11) and clip to outside of notes until complete.

It is the responsibility of the Ward/Department Sister to ensure that the General Practitioner or other relevant Community HSC Services are informed of the patient's death within one working day. This task may be delegated to other members of the ward team, e.g. Nurse in charge of the shift or Ward Clerk.

Removal Procedure

Across the Trust there are various removal arrangements in place, these are outlined below.

- Allow families time with their loved one before completing Last Offices.
- Before the removal takes place check that all of Section A of the Body Transfer Form has been completed in full (**all parts are important**!) and add any missing information. Record your name, designation and time of removal.
- Ask family if they are considering cremation and tell them additional documentation is required. Inform the patient's clinician if cremation is the family's choice as a doctor has to see the patient and complete cremation

documentation before removal. If this doesn't happen in the ward is the doctor will have to attend the Mortuary.

In **BCH, MIH, RVH** all deceased patients are transported to the Trust Mortuary on the Royal site by the Trust Contracted Funeral Director.

- Last Offices must be completed **before** requesting the Trust Contracted Funeral Director via switchboard as he may be on site and arrive before you are ready
- When contacting switchboard (0) to request attendance of the Trust Contracted Funeral Director provide: Name of ward, Name of patient, Any infection or manual handling risk.

In **MPH** the arrangement is that a Family Funeral Director is requested to attend the ward and remove the deceased patient. Any MPH patients, whose deaths cannot immediately be certified, should be transferred to the Trust Mortuary on the Royal site by the Trust Contracted Funeral Director. This can be arranged by contacting switchboard (0) and following the procedure outlined above.

In **Muckamore Abbey and Knockbracken Healthcare Park** the arrangement is that a Family Funeral Director is requested to attend the ward and remove the deceased patient. If the patient has no family or next of kin a local funeral director can be used.

NB. In the event of an unexplained or suspicious death all removals will be arranged by the PSNI and carried out by the Coroner's Contracted Funeral Director.

When the Funeral Director arrives to remove the deceased patient the name of the patient must be checked by ward staff and Funeral Director together. The ward will provide the equipment required for manual handling of the body.

- Check patient name and important information recorded in Section A, Body Transfer Form.
- Complete Section B of Body Transfer Form in full, i.e. removal time and name of Funeral Director.
- Give top 2 copies of Body Transfer Form to Trust Contracted Funeral Director or top copy only to Family Funeral Director.
- Prepare the ward and other patients for removal of the deceased patient, where possible pulling curtains

Multi faith/cultural considerations Appendix 9

This section contains information that will enable the provision of appropriate religious/spiritual care of the body after death. Hospital chaplains, the family or relevant faith community representatives may also provide specific support and information. The acute sites have 24/7 chaplaincy cover. Contact details for the on-call chaplains are available from Switchboard.

Even if a patient has not previously declared any particular religious affiliation it should not be assumed they/their family will have no spiritual or pastoral needs. The services of chaplains should also be offered in these situations, where appropriate.

For fuller information see:

- BHSCT Multi Cultural & Beliefs Handbook for all health and social care staff (2012)

Agnostic or atheistic

Last Offices – Normal procedures are appropriate

Bahá'í

Last Offices – Normal procedures are appropriate. Bahá'ís believe that after death the body should be treated with respect. Embalming is not allowed. It is customary for Bahá'ís to place a ring on the finger after death. In such circumstances it should not be removed.

Brahma Kumaris

Last Offices - Normal procedures are appropriate. Dedicated Brahma Kumaris would prefer the body to be in special white clothes although there is some flexibility in this.

Buddhist

A priest from the patient's tradition should be contacted as soon as possible and the body should not be moved too much before the priest arrives. Depending on the tradition, prayers could take an hour. It is possible that the priest will decide to recite prayers where he is or in a temple rather than come to the ward. In this case, last offices can continue as normal.

Last Offices - Normal procedures are usually acceptable, but check with family.

Christian

Last Offices - Routine Last Offices are appropriate.

Christian Science.

Last Offices -. Normal procedures are appropriate. Female staff should handle females after death (so far as possible).

Hindu

Some families may call a Hindu priest, a pandit, to perform holy rites. He may tie a thread around the shoulder down to the waist or round the neck or wrist of the dying person. Do not remove this thread or any other religious items before or after death without the family's agreement. When a Hindu dies, a priest is called to invoke blessings on the body.

Last Offices - After death the patient's body should be left uncovered. Consult the family about what they wish to be done and whether they wish to wash the body themselves

before taking it from the hospital. Often, elders in the family wash and prepare the body for the funeral. Non-Hindus handling the body can cause distress. Disposable gloves should be worn for necessary procedures not performed by the family. Religious items such as sacred threads and perhaps jewellery should not be removed except with the family's permission and, if possible, in their presence.

Humanist

Last Offices - Normal procedures are appropriate

Jain

Last Offices - The family may provide a white gown or shroud for the dead patient. They may also wish to be present and assist; this should be checked with the family.

Jehovah's Witness

Last Offices – Routine last offices are appropriate

Jewish

Last Offices - In some cases the son or nearest relative (if present) may wish to close the eyes and mouth. The arms should be extended by the side. The body is cleaned and wrapped in a plain linen shroud in preparation for burial.

Some Orthodox Jews will wish the deceased's body to remain where it is until their funeral director can come to take it away, but most will be happy for the body to be taken to the hospital mortuary until it can be collected. If the patient dies on the Sabbath, this, in any case, will be necessary, as they cannot be collected on that day.

Orthodox Jewish families will probably want watchers to stay with the deceased until collection. In this situation, necessary arrangements will need to be made with the Mortuary.

Mormon

Last Offices - Normal procedures are appropriate. A sacred garment must be placed on the body, following last offices.

Muslim

Last Offices - DO NOT wash the body or cut nails and hair

Wrap in a plain white sheet and do only the practical essential tasks following death and wear disposable gloves. The family and Muslim undertakers will carry out all Islamic requirements and you could distress the family by carrying out normal last offices. Muslims believe that the deceased retains some awareness until he/she is buried. Talk to the family and be guided by them on what is acceptable or helpful to them in carrying out the last offices.

It is normal practice for relatives of the deceased to wash the body. The body is dressed in a Kaffon (white shroud) and the foot of the bed is turned to face Mecca or the patient's head will be turned to the right shoulder in order that the deceased's face looks towards Mecca..

Pagan

Last Offices – Normal procedures are appropriate

Quaker

Last Offices - Normal procedures are appropriate.

Rastafarian

Last Offices – Normal procedures are appropriate.

Scientologist

Last Offices – Normal procedures are appropriate.

Seventh Day Adventist

Last Offices – Normal procedures are appropriate.

Sikh

Last Offices - Normal procedures are appropriate but DO NOT remove 5 K'S.

KESH - do not cut hair, beard or remove turban

KANGHA - comb

KARA - Sikh bracelet

KACHHA - special shorts/underwear

KIRPAN - sword.

NB. If, for any reason, the patient's KACHHA has to be removed, they should be replaced by another pair.

Spiritualist

Last Offices - Normal procedures are appropriate.

Zoroastrian

Last Offices - Normal procedures are appropriate The body should be placed in white clothing. The family may provide a special shirt to be worn under the clothing with the girdle. They may also wish for the head to be covered by a cap or scarf.

Body Transfer Forms 1a and 1b **Appendix 10**

Health and Social Care in Northern Ireland

BODY TRANSFER FORM (1A) ID number
USE TO TRANSFER ALL DECEASED CHILDREN AND ADULTS

Section A - To be completed before body is moved from place of death

Hospital/Facility: Ward/Dept: Consultant:

Name DOB:	Address:
Male ☐ Female ☐ H&C no.	Date of Death: Time of Death:

Death Certificate issued: Yes ☐ **IF NOT**, specify reason:
Has death been reported to the Coroner? No ☐ Yes ☐
If Yes, has Coroner ordered PM examination? No ☐ Yes ☐ Unsure ☐

Is a hospital PM examination to take place? No ☐ Yes ☐

Organ retrieval has occurred/is to take place. No ☐ Yes ☐ Specify:

Additional Information - if yes please specify. Detail:

Infection Risk (if pathogen 3 apply sticker) No ☐ Yes ☐_____

Property left on body No ☐ Yes ☐_____

Drains, tubes left in situ No ☐ Yes ☐_____

Cardiac pacemaker/implantable defibrillator in situ No ☐ Yes ☐_____

Spiritual/religious/cultural requirements No ☐ Yes ☐_____

Section A completed by:_____ (**PRINT NAME AND DESIGNATION**)

Section B - To be completed at time of transfer from place of death to:

Hospital mortuary ☐ State Pathology ☐ Family funeral director ☐ Own home ☐ Other ☐

Patient's Name checked by person releasing:_____ and person removing the body:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Section C - To be completed ONLY if body is transferred to hospital mortuary

C1 Patient named above admitted into mortuary **Date:** **Time:**
By: _____(**PRINT NAME AND DESIGNATION**)

C2 Patient released from mortuary **Date:** **Time:**

Patient's Name checked by person releasing:_____ and person removing the body:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Release authorisation: Death Certificate issued ☐ Coroner authorised ☐ Transferring for PM ☐

Health and Social Care in Northern Ireland

BODY TRANSFER FORM (1B) ID number USE TO TRANSFER ALL BABIES OVER 12 WEEKS GESTATION

Section A - To be completed before baby is moved from place of birth/death

Hospital/Facility: Ward/Dept: Consultant:
Name of mother: Address:
H&C no.

Complete Section A1) if baby miscarried/stillborn OR A2) if baby died after birth

A1) Baby miscarried/stillborn at ___weeks gestation Baby name (if given):
Date of delivery: Time: If required has Stillbirth Certificate been issued? Yes ☐ No ☐

A2) Baby born live at ___ weeks gestation Baby name (if given):
Date of birth: Date of death: Time: H&C no.
Death Certificate issued: Yes ☐ **IF NOT** specify reason:_____

Additional Information - if yes please specify. Detail:
Infection Risk (if pathogen 3 apply sticker) No ☐ Yes ☐_____
Drains, tubes left in situ No ☐ Yes ☐_____
Is hospital PM examination to take place? No ☐ Yes ☐
Has death been reported to the Coroner? No ☐ Yes ☐
If Yes, has Coroner ordered PM examination? No ☐ Yes ☐ Unsure ☐
Spiritual/religious/cultural requirements. No ☐ Yes ☐_____

Section A completed by:_____(**PRINT NAME AND DESIGNATION**)

Section B - To be completed at time of transfer from place of death to:

Baby transferring to: Hospital mortuary ☐ Family funeral director ☐ Own home ☐ Other ☐

Baby's/Mother's Name checked by person releasing:_____ and person

removing the baby:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Section C - To be completed ONLY if body is transferred to hospital mortuary

C1 Baby named above admitted into mortuary **Date:** **Time:**
by: _____ (**PRINT NAME AND DESIGNATION**)

C2 Baby released from mortuary **Date:** **Time:**

Baby's/Mother's Name checked by person releasing:_____ and person

removing the baby:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Release authorisation: Dr/Midwife authorised release ☐ Death or Stillbirth Certificate issued ☐
Coroner authorised ☐ Transferring for PM ☐ Baby returning to ward ☐

Appendix 11

2017 Check List of Nursing Actions required following Death of a Patient

- To be commenced by nursing staff conducting Last Offices Procedure
- Attach to front of Patient's Health Record until all sections completed
- File in Patient's Health Record on completion

Name and H&C No. of patient:		
GP Name and Telephone Number:		
	Time	Sign
Date and time of death is recorded in patient's health record		
Water Lily symbol displayed		
Next of Kin/ recorded carer has been informed		
Next of Kin/recorded carer attended after death		
General Practitioner has been informed		
Last Offices Procedure carried out by: Name (Printed): Designation: Name (Printed): Designation:		
Body Transfer Form Sections A & B completed		
Contracted Funeral Director (RVH BCH MIH via switchboard) or Family Funeral Director contacted		
Trust Bereavement Booklet/s given to family		
Patient Property placed in purple bag and returned to family		
Mortuary notified that MCCD is issued if appropriate (Tel. no. 90633679)		
Water Lily symbol removed		
Sympathy card signed and sending date recorded		
Other staff and services involved with patient informed		

Northern Ireland Regional Infection Control Manual Date Oct 2008 Appendix 12

Guidelines for cadavers with infections: www.infectioncontrolmanual.co.ni Issue

Advisable Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic Preparation
Low	Acute encephalitis	No	Yes	Yes	Yes
	Chickenpox/shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Lyme disease	No	Yes	Yes	Yes
	Measles	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Meticillin-resistant Staphylococcus aureus (MRSA)	No	Yes	Yes	Yes
	Ophthalmia neonatorum	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
Medium	Acute poliomyelitis	No	Yes	Yes	Yes
	Cholera	No	Yes	Yes	Yes
	Diphtheria	Adv*	Yes	Yes	Yes
	Dysentery	Adv*	Yes	Yes	Yes
	Food poisoning	No	Yes	Yes	Yes
	Hepatitis A	No	Yes	Yes	Yes
	HIV/AIDS	No	Yes	No	No
	Leptospirosis (Weil's disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes	Yes
	Paratyphoid fever	Adv*	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
	Relapsing fever	Adv*	Yes	Yes	Yes
	Meningococcal septicaemia	Adv*	Yes	Yes	Yes
	Scarlet fever	Adv*	Yes	Yes	Yes
	Tuberculosis	Adv*	Yes	Yes	Yes
	Typhoid fever	Adv*	No	No	No
	Typhus				
High	Anthrax	Adv*	No	No	No
	CJD and TSE	No	Yes	No	Yes
	Group A streptococcal infection (invasive)	No	Yes	Yes	Yes
	Hepatitis B and C	Yes	Yes	No	Yes
	Plague	Yes	No	No	No
	Rabies	Yes	No	No	No
	Smallpox	Yes	No	No	No
	Viral haemorrhagic fever	Yes	No	No	No
	Yellow Fever	Yes	No	No	No

References:
1. Healing TD, Hoffmann PN, Young SEJ. The infection hazards of Human Cadavers. CDR review 1995; (5); 61-68. (Available at: **www.hpa.org.uk/cdr/archives/CDRreview/1995/cdrr0595.pdf**)
2. Health and safety executive: Controlling the risks of infection at work from human remains. (Available at: **www.hse.gov.uk/pubns/web01.pdf**)

2.033

Belfast Health and Social Care Trust

Reference No: TP095/14

Title:	**Procedure for Grading an Incident**		
Author(s)	Claire Cairns Gillian Moore		
Ownership:	Medical Directorate		
Approval by:	Policy Committee Executive Team	**Approval date:**	7 April 2014 9 April 2014
Operational Date:	June 2014	**Next Review:**	June 2017
Version No.	V1 **Supercedes**		
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Investigating an Incident Guidance on RIDDOR reporting Guidelines for Writing a Statement following an Incident Being Open Policy Whistleblowing Policy		

Date	Version	Author	Comments
20/06/2013	0.1	G Moore	Initial Draft
27/06/2013	0.2	G Moore	Comments from Corporate Governance team
30/10/2013	0.3	G Moore	Comments from Corporate Governance team
20/11/2013	0.4	G Moore	Comments from Corporate Governance team
06/03/2014	0.5	G Moore	Comments from Directorate Governance colleagues

1.0 INTRODUCTION

All adverse incidents should be investigated commensurate with the actual severity (actual harm, loss or damage) and/or the potential risk grading. The grading will assist in deciding what level of investigation is required and at what level within the Trust the investigation should be conducted. An initial assessment of the incident severity and risk grade should be undertaken to allow staff to progress appropriately. This can be reviewed following further investigation and amended accordingly.

Tables 1, 2 and 3 below have been agreed regionally to assist in assessing severity and risk grade as objectively and consistently as possible, however it is inevitable that the process will involve a degree of subjectivity. It is recognised that not all incident scenarios fit neatly into one or other of the domains but staff should use their judgement, and view the tables 1and 2 as a guide to assist them towards effective and consistent grading.

The severity and risk grade will be decided initially by the reporting area but may be subject to review by the Corporate Governance Department as part of the quality assurance process. As a result of this, the reporting area may be contacted and asked to review the grading.

2.0 SCOPE OF THE PROCEDURE

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

3.0 ROLES/RESPONSIBILITIES

3.1 Responsibilities of the Incident Reporter

Determining the Severity (actual harm, loss or damage)

3.1.1 Ensure you have included **all** the relevant facts in the description on the incident form. This will assist in accurately grading the incident at the time and will allow for a clear understanding of the basis for the grading decision, either at a later date or for other staff viewing the incident.

3.1.2 Based on the perceived outcome of the incident **at the time**:

- Using table 1 below, choose the most appropriate domain(s) for the adverse incident from the left hand side of the table.
- Work along the columns in the row to assess the most applicable severity. If the incident could fall into more than one domain and the severity differs between these, a general rule of thumb is to choose the highest severity.

3.1.3 Enter this severity on the electronic incident form (Datixweb).

(For areas still using paper incident forms, b) and c) above will be completed by the line manager.)

3.2 Responsibilities of the Approving / Line Manager

3.2.1 Review the severity grading on the electronic incident form (Datixweb). If you feel it is incorrect, discuss this with the reporter and change the severity as required. (For areas still using paper incident forms complete points b) and c) above and complete section 10 of the form.)

Determining the Risk Grade

3.2.2 Using table 1 below, choose the most appropriate domain for the adverse incident from the left hand side of the table.

3.2.3 Work along the columns in the same row to assess the most probable potential consequence if this type of incident were to happen again. If the incident could fall into more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

3.2.4 Using table 2 below, and based on your knowledge of your own area, determine the likelihood of this type of incident happening again under similar circumstances. The frequency column is the one most often used however the time framed descriptions of frequency or the probability can be used instead, if considered more appropriate.

3.2.5 Plot the consequence and likelihood on the risk matrix in the electronic incident form (Datixweb), (also illustrated in table 3 below) to determine the risk grade – low, medium, high or extreme. (For areas still using paper incident forms complete section 12 of the form.)

The severity and/or risk grade now determines the level of investigation required. See the Investigation procedure for full guidance.

3.2.6 If following investigation, the severity and/or risk grading requires amendment, the approving / line manager should action this on the Datixweb incident form. (For areas still using paper incident forms, contact Corporate Governance to amend the record on your behalf.)

Table 1

Appendix 1

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Table 3

	Consequence Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

SIGNATORIES

Name Dr Tony Stevens
Title Medical Director

Date: 9 April 2014

Name Colm Donaghy
Title Chief Executive

Date: 9 April 2014

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP095/14

Title:	**Procedure for Grading an Incident**			
Author(s)	Claire Cairns, Senior Manager Corporate Governance Gillian Moore, Admin & Datix Manager			
Ownership:	Medical Directorate			
Approval by:	Policy Committee Executive Team		**Approval date:**	11th January 2018 24th January 2018
Operational Date:	January 2018		**Next Review:**	January 2023
Version No.	V2	**Supercedes**	V1 – June 2014 - 2017	
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Investigating an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Guidelines for Writing a Statement following an Incident Being Open Policy Whistleblowing Policy			

Date	Version	Author	Comments
20/06/2013	0.1	G Moore	Initial Draft
27/06/2013	0.2	G Moore	Comments from Corporate Governance team
30/10/2013	0.3	G Moore	Comments from Corporate Governance team
20/11/2013	0.4	G Moore	Comments from Corporate Governance team
06/03/2014	0.5	G Moore	Comments from Directorate Governance colleagues
29th November 2017	1.1	Gillian Moore	Interim update pending regional policy / procedures.

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The severity and risk grade will be decided initially by the reporting area but may be subject to review by the Corporate Governance Department as part of the quality assurance process. As a result of this, the reporting area may be contacted and asked to review the grading.

2.0 SCOPE OF THE PROCEDURE

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

3.0 ROLES/RESPONSIBILITIES

3.1 Responsibilities of the Incident Reporter

Determining the Severity (actual harm, loss or damage)

3.1.1 Ensure you have included **all** the relevant facts in the description on the incident form. This will assist in accurately grading the incident at the time and will allow for a clear understanding of the basis for the grading decision, either at a later date or for other staff viewing the incident.

3.1.2 Based on the perceived outcome of the incident **at the time**:

- Using table 1 (Appendix 1), choose the most appropriate domain(s) for the adverse incident from the left hand side of the table.
- Work along the columns in the row to assess the most applicable severity. If the incident could fall into more than one domain and the severity differs between these, a general rule of thumb is to choose the highest severity.

3.1.3 Enter this severity on the incident form

3.2 Responsibilities of the Approving / Line Manager

3.2.1 Review the severity grading on the incident form. If you feel it is incorrect, discuss this with the reporter and change the severity as required.

Determining the Risk Grade

3.2.2 Using table 1 (Appendix 1), choose the most appropriate domain for the adverse incident from the left hand side of the table.

3.2.3 Work along the columns in the same row to assess the most probable potential consequence if this type of incident were to happen again. If the incident could fall into more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

3.2.4 Using table 2 (Appendix 1), and based on your knowledge of your own area, determine the likelihood of this type of incident happening again under similar circumstances. The frequency column is the one most often used however the time framed descriptions of frequency or the probability can be used instead, if considered more appropriate.

3.2.5 Plot the consequence and likelihood on the risk matrix in the incident form (Datixweb), (also illustrated in table 3, Appendix 1) to determine the risk grade – low (green), medium (yellow), high (amber) or extreme (red). (For areas still using paper incident forms complete section 12 of the form.)

The severity and/or risk grade now determines the level of investigation required. See the Investigation procedure for full guidance.

3.2.6 If following investigation, the severity and/or risk grading requires amendment, the approving / line manager should action this on the incident form. (For locations still using paper incident forms, contact the Corporate Governance Dept at incident.reporting@belfasttrust.hscni.net to amend the record on your behalf.)

SIGNATORIES

24 January 2018

Date: _____

Name Dr Cathy Jack
Title Deputy Chief Executive/
Medical Director

24 January 2018

Date: _____

Name Martin Dillon
Title Chief Executive

Table 1 **Appendix 1**

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Table 3

	Consequence Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Belfast Health and Social Care Trust
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Reference No: TP096/14

Title:	**Guidelines for Writing a Statement following an Incident**			
Author(s)	Claire Cairns, Senior Manager Corporate Governance			
Ownership:	Medical Directorate			
Approval by:	Policy Committee Executive Team		**Approval date:**	11th January 2018 24th January 2018
Operational Date:	January 2018		**Next Review:**	January 2023
Version No.	V2	**Supercedes**	V1 – June 2014 - 2017	
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Grading an Incident Procedure for Investigating an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Being Open Policy Whistleblowing Policy			

Date	Version	Author	Comments
24th April 2013	0.1	Claire Cairns Gillian Moore	Final version
December 2013	0.2	Claire Cairns Gillian Moore	Revised version
June 2014	1	Claire Cairns Gillian Moore	Revised version
29th November 2017	1.1	Gillian Moore	Interim update pending regional AI policy / procedures

Guidelines for Writing a Statement following an Incident

1. There are many circumstances in which you may be called upon to provide a written statement. This may be as a result of being asked to give an opinion as a health care professional, or as part of an investigation into an adverse incident, complaint or claim. Reports may be of a factual nature, such as a description of the events surrounding an adverse incident, or an opinion, which is an interpretation of facts such as an evaluation of a patient's prognosis. The report should be directed to the purpose for which it is required, it is therefore important that you recognise what type of statement you are being required to give.

2. These guidelines aim to provide you with some simple advice on preparing a statement of fact, which has been requested for an investigation into an untoward event that has occurred during the course of your employment.

3. You must assume that the reader of your statement knows nothing of the facts of the case, of the patient/service user's medical history or of hospital routines. The statement will thus form a story which will tell an intelligent lay person (the coroner in the case of a death) the circumstances of the adverse incident as you remember them.

4. If you were the witness to an adverse incident, the Witness Statement form (Appendix 1) is provided for your use.

5. Use good quality A4 paper. Do not use scraps of paper, pages from notepads, medical records sheets, or the backs of documents designed for other purposes.

6. Statements should be typed using only one side of each page. Wide margins and double line spacing are recommended. If it is not possible to have your statement typed you must write neatly using black ink.

7. Each page should be numbered consecutively in the right hand corner and all of the pages should be securely fastened together.

8. Each page should include the adverse incident, complaint or claim reference number.

9. Begin the statement with your name, professional qualifications, length of service and what post you hold within the Trust.

10. Be clear about the times you were on and off duty on the days in question and about what you saw and heard. Put events in the order in which they happened giving precise dates and times (using am or pm or the 24 hour clock). Explain what was happening at the time of the incident and describe the environment in which the incident occurred.

11. State your location at the time of the adverse incident and name any other witnesses who were present. When referring to other people in your statement give their full names and job titles.

12. Stick to facts and avoid expressing opinions. Only include facts or conversations you have actually witnessed or taken part in. Do not include things that other people told you happened or conversations reported to you.

13. Write the statement in simple terms and avoid using jargon or abbreviations. Be as brief as possible while covering all essential points.

14. All numbers, including dates, should be expressed in figures, not words.

15. If you include in your statement any information you have read in professional records, documents, papers or notes you should include references as to where it can be found e.g.: "It is recorded on 23/9/2002 on Mrs Smith's communication sheet that a request for a CT scan had been sent to Radiology."

16. Your statement should be written in the first person i.e.: "I was asked by Staff Nurse Jane Smith to record Mr Green's blood pressure."

17. Any alterations to your statement should be made by drawing a single line through the words you wish to change. This should then be initialled.

18. The final paragraph of your statement should read: "This statement is true to the best of my knowledge and belief."

19. Your statement should be signed and dated. You should also print your full name and job title.

20. Double check your statement before signing it. It is recommended that you keep a copy of your statement for your own records.

21. Remember that statements should be factual and accurate and you should make sure that you are happy for others to read it. If you need help or advice in writing a statement, ask your manager.

SIGNATORIES

Date: 24 January 2018

Name Dr Cathy Jack
Title Deputy Chief Executive/ Medical Director

Date: 24 January 2018

Name Martin Dillon
Title Chief Executive

Appendix 1

Belfast Health and Social Care Trust
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WITNESS STATEMENT FORM										
Surname (PRINT)										
Forename (PRINT)										
Title	Dr.		Mr.		Miss.		Ms.		Mrs.	
Job Title(PRINT)										
Directorate/Area										
Home Address										
Contact phone no:										

INCIDENT DETAILS			
I was a witness to an incident that occurred:			
Site:			
Exact locations – section room etc			
Date		Time	
Incident form reference no:			

Factual description of the incident
I confirm that the contents of this, my statement, are true to the best of my knowledge, information and belief.

Signed		**Date**	

2.044

Belfast Health and Social Care Trust

Belfast Health and Social Care Trust

Reference No TP98/14

Title:	Procedure for sharing learning		
Author(s)	Claire Cairns, Senior Manager, Corporate Governance Shane McCaul, Governance Manager, Corporate Governance		
Ownership:	Medical Directorate		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	30 June 2014 09 July 2014
Operational Date:	June 2014	**Next Review:**	March 2015
Version No.	V(1)	**Supercedes**	
Key words:	Incident, Serious Adverse Incident, SAI, Learning, Investigation, Action Plan, Complaint, Litigation, Incident feedback, Sharing learning, Shared learning		
Links to other policies	- Adverse Incident Reporting & Management Policy - HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013		

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3.0 Sources of learning	**4**
4.0 Incident investigation	**4**
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7.0 Evidence base	**7**
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Belfast Health and Social Care Trust

1.0 Introduction

This procedure concerns primarily the learning from Adverse Incidents including those resulting in a near miss.

When an adverse incident occurs or a patient/client has sub-optimal experience in our service or in another Trust we owe it to our service users and ourselves to learn from such events and reduce the chance of similar experiences happening again.

Sir Liam Donaldson, speaking on patient safety, said in 2007: -

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable"

Learning obtained from incidents can be defined as safety, practice and process issues which have contributed to the incident but from which others can learn.

Examples of learning are:-

- Solutions to address incident root causes which may be relevant to other teams, services and provider organisations.
- Good practice which reduced the potential impact of the incident.
- Early detection or intervention which reduced the potential impact of the incident.
- Lessons from conducting the investigation which may improve the management of investigations in future.

Other Sources of Learning

Learning may also be derived from a number of other sources. These include:-

- a complaint,
- litigation,
- an audit,
- Other established processes which identify learning for sharing such as Mortality and Morbidity reviews / Cardiac arrest reviews,
- Events in other Trusts sometimes result in a learning letter from that Trust, HSCB or the DHSSPS.

1.1 Purpose of this procedure

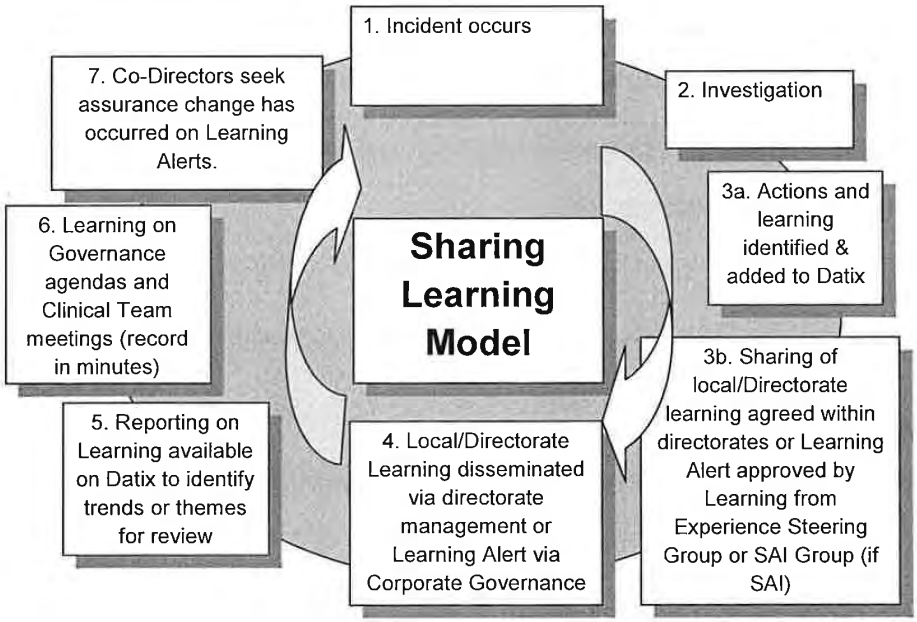
Belfast Health and Social Care Trust

Staff learn from incidents but there needs to be an approved procedure for ensuring learning is shared with all parts of the organisation to which it applies. This includes the need to have a learning repository for staff to refer to. The Trust "Safety Matters" newsletter exists to support this role. This procedure will outline how learning should be captured and shared in the Belfast Health & Social Care Trust.

1.2 Scope of this procedure

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

2.0 Shared Learning Model



3.0 Sources of Learning

This procedure concerns primarily the learning from Adverse Incidents including those resulting in a near miss. Please note that the learning may also be derived from a complaint, litigation, or an audit finding in the Belfast Trust and will be escalated to the Learning From Experience Steering Group via the assurance framework committee structure. Work has commenced to further develop the learning model to improve links with established processes

which identify learning for sharing such as Mortality and Morbidity reviews and this will be reflected in version 2.

Events in other Trusts sometimes result in a learning letter from that Trust, HSCB or the DHSSPS. In this case the learning cycle will be initiated by the Medical Director's Directorate.

4.0 Incident Investigation

4.1 Incidents (except Serious Adverse Incidents (SAIs))

All incidents must be investigated as per the Trust Incident Investigation Procedure (excluding SAI's) and any identified learning shared as set out in section 5 below.

4.2 SAIs

All SAIs must be investigated as per the HSCB Procedure for the reporting and follow up of SAIs October 2013, using the investigation report templates contained within that procedure. The templates for Level 1and Level 2&3 type investigations include a section on Learning.

Within investigation reports it is important that: -

- Learning is clearly identified and addressed by the recommendations and relates to the findings.
- A learning section should indicate to whom learning needs to be communicated.

4.3 Action Plans

SAI action plans should include actions for sharing of lessons learned from SAI investigations as appropriate.

5.0 Types of Learning

5.1 Local learning (ward/department)

Learning deemed relevant only to the ward or department where the incident occurred should be discussed at the local staff/team meeting and recorded on the Datix system. The incident approver on Datixweb should ensure the learning is entered in the appropriate field within the Investigation section of the incident form along with any investigation completed and action taken.

Local Learning from incidents reported on paper forms should be forwarded along with any investigation/action taken to Corporate Governance department quoting the incident reference number for inclusion on the Datix system with that incident. These will then be available for sharing electronically as appropriate with the ability to cross-reference to the incident for context and coding of themes.

5.2 Shared Learning

Often learning from incidents will be relevant to other areas across the specialty or directorate where the incident occurred. In these circumstances the learning should be shared via Directorate assurance structures and Governance groups as well as using the Datix system as above to ensure learning is captured. The learning should all be included in directorate governance agenda and discussion/action noted in minutes (for audit trail).

Where learning is relevant beyond the directorate responsible, a Learning Alert may be used in addition to the methods above. This should be used within the functions of the assurance framework and reported through to the learning from Experience sub-committee who provide assurance that learning is shared appropriately.

5.3 Learning Alert

A learning alert notice is a communication tool, to enable one service to share the learning from an adverse incident, with other relevant services. The learning alert will be usually a one page document recorded on a Shared Learning Template (see appendix 1). This can be easily read, displayed and filed.

The drafting of the Learning alerts will be the responsibility of the Director / Co-Director responsible for the incident.

Learning Alerts should not name staff or the specific unit where the learning event occurred.

Learning that is deemed relevant to other directorates should be tabled by the relevant Director / Co-Director at the Learning from Experience Committee for a decision for sharing as a learning alert. If approved for sharing, the Learning Alert will then be disseminated by Risk & Governance department to the relevant directorates for confirmation of action taken within 3 months. Please see flowchart in appendix 2.

All learning alerts disseminated will be inserted into a folder in the Risk & Governance webpage in the Hub for easy reference.

5.4 Learning from SAIs

Members of the SAI Group (Co-directors/ Governance & Quality Managers) will provide a report on any learning from their current SAIs for sharing beyond their directorate (or other issues to be raised).

The Shared learning template (appendix 1) should be used for this purpose. The SAI Group will be responsible for the final wording and dissemination of the alert both Trust wide and regionally.

5.5 Regional shared learning

The Trust receives and is expected to act upon learning letters from HSCB, DHSSPS or other agencies and in external/regional audit findings.

The HSCB has a responsibility to share learning across relevant agencies from Trust SAI Investigation reports and associated action plans.

However, if the Trust has identified learning that other Trusts should be alerted to either urgently or outside the SAI process, if possible this should be shared promptly from Trust to Trust. The Learning Alerts will be used for this purpose and a decision on sharing the learning will be made by the SAI Group/ Medical Director. The Learning Alerts will be shared externally through the Corporate Governance Department.

6.0 Monitoring

The process for monitoring the effectiveness of all of the above will be managed via the following arrangements:

- Accountability/Performance Management Reviews
- Adverse Incident Training records
- Assurance Framework
- Belfast Risk Audit & Assessment Tool (BRAAT)
- Controls Assurance Standards
- Directorate Assurance meetings
- Serious Adverse Incident Group

7.0 Evidence Base

See Adverse Incident Reporting & Management policy

8.0 Consultation process

Serious Adverse Incident Group

9.0 Equality Statement

Belfast Health and Social Care Trust

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 procedure should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this procedure is:

Major Impact	☐
Minor Impact	☐
No impact	X

SIGNATORIES

Name Dr Tony Stevens
Title Medical Director

Date: 9 July 2014

Name Martin Dillon
Title Interim Chief Executive

Date: 9 July 2014

Belfast Health and Social Care Trust

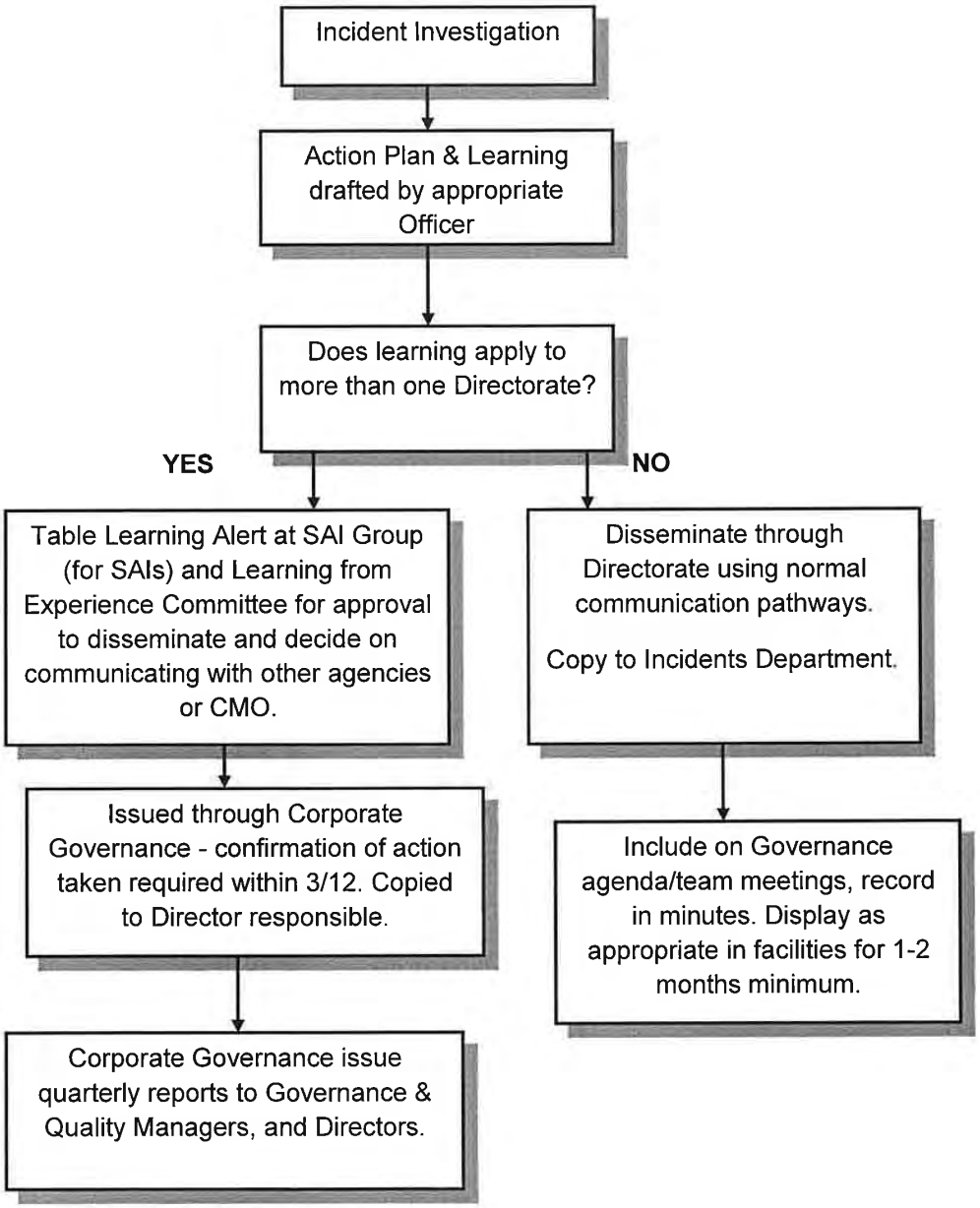
Appendix 1

Shared Learning Template Belfast Health and Social Care Trust	**Incident/SAI Ref:**	**Date:**
Directorate		
Service Area		
Summary of event		
Learning for sharing beyond directorate		
Learning applicable to:		
Specific Directorate(s)		Trust wide
		Regional
Action required (*for discussion and agreement at Learning from Experience/SAI Group*)		
Date:	Signed:	Designation:

Belfast Health and Social Care Trust

Appendix 2

DISSEMINATION OF BHSCT TRUST LEARNING ALERTS



2.045

Belfast Health and Social Care Trust
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Reference No: TP 98/14

Title:	**Policy for sharing learning**			
Author(s)	Colin McMullan, Senior Manager Corporate Governance (Version 2) Claire Cairns, Senior Manager, Corporate Governance Shane McCaul, Governance Manager, Corporate Governance			
Ownership:	Cathy Jack, Medical Director			
Approval by:	Trust Policy Committee Executive Team		**Approval date:**	11 April 2016 20 April 2016
Operational Date:	May 2016		**Next Review:**	May 2019
Version No.	V2	**Supercedes**	V1 – June 2014- March 2015	
Key words:	Incident, Serious Adverse Incident, SAI, Learning, Investigation, Action Plan, Complaint, Litigation, Incident feedback, Sharing learning, Shared learning, Mortality and Morbidity			
Links to other policies	- Adverse Incident Reporting & Management Policy - HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013 - Complaints and Compliments Policy - Claims Management Policy - General Health & Safety Policy and other specific Trust Health & Safety Policies			

Consultation with:

- SAI Group
- Claims Review Group
- Complaints Review Group
- Outcomes Review Group
- Standards & Guidelines Committee
- Medicines Management Group
- Safety Improvement Team
- Strategic Group for Quality Improvement & Development (SQUID)
- Deteriorating Patient Group

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This policy covers learning identified from internal sources such as incidents, litigation, complaints and compliments, Mortality and Morbidity meetings, and also learning from external sources such as NIAIC, other HSC Trusts and Learning Letters from Commissioners.

When an incident occurs or a patient/client has sub-optimal experience in our service or in another Trust we owe it to our service users and ourselves to learn from such events and reduce the chance of similar experiences happening again.
Sir Liam Donaldson, speaking on patient safety, said in 2007: -

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable"

Learning obtained from incidents can be defined as safety, practice and process issues which have contributed to the incident but from which others can learn. Examples of learning from an incident are:

- Solutions to address incident root causes which may be relevant to other teams, services and provider organisations.
- Good practice which reduced the potential impact of the incident.
- Early detection or intervention which reduced the potential impact of the incident.
- Lessons from conducting the investigation which may improve the management of investigations in future.

Learning may also be derived from a number of other sources, including a complaint or compliment, mortality review, litigation, audit, regional learning shared by DHSSPS / HSCB.

1.2 Purpose

This policy outlines how learning should be captured and shared in the Belfast Health & Social Care Trust.

1.3 Objectives

1.3.1 To ensure that learning is shared with all parts of the organisation to which it applies.

1.3.2 To keep and make available a central repository of learning on the hub.

2.0 SCOPE OF THE POLICY

This policy applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency staff, contractors and volunteers.

3.0 ROLES/RESPONSIBILITIES

Corporate Governance will take responsibility for receiving all Trust-wide learning from the various sources. They will be responsible for dissemination to Directorates and for maintaining a central repository of all learning shared.

Directors will be responsible for ensuring that all Shared Learning received is disseminated to teams and relevant staff. As well as the dissemination of learning via email, it is important that learning is discussed with clinical teams if relevant for the specialty or at Directorate governance meetings.

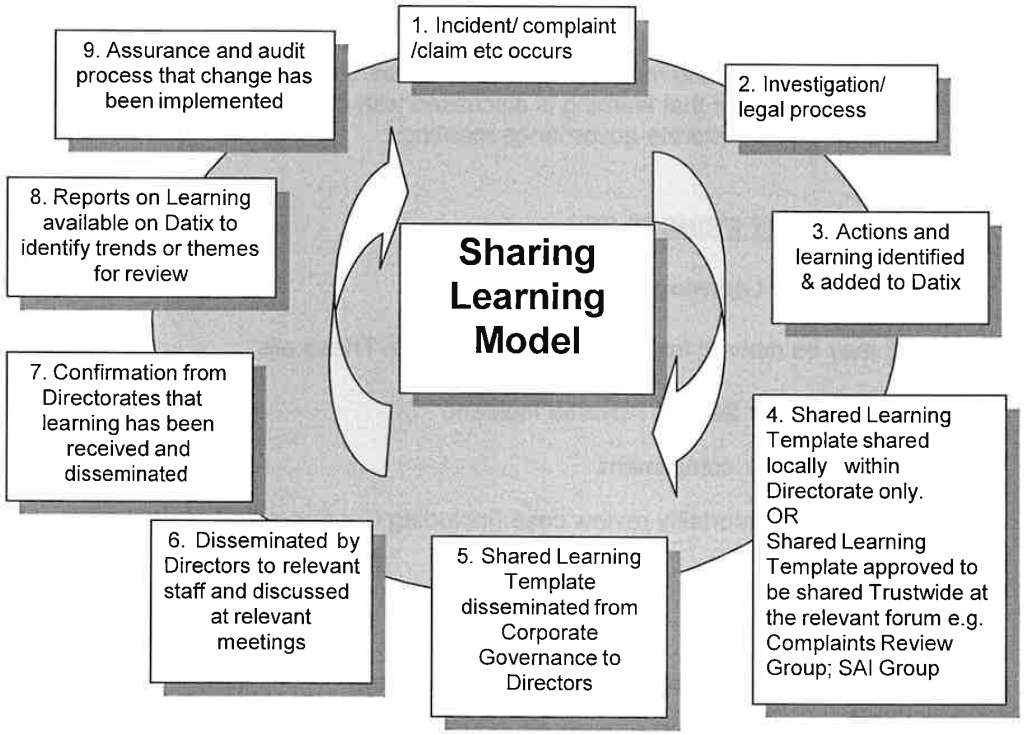
4.0 KEY POLICY PRINCIPLES

4.1 Sources of Learning

Learning may be derived from a number of sources. These are:

- An incident or Serious Adverse Incident,
- a complaint or compliment,
- a morbidity / mortality review case (including Cardiac Arrest reviews),
- a litigation case,
- an audit,
- A Case Management Review (child protection),
- Events in other Trusts sometimes result in a learning letter from that Trust, the Health and Social Care Board (HSCB) or the DHSSPS,
- Concerns raised by staff.

4.2 The Shared Learning Model



4.3 Incident Investigation

4.3.1 Incidents (except Serious Adverse Incidents (SAIs))

All incidents must be investigated as per the Trust Incident Investigation Procedure (excluding SAI's) and any identified learning shared as set out in section 4.4 below.

4.3.2 SAIs

All SAIs must be investigated as per the HSCB Procedure for the reporting and follow up of SAIs October 2013, using the investigation report templates contained within that procedure. The templates for Level 1and Level 2&3 type investigations include a section on Lessons Learnt.

Within investigation reports it is important that:

- Learning is clearly identified and addressed by the recommendations and relates to the findings.
- A learning section should indicate to whom learning needs to be communicated.

4.3.3 Action Plans

Action plans in response to SAIs, Complaints, Audit, etc., should include actions for sharing of lessons learned from investigations as appropriate.

4.4 Types of Learning

4.4.1 Local learning (ward/department)

Learning deemed relevant only to the area or department where the incident or complaint occurred should be discussed at the local staff/team meeting and recorded on the Datix system. The incident approver on Datixweb should ensure the learning is entered in the appropriate field within the Investigation section of the incident form along with any investigation completed and action taken.

4.4.2 Shared Learning within Directorates

Often learning from incidents or complaints will be relevant to other areas across the specialty or Directorate where the incident occurred. In these circumstances the learning should be shared via Directorate assurance structures and Governance groups as well as using the Datix system as above to ensure learning is captured. The learning should be included on Directorate governance agendas and discussion/action noted in minutes (for audit trail).

Where learning is relevant beyond the Directorate responsible, a Shared Learning Template (see 4.4.3) may be used in addition to the methods above. This should be discussed and approved at the relevant Group within the Assurance Framework and reported through to the Learning from Experience Steering Group which provides assurance that learning is shared appropriately.

4.4.3 Shared Learning Template – Trustwide

A Shared Learning Template is a communication tool to enable one service to share learning from an adverse incident, complaint, or other event, with other relevant services. The Shared Learning Template will usually be a one page document (see Appendix 1). This can be easily read, displayed and filed.

Shared Learning Templates should not name staff or the specific unit where the event occurred. Patient/client/service user confidentiality must not be breached and information is shared within the confines of the Data Protection Act.

Learning that is deemed relevant to other Directorates should be tabled by the Director / Co-Director at the relevant meeting, such as SAI Group, Complaints Review Group, etc., or at the Learning from Experience Steering Group for a decision for sharing across the Trust. If approved for sharing, the Shared Learning Template will then be disseminated by the Corporate Governance department to the relevant Directorates. Confirmation that learning has been received and disseminated will be sought by the Corporate Governance team. Please see flowchart in Appendix 2. All Shared Learning Templates disseminated will be available on the Risk & Governance webpage on the Hub.

4.4.4 Regional shared learning

The Trust receives and is expected to act upon Learning Letters from HSCB, DHSSPS or other agencies and from external/regional audit findings. External Learning Letters will be disseminated from the Corporate Governance department to Directors for onward dissemination.

The HSCB has a responsibility to share learning across regional HSC organisations as appropriate. However, if the Trust has identified learning that other Trusts should be alerted to urgently this should be shared promptly from Trust to Trust.

4.4.5 Other methods of sharing learning within the Belfast Trust

Safety Matters is the Trust newsletter relating to improving the safety and quality of services and sharing learning from incidents and other events.

Safety Message of the Week is published weekly on the hub and is discussed at relevant governance meetings. All teams across the Trust can contribute safety messages for publication.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Following approval, the policy will be disseminated widely. Implementation will begin immediately through issuing of shared learning from Corporate Governance.

5.2 Resources

The dissemination of learning templates from Corporate Governance will initially be done via e-mail. Corporate Governance are exploring using DATIX to issue the learning as this would support a process where we could formally close off that learning has been shared (as it is used for medical device alerts). This will be investigated and may require some resource.

5.3 Exceptions

None.

6.0 MONITORING

The process for monitoring the effectiveness of all of the above will be managed via the following arrangements:

- Accountability/Performance Management Reviews
- Adverse Incident Training records
- Assurance Framework
- Belfast Risk Audit & Assessment Tool (BRAAT)
- Controls Assurance Standards
- Directorate Assurance meetings
- Serious Adverse Incident Group
- Claims Review Group
- Complaints Review Group

Learning that is to be shared Trustwide, from any source, will be formally signed off by Directorates. Co-Directors / Governance & Quality Managers will confirm that the Shared Learning Template was received and disseminated appropriately. Co-Directors / Governance & Quality Managers will provide this assurance at the

relevant meeting (SAI Group, Claims Review Group, Complaints Review Group etc), or upon request to the Corporate Governance department. An electronic or online method will be sought for this assurance.

If a Shared Learning Template identifies a gap or inadequacy within a service area this should be highlighted on the appropriate Risk Register and via Directorate governance structures.

7.0 EVIDENCE BASE / REFERENCES

- See Adverse Incident Reporting & Management policy; Complaints and Compliments Policy

8.0 CONSULTATION PROCESS

- Serious Adverse Incident Group
- Claims Review Group
- Complaints Review Group
- Outcome Review Group, including feedback from Morbidity & Mortality Leads.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Shared Learning Template
Appendix 2 - Dissemination of BHSCT Shared Learning Templates

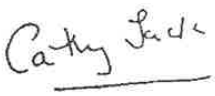
10.0 EQUALITY STATEMENT

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. X

SIGNATORIES

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



Date: 20 April 2016

Dr Cathy Jack
Medical Director

Date: 20 April 2016

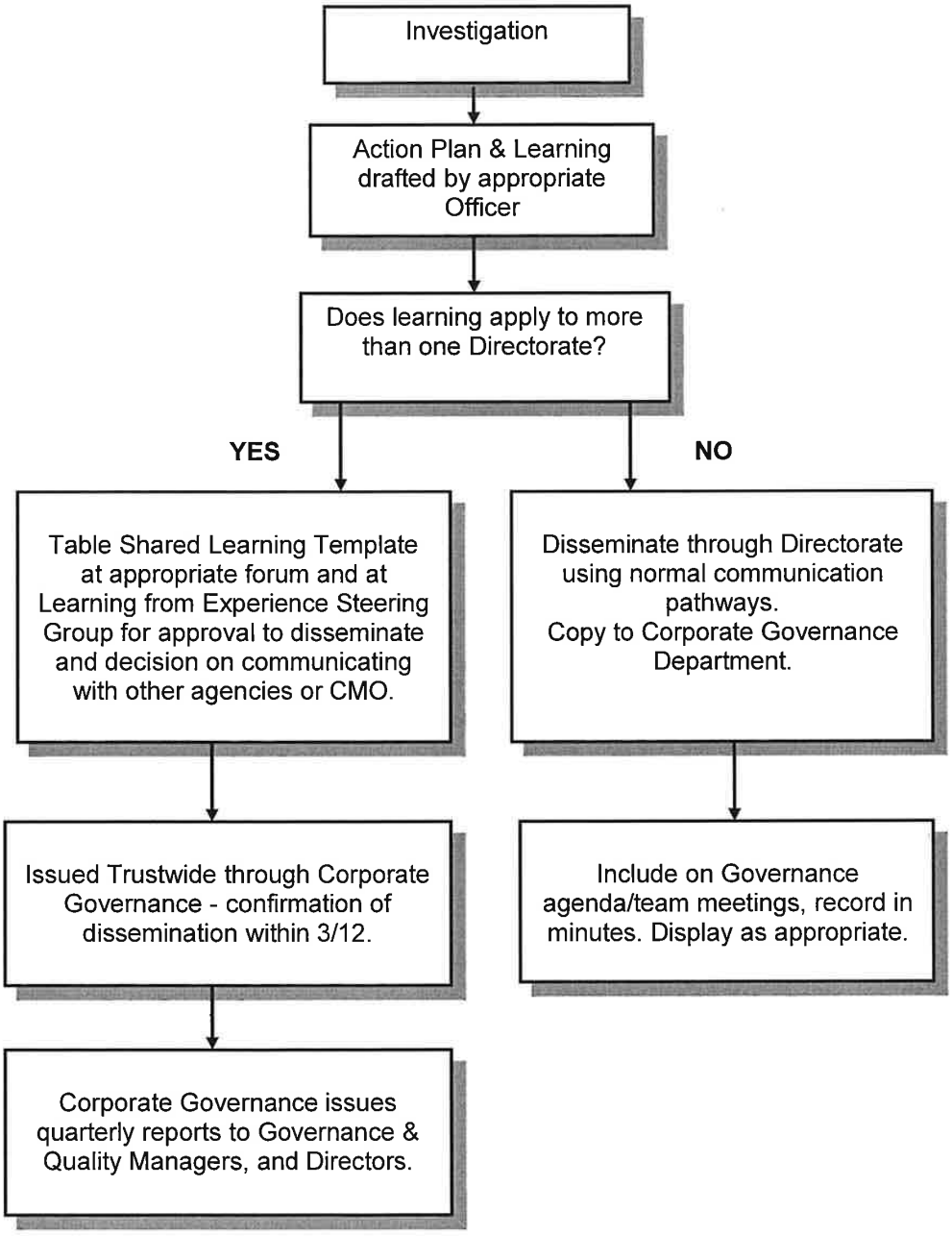
Dr Michael McBride
Chief Executive

Appendix 1

Shared Learning Belfast Health and Social Care Trust caring supporting improving together	**Incident/SAI/Complaint/ Compliment/Audit/ External Letter/ M&M Review/ CMR/Litigation Ref. No.**	**Date issued:**
Safety Message:		
Summary of Event		
Learning Points		
Learning applicable to:		
Specific Directorate(s) (specify):		Trustwide
Other (specify):		Regional
Action Required *(for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group)*		
Approved by:	Designation:	Date approved:

Appendix 2

DISSEMINATION OF BHSCT SHARED LEARNING TEMPLATES



Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 98/14

Title:	**Policy for Sharing Learning**		
Policy Author(s)	Claire Cairns, Co-Director, Risk and Governance Tel: [redacted] Robert Henry, Senior Manager, Corporate Governance Tel: [redacted] Gillian Harkness, Governance Manager, Corporate Governance Tel: [redacted] Fiona Gribben, Assurance Co-Ordinator, Risk and Governance Tel: [redacted]		
Responsible Director:	Chris Hagan, Medical Director		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☐	Non Clinical Trust Wide ☒
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			
Date:			

Approval process:	Trust Policy Committee Executive Team	**Approval date:**	08 October 2020 13 October 2020
Operational Date:	October 2020	**Review Date:**	October 2025
Version No.	3	**Supercedes**	V2 – May 2016 – May 2019
Key Words:	Incident, Serious Adverse Incident, SAI, Learning, Investigation, Action Plan, Complaint, Litigation, Incident feedback, Sharing learning, Shared learning, Mortality and Morbidity, Safety and Quality Alerts, SQAs		
Links to other policies	BHSCT Adverse Incident Reporting and Management Policy (2018) TP 94/14 BHSCT Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments (2020) TP 45/10 BHSCT Claims Management and the Engagement of Legal Services (2017) TP 27/08 BHSCT Health and Safety Policy (2018) TP 50/08 Other specific BHSCT Health and Safety Policies HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents HSCB/PHA Regional Policy for Safety and Quality Alerts BHSCT Whistleblowing Policy Appendix 1: Shared Learning Template		

Date	Version	Policy Author	Comments
October 2020	2.1		Policy reviewed

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1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

This policy covers learning identified from internal sources such as adverse and serious incidents; litigation; complaints and compliments; Mortality and Morbidity meetings; and learning from external sources such as NIAIC, other HSC Trusts, and learning from Commissioners.

When an incident occurs or a patient/client has sub-optimal experience in our service or in another Trust we owe it to our service users and ourselves to learn from such events and reduce the chance of similar experiences happening again.

Sir Liam Donaldson, speaking on patient safety, said in 2007:

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable"

Learning obtained from incidents can be defined as safety, practice and process issues which have contributed to the incident but from which others can learn.

Examples of learning from an incident are:

- Solutions to address incident root causes which may be relevant to other teams, services and provider organisations.
- Good practice which reduced the potential impact of the incident.
- Early detection or intervention which reduced the potential impact of the incident.
- Lessons from conducting the investigation which may improve the management of investigations in future.

Learning may also be derived from a number of other sources, including a complaint or compliment, mortality review, litigation, audit, regional learning shared by DHSSPS / HSCB.

1.2 Purpose

This policy outlines how learning should be captured and shared across the Belfast Health & Social Care Trust (BHSCT).

1.3 Objectives

1.3.1 To ensure that learning is shared with all parts of the organisation to which it applies.

1.3.2 To keep and make available a central repository of learning on the hub.

2.0 SCOPE OF THE POLICY

This policy applies to all staff in the Belfast Health & Social Care Trust including permanent, temporary, locum, agency, bank, contractors and voluntary staff.

3.0 ROLES AND RESPONSIBILITIES

3.1.1 Corporate Governance

The Corporate Governance Department has responsibility for overseeing the implementation of this policy across the Trust, the Shared Learning Review Group (SLRG) within the Assurance Framework structure and maintain a central repository of Shared Learning issued by the Trust, ensuring that they are accessible to all staff via the HUB.

3.1.2 Shared Learning Review Group (SLRG)

SLRG has responsibility to quality assure and review all final draft Shared Learning prior to submission to the relevant Assurance Framework Group for approval.

3.1.3 Assurance Framework Groups

The Assurance Framework Groups are responsible for final approval of Shared Learning relevant to their area. For example, the SAI Review Group will give final approval of any Shared Learning related to Adverse Incidents (AIs) or Serious Adverse Incidents (SAIs) before they are disseminated across the Trust.

3.1.4 Directors

Directors have responsibility to ensure that approved Shared Learning is disseminated to all appropriate teams and staff where applicable. This dissemination of learning will be via email, but in addition it essential that any shared learning disseminated is also discussed with clinical teams if relevant for the specialty or at Directorate governance meetings.

3.1.5 All Managers

All Managers are responsible for ensuring that there are operational systems in place within their teams to fulfil the requirements of this policy, including fostering a culture of learning from experience and sharing lessons learned.

3.1.6 All Staff

All Staff have a responsibility to contribute to the process of shared learning and changing practice where applicable.

4.0 CONSULTATION

Shared Learning Review Group (SLRG)
SAI Review Group (SAIRG)
Claims Review Group
Service & User Experience Feedback Group
Outcomes Review Group
Standards & Guidelines Committee
Medicines Management Review Group (MMRG)
Safety Improvement Team (SIT)
Strategic Group for Quality Improvement & Development
Deteriorating Patient Group
Serious Adverse Incident (SAI) Review Group
Service User & Experience Feedback Group
Shared Learning Review Group (SLRG)
Outcome Review Group, (including feedback from Morbidity & Mortality Leads.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Sources of Learning

Learning may be derived from a number of sources including:

- **An Adverse Incident:** “any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation”.

- **An Audit:** a process that has been 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.

- **A Case Management Review (CMR) (child protection):** takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons than can help prevent similar incidents from happening in the future.

- **A Claim:** a clinical claim or employers/public liability case.

- **A Complaint:** an expression of dissatisfaction by one or more members of the public about the Trust’s action or lack of action, or about the standard of a service, whether the action was taken by the Trust itself or by somebody acting on behalf of the Trust.

- **Concerns raised by staff.**
  - Directly, or
  - through Whistleblowing Policy

- **Events in others Trusts** sometimes result in learning from that Trust, the Health & Social Care Board (HSCB) or the DHSSPS:

- **An Inquest:** a judicial inquiry into any case of sudden or violent death.

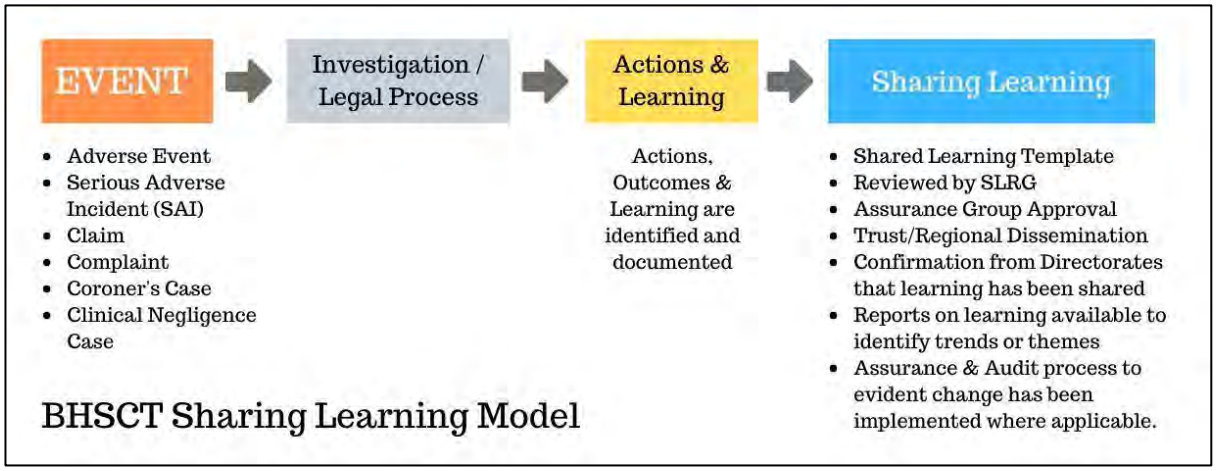
- **A Morbidity / Mortality review case (including cardiac arrest reviews)**: a formal structured meeting comprising of a number of consultants, medical trainees and (in some cases) non-medical staff. Individual cases are discussed with aim for early dissemination of learning.

- **A Never Event:** an event defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative action have been implemented

- **A Plaudit:** an expression of approval or praise.

- **A Serious Adverse Incident (SAI):** any adverse incident that meets one or more of the SAI criteria as set out by HSCB Procedures (*see TP 97-14 SAI Policy).*

5.2 The Sharing Learning Model



5.3 Incident Investigation

- **Adverse Incidents:** All incidents must be investigated as per the Trust Incident Investigation Procedure (excluding SAIs) and any identified learning shared as set out in section 4.4 below.

- **Serious Adverse Incidents (SAIs):** All SAIs must be investigated as per Regional HSCB Procedures (*see HSCB Procedure for Reporting and Follow-Up of Serious Adverse Incident, Version 1.1 – revised November 2016*), using the investigation report templates contained within that procedure (which include a section on lessons learnt). These templates are available on the HUB via the following link: http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Corporate%20Governance/Serious-Adverse-Incidents0911-9361.aspx

Within investigation reports it is important to ensure:
- Learning is clearly identified and addressed by the recommendations and relates to the findings.
- A learning section should indicate to whom the leaning needs to be communicated.

- **Action Plans:** Action plans in response to SAIs, Complaints, Audit, etc, should include actions for sharing of lessons learned from investigations as appropriate.

5.4 Types of Learning

Local Learning (Ward / Department Level): Learning deemed relevant only to the area of Department where the event occurred should be discussed at the local staff/team meeting and documented in the minutes taken if applicable.

Where this local learning relates to Adverse Incidents, SAIs or Complaints then the Datix system should be updated. The incident approved on Datixweb should ensure that the learning is entered in the appropriate field within the investigation section of the Datix Incident form, along with details of any investigation completed and action taken.

Shared Learning (Within Directorate): Often Shared Learning will be relevant to other areas across the specialty or Directorate where the incident occurred.

In these circumstances the learning should be shared via Directorate assurance structures and governance groups as well as recording on the Datix system (see 4.4.1) to ensure learning is captured.

The learning should be included on Directorate governance agendas and discussion/action noted in minutes (in order to maintain an audit trail).

Where learning is relevant beyond the Directorate responsible, a Shared Learning Template (Appendix 1) may be used in addition to the methods above. This should be submitted to the Directorate Governance Manager who will table at the next SLRG meeting for review.

All draft Shared Learning should be submitted to the Shared Learning Review Group (SLRG) for review before going for approval to the relevant Assurance Framework Group (such as SAI Group, Service User & Experience Feedback Group, and/or the Outcomes Review Group) in order to provide assurance that learning is shared appropriately (*see Guidance for Completing Shared Learning in Appendix 2*)

Once Shared Learning has been approved it should be forwarded to the Assurance Coordinator within the Corporate Governance team who will share with the relevant Directorates for dissemination.

Shared Learning (Trustwide): A Shared Learning Template (*Appendix 1*) is a communication tool to enable one service to share learning from an Adverse Incident, SAI, Complaint, or other event, with other relevant services. The Shared Learning Template will usually be a one page document that can be easily read, displayed and filed.

Sharing Learning should not name staff or the specific unit where the event occurred. Patient/client/service user confidentiality must not be breached and information is shared within the confines of the Data Protection Act.

Learning that is deemed relevant to other Directorates should be tabled for review at the next Shared Learning Review Group (SLRG) meeting. The SLRG is responsible for quality assuring and reviewing draft Shared Learning prior to them being submitted to the relevant Assurance Framework Group for approval.

Once reviewed by SLRG and ready for approval Shared Learning should be tabled by the Director / Co-Director at the relevant meeting such as SAI Review Group, Complaints Review Group, etc; or at the Learning from Experience Steering Group for a decision on sharing across the Trust.

If approved for sharing, the Shared Learning Template should be submitted to the Assurance Coordinator within the Corporate Governance team who will share with the relevant Directorates for onward dissemination to the appropriate departments/teams.

Please see flowchart in Appendix 2. All Shared Learning Templates disseminated will be available on the BHSCT Hub via the following link: http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Shared%20learning/Audit.aspx

Shared Learning (Regional): The Trust receives and is expected to act upon learning from HSCB, DHSSPS or other agencies and from external/regional audit findings. External learning will be disseminated from the Corporate Governance Department to Directors for onward dissemination.

The HSCB has a responsibility to share learning across regional HSC organisations as appropriate.

Where a Trust Shared Learning indicates regional learning then the process outlined in the HSCB/PHA Regional Procedure for Safety and Quality Alerts (SQAs) will be followed. However, if the Trust has identified learning that other Trusts should be alerted to urgently then this should be shared promptly from Trust to Trust as appropriate.

Once a Shared Learning has been approved in the Trust for sharing, the Directorate should complete a HSCB/PHA Learning Notification Form (*see Appendix 4, HSCB/PHA Regional Procedure for Safety & Quality Alerts, V1, 2018*) with support from the Corporate Governance Department.

Procedures are in place for the sharing learning from sources such as SAIs, Complaints, Post Fall Reviews and Early Alerts. However, where regional learning has been identified from other sources such as Adverse Incidents, M&M, Coroner's Inquests, Claims, Audits or other concerns, then a Learning Notification Template should be completed and submitted in line with the Regional HSCB/PHA Policy for Safety & Quality Alerts (*see Appendix 4*).

You can contact the Corporate Governance Department to obtain a copy of the latest template. Please note that HSCB/PHA will ask for clarification on learning points to be considered and suggested methods for dissemination including details of the programme of care where the learning is applicable.

The Corporate Governance Department will submit completed Learning Notification Forms to the HSC Alerts Team for action and log to their central repository to maintain a record that the learning has been shared as appropriate.

Other methods of sharing learning

Safety Matters is the BHSCT Newsletter relating to improving the safety and quality of services and sharing learning from incidents and other events.

Safety Messages of the Week (SMOTW) are reviewed alongside Shared Learning templates at the Shared Learning Review Group (SLRG) and are published on the hub. They are also discussed at relevant governance meetings across Directorates.

The process for submission of SMOTW is the same as for Shared Learning. A SMOTW template should be completed in discussion with the Directorate Governance Manager and tabled for review at the next SLRG meeting. All teams across the Trust can contribute to safety messages for publication.

5.5 Dissemination

Following approval, the policy will be disseminated widely. Implementation will begin immediately through issuing of shared learning from Corporate Governance.

5.6 Resources

The dissemination of learning templates from Corporate Governance will initially be done via e-mail. Corporate Governance are exploring using DATIX to issue the learning as this would support a process where we could formally close off that learning has been shared (as it is used for medical device alerts). This will be investigated and may require some resource.

5.7 Exceptions

None.

6.0 MONITORING AND REVIEW

The process of monitoring the effectiveness of all of the above will be managed by the following arrangements:

- Accountability / Performance Management Reviews
- Adverse Incident Training records
- Assurance Framework
- Belfast Risk Audit & Assessment Tool (BRAAT)
- Organisational Assurance Standards
- Directorate Assurance meetings
- Serious Adverse Incident (SAI) Group
- Service User & Experience Feedback Group
- Shared Learning Review Group (SLRG)

Learning that is to be shared Trustwide, from any source, will be formally signed off by Directorates. Co-Directors / Governance & Quality Managers will confirm that the Shared Learning Template was received and disseminated appropriately. Co-Directors / Governance & Quality Managers will provide this assurance at the relevant meeting (SAI Group, etc), or upon request to the Corporate Governance Department. An electronic or online method will be sought for this assurance.

If a Shared Learning Template identifies a gap or inadequacy within a service area this should be highlighted on the appropriate Risk Register and via Directorate governance structures.

7.0 EVIDENCE BASE/REFERENCES

BHSCT Adverse Incident Reporting and Management Policy (2018) TP 94/14
BHSCT Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments (2020) TP 45/10

8.0 APPENDICES

Appendix 1: Shared Learning Template
Appendix 2: Guidance for Completing a Shared Learning Template
Appendix 3: Process for Dissemination of BHSCT Shared Learning Templates
Appendix 4: Shared Learning Review Group (SLRG) Terms of Reference

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **Policy for Sharing Learning** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse,

registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the

policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

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

08/10/2020

Date: _____

Chris Hagan, Medical Director

13/10/2020

Date: _____

Dr Cathy Jack, Chief Executive

APPENDIX 1: Shared Learning Template

Belfast Health and Social Care Trust
caring supporting improving together

SHARED LEARNING

Reference No.	Date Issued:
<type here>	<type here>

SAFETY MESSAGE:
<type here>

Summary of Event:
<type here>

Learning Points:
<type here>

Type of Learning:

- ☐ Specific Directorate(s)
- ☐ Trust-wide
- ☐ Regional*
- ☐ Other

Specify learning details: (include details of actions by HSCB/PHA)
<type here>

***If learning is regional then completion of HSCB/PHA Regional Learning Notification Template should be considered.**

Action Required: (*For discussion and agreement at the relevant Assurance Framework Group – if learning is to be progressed sooner, other approval processes may need to be completed to ensure learning is disseminated in a timely manner)*
<type here>

Approved by:	Designation:	Date Approved
<type here>	<type here>	<type here>

APPENDIX 2: Guidance for Completing a Shared Learning Template

Details of how to complete a Shared Learning Template are set out below. If you need any assistance, please contact your Directorate Quality & Governance Lead.

INITIAL DRAFT

When you are creating your initial draft shared learning you only need to complete the following sections:

- **Reference Number:** you MUST include the reference number from the Incident / SAI / Complaint / Audit / External Letter / M&M Review/Case Management Review and / or Litigation Case (where applicable), so that Corporate Governance can track the learning. If you do not have a reference number please discuss with your Directorate Governance Manager in the first instance.

- **Safety Message:** this should be one sentence that gives a brief overview of the learning needed.

- **Summary of Event:** Provide a summary background as to where the learning was identified (for example from an incident) while ensuring that confidentiality is maintained and no patient/staff identifiers are included.

- **Learning Points:** this will usually a bullet list of the key learning points identified from the event.

- **Type of learning:** indicate what type of learning is required, choosing more than one option if applicable. Where 'other' is selected please provide details in the specify learning section.

- **Specify learning details:** include details of specific Directorates or regional areas that the learning relates to, i.e. whom the learning should be shared / disseminated to, and note any comments for action by the HSCB/PHA where applicable e.g. for consideration of regional learning by a specific specialty or department.

SHARED LEARNING REVIEW GROUP

Once your shared learning has been drafted (*making sure the all the relevant people have been involved in its development*) you should liaise with your Directorate Governance Manager who will table for review at the next SLRG meeting (*see Appendix 4 for SLRG Terms of Reference*).

You may be invited to attend the next SLRG meeting to present your Shared Learning. The members of the group will review its content and suggest edits where applicable. Where complex edits are required the SLRG group may request that you bring back an amended version to a subsequent meeting.

If SLRG have recommended minor edits and then for tabling at the next appropriate

Assurance Framework group for approval, then you should update your Shared Learning to include the following:

- **Action Required:** include details of discussion points for the relevant Assurance Framework Group and note requesting approval.

ASSURANCE FRAMEWORK GROUP – FOR APPROVAL

Your Final Draft Shared Learning should be tabled for discussion at the next appropriate Assurance Framework Group meeting.

Following discussion If approval has been given you should update the following fields on your Shared Learning template and

- **Approved by:** you should note here which Assurance Framework Group has given approval and include the name of the person if applicable.
- **Designation:** this may be the designation of the approver i.e. the Chair of the group giving approval.
- **Date Approved:** this would be the date of the approval i.e. the date of the meeting where the Shared Learning was approved.

CORPORATE GOVERNANCE – RECORDING AND DISSEMINATION

You should then forward your Shared Learning to your Directorate Governance Manager who will send on to the Corporate Governance team for dissemination to the appropriate Directorates or external organisation such as HSCB/PHA in the case of regional learning.

The Corporate Governance team will review the document and update the following fields:

- **Issue Date:** the Corporate Governance team will add the date that the Shared Learning has been disseminated for sharing.

Corporate Governance will then update the HUB to ensure that the Shared Learning is accessible to all staff. In addition, Corporate Governance will update their central repository of Shared Learning issued by the Trust to maintain a record that the learning has been shared as appropriate. These records will be used to provide assurance as required.

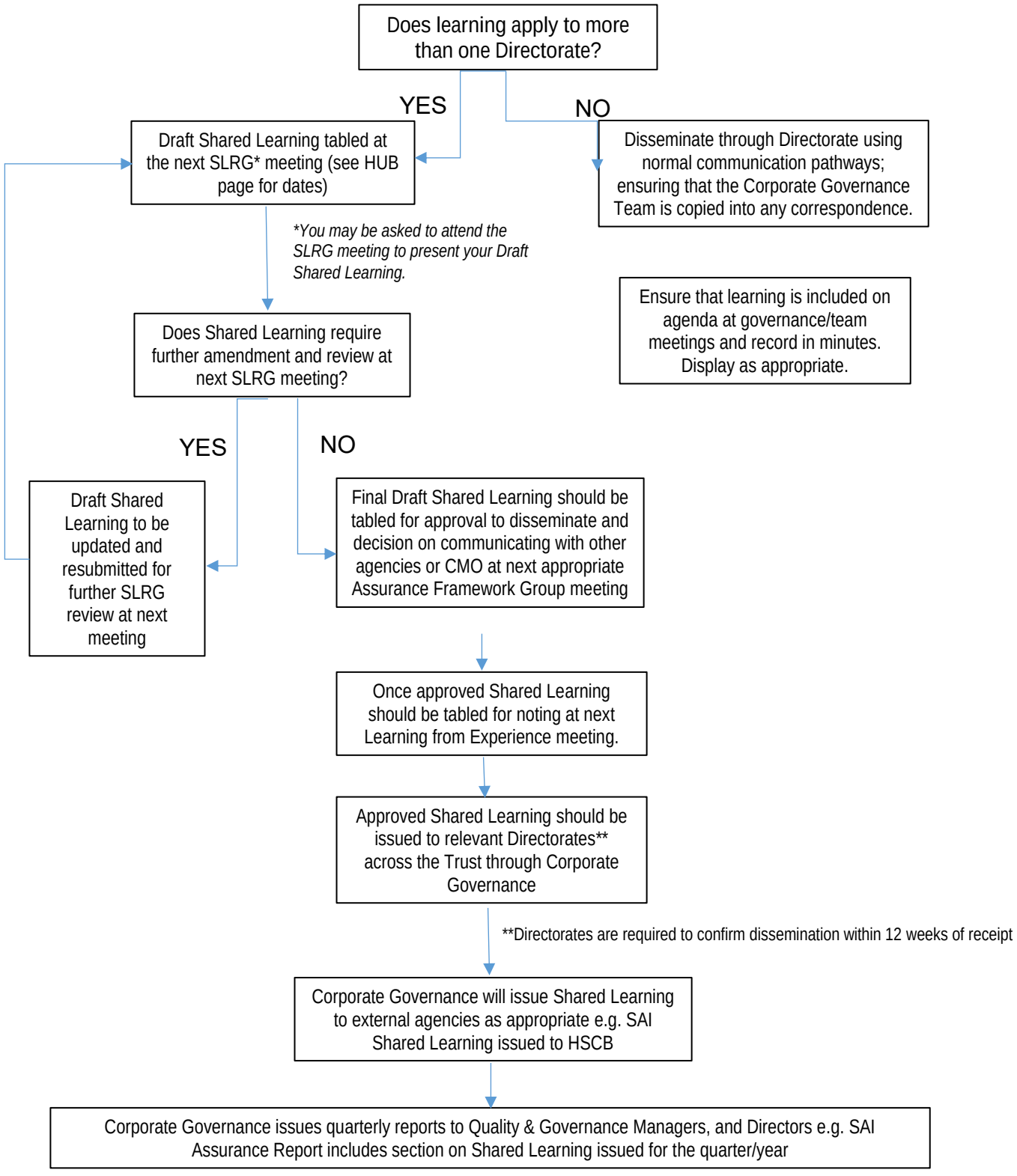
AMENDED SHARED LEARNING

In the likelihood that a previously disseminated Shared Learning requires amendment, it will follow the same process as outlined above.

Amended Shared Learning will require re-approval and then they will be re-issued from the Corporate Governance team as required.

APPENDIX 3: Process for Review, Approval & Dissemination of BHSCT Shared Learning Templates

Once your investigation is complete and learning has been identified a Shared Learning should be drafted by an appropriate Officer. You should liaise with your Directorate Quality & Governance lead to process as appropriate, see below.



APPENDIX 4: Shared Learning Review Group (SLRG) Terms of Reference

COMMITTEE	**Shared Learning Review Group**
PURPOSE	To review and quality assure shared learning with potential learning at Trustwide/Regional level prior to submission to the relevant Assurance Framework Group for their approval.
MEMBERSHIP	**Rotating Chair:** Governance Manager S&SS; June 2017 - June 2018 **Administrative support:** Corporate Governance team **Membership:** • Governance representatives from Service Directorates • Corporate Governance team representative • Complaints team representative • Medicines Governance Pharmacist • Corporate Nursing Representative Other members of Trust staff may be required to attend meetings when considered necessary.
DUTIES	• To provide a process for the review of draft Shared Learning to ensure quality and consistency in relation to: ➢ standardization and layout of the shared learning ➢ understanding of the learning ➢ ensure learning message is clear and easy to understand ➢ key summary ➢ who learning is applicable to • To quality assure the learning for onward approval through the relevant Assurance Framework Group. • To seek clarity on any unclear issues. • To seek assurance that shared learning has been agreed with staff and the service involved.
AUTHORITY	The Shared Learning Review Group is authorised by the chair of the Learning from Experience Group to quality assure and review draft shared learning prior to them being submitted to the relevant Assurance Framework Group for approval.

MEETINGS	**Quorum** At least 3 members of the group and at least one service representative **Frequency of Meetings** Monthly **Papers** Draft shared learning to be circulated electronically at least 3 working days prior to the meeting. Actions points from the meeting will be recorded.
REPORTING	The Shared Learning Review Group (SLRG) will report to the Learning from Experience Group
CONFLICT OF INTEREST	The chair will seek any declaration or conflict of interest from members prior to every meeting.
REVIEW	Annually

2 025

Belfast Health and Social Care Trust

Standards and Guidelines Committee

***'Being Open'* policy – saying sorry when things go wrong.**	
Summary	This policy defines the BHSCT's commitment to '*Being open*' by establishing a culture where there is a commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. The BHSCT will have • a culture that is open and fair. • a '*Being open*' policy and mechanisms to raise awareness about it. • staff and patient support for '*Being open*'.
Purpose	The purpose of this policy is to ensure that rapid and open disclosure and emotional support is available to patients and families who experience incidents leading to harm. These guidelines will also address ways to support and educate staff involved in such incidents. These guidelines deal with patient safety incidents, which have caused moderate, major or catastrophic harm.
Operational date	November 2011
Review date	November 2013
Version Number	V1
Supersedes previous	Legacy Policies
Director Responsible	Dr AB Stevens, Medical Director
Lead Author	JR Johnston
Lead Author, Position	Co-Chair, Standards and Guidelines Committee.
Additional Author(s)	Olive Macleod, Co Director of Nursing
Department / Service Group	Medical Director's Office
Contact details	Standards, Quality and Audit Dept. Tel: 02890 636380 [redacted]

Reference Number	SG 56/11
Supercedes	Legacy Trust

Version Record

Date	Version	Author	Comments
Jan 2009	V1.0	Olive Macleod	Initial draft
August 2011	V 0.2	JR Johnston	Formatting: Redrafting
01Sep11	V0.3	C Murphy	Appendix 4a updated to include incident category as per incident reporting policy
22 Sep 2011	V0.4	C Murphy	Correction to 8.6 – Patient Client Council
26/09/2011	V0.5	JRJ & CM	Ombudsman doc. : after ABS and Ann Maginnis comments
27/10/2011	V0.6	JRJ	After Assurance Group comments
27/10/2011	V0.7	JRJ	Final Draft
21/11/2011	V0.8	JRJ	Corporate Governance comments; Implementation and Source changes; + Appendix 8.
14/12/2011	V0.9	CM	Addition of Staff care information, removal of text re: Area Bereavement Councillor on pg 10.
27/02/2012	V0.10	JS-O'D (following consultation by Trade Unions)	Page 4, paragraph 2 word change – seek emotional support – changed to permission will be given to seek emotional support.
25/06/2012	V0.11	JRJ	Approved by Ethics Committee
16/07/2012	V0.12	A McKimm	Up to date NPSA links

Policy Record

		Date	Version
Author (s)	Approval		
Director Responsible	Approval		

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval	17/05/2012	V0.10
Policy Committee	Approval		
Executive Team	Authorise		
Appropriate Director	Sign Off		

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Full Description

Reference No: *To be allocated*

1 **"Being Open" policy – saying sorry when things go wrong.**

2 **INTRODUCTION**

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

'Being open' involves:

- acknowledging, apologising and explaining when things go wrong.
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT *'Being open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of 'Seven steps to Service user Safety' (appendix 1).

3 **Purpose:**

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind *'Being open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

4 **SCOPE**

The BSHCT Adverse Incident Reporting and Management Policy encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

This *'Being Open'* Policy only relates to those incidents that are moderate, major or catastrophic severity as defined in appendix 2a+b and within step 1 of the BHSCT Procedure for grading an adverse incident; incidents that are regarded as insignificant or minor are not within the scope of this policy although the principles can be applied (section 7.3).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies.

"only relates to those incidents that are Moderate, Major or Catastrophic"

It sets the scene of openness as a founding principle behind:-

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

5 Objectives:

This policy defines the BHSCT's commitment to *'Being open'* by establishing a culture where:

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.
- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

6 ROLES AND RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the concept of this *'Being open'* culture of openness applying throughout the organization.

Trust Board

The Trust Board are responsible

- for actively championing the *'Being open'* process.
- by promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

Executive Directors

Medical Director/Director of Nursing/Director of Primary and Social Care

Overall professional responsibility for managing the *'Being Open'* process.

Service Directors
Responsibility within their own service directorate for managing the '*Being Open*' process.

Managers

- Supporting staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare http://intranet.belfasttrust.local/Pages/News/Staffcare---A-confidential-counselling-service-for-Trust-employees.aspx

- Notifying the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.

  - Medical Director } that the '*Being Open*' process has
    Nursing Director } been initiated for an incident causing
    Primary and Social Care Director } major or catastrophic harm.
    Service Director }

All Healthcare Staff
All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:-

- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.
- recording and documenting discussions with patients and families
- complying with the '*Being Open*' policy.

7 The definition and background of the policy:

7.1 Background
Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The General Medical Council in their document Good Medical Practice sets out the principles and values on which good practice is founded. It contains a section on: Being open and honest with patients if things go wrong when:-

- If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.
- Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being open*' policies. Their guidance was replaced in November 2009 by Being open: communicating patient safety incidents with patients, their families and carers in response to changes in the healthcare environment and in

order to strengthen '*Being open'* throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being open'* policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being open'* at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based on the '*Being open'* Framework document.

7.2 **A. Open and fair culture**

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any incident.
- organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

B. 'Being Open' policy

A *'Being open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being open'* it is vital that:

- patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it.

To implement '*Being open*' successfully, the BHSCT will have the following foundations:
A. a culture that is open and fair.
B. a '*Being open*' policy and mechanisms to raise awareness about it.
C. staff and patient support for '*Being open*'.

7.3 **Prevented and 'no harm' incidents**

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm patient safety incidents are discussed with patients as this would cause undue and unnecessary anxiety. This does not absolve staff or their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

7.4 *Being open*

The main thrust of this '*Being open*' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 4). It describes the process of '*Being open*' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

7.5 Definitions

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

"Harm" is the condition of promoting injury or damage.

8 POLICY STATEMENTS:

8.1 Patient safety incidents will be managed using the principles outlined in this BHSCT '*Being open*' policy. Each incident will trigger a 5 stage process as set out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

8.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a patient's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the patient's illness, its treatment and the factors causing and/or contributing to the patient's death are discussed with the relatives and recorded in the clinical record.

8.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

8.4 The most appropriate person must **communicate** with the patient about an incident in a truthful open and timely manner. Information must be based solely on the facts. Patients will not receive conflicting information from different members of staff.

8.5 Patients and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a patient safety incident.

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

10 principles of 'Being open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 8).

8.6 Support for the Patient

A key part of '*Being open'* is considering the patient's needs, or the needs of their carers or family in circumstances where the patient has been involved in a serious patient safety incident or died. The Trust will ensure early identification of and provision for the patient's practical and emotional needs.

Patients and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a patient safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the patient has agreed that information about their health care can be

given. This person (or people) may be different to both the patient's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the patient safety incident.

The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the patient identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the patient, using the most appropriate method of communication from the patient's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

Public information statement
'*Being open*' if things go wrong:
We will
- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

It is important to identify at the outset if there are any special restrictions on openness that the patient would like the healthcare team to respect. It is also important to identify whether the patient does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

8.7 Support for Families, Carers
Patients and/or their carers may need considerable practical and emotional help and support after experiencing a patient safety incident. Support may be provided by patients' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the patient needs more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counseling services, e.g. Cruse (the UK's largest bereavement charity).

A patient and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

8.8 Information on the '*Being open*' process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

8.9 Support for staff
These guidelines apply to all staff that have a role in providing patient care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a patient safety incident occurs, healthcare professionals involved in the clinical

care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for '*Being open*' discussions should be given access to assistance, support and any information they need to fulfill this role.

To **support staff** involved the trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report patient safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the patient safety incident will be available.
- Provide advice and training on the management of patient safety incidents.
- Provide counselling by professional bodies for staff distressed by patient safety incidents. Stress management courses for staff that have responsibilities for leading "Being open" discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with patients and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

8.10 Patient safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The '*Being Open*' policy is part of an integrated approach to addressing patient safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

8.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the patient's care. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the '*Being open*' process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the '*Being open*' process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

8.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance framework** in which patient safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of patient safety issues and the value of '*Being open*'.

8.13 Full **confidentiality** of and respect for patients, carers and staff will be maintained.

Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating patients. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

8.14 Patients are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion.

If a patient expresses a preference for their healthcare needs to be taken over by another team, the Trust will make every effort to make the appropriate arrangements unless it is clearly obvious not to be in the patient's best interests.

9. Implementation

There will be training implications from this policy; from Corporate Governance through to staff working directly with patients.

The NPSA have a '*Being open*' e-learning package which can be accessed at

http://www.nrls.npsa.nhs.uk/beingopen/

10. Source(s) / Evidence Base:

Legacy Trust Guidance
BSHCT Adverse Incident Reporting and Management Policy
BHSCT Risk Management Strategy 2008-11.
National Patient Safety Agency documents.
Australian Open Disclosure Project - Open Disclosure Policy Directive
Australian Commission on Safety and Quality in Healthcare – Open Disclosure Standard

11. References, including relevant external guidelines:

National Patient Safety Agency

1. Seven steps to patient safety: full reference guide – July 2004.
2. Being open: communicating patient safety incidents with patients, their families and carers
3. 'Being open' Framework – November 2009.

12. Consultation Process:

Trust Service Group Directors & Staff Side
Standards and Guidelines Committee.
BHSCT Clinical Ethics Committee

Equality and Human Rights screening carried out:

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, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

13. ☐ Screening completed No action required. ☐ Full impact assessment to be carried out.

14. Procedures

Appendix 1 = Benefits for patients
Appendix 2 = Benefits for Staff patients
Appendix 3 = Seven Steps for Safety
Appendix 4a = NPSA grade and definition of patient safety incident
Appendix 4b = Grades and consequent actions following Patient Safety Incidents
Appendix 5 = The '*Being open*' process
Appendix 6 = Being open in particular circumstances

Appendix 7 = NPSA '*Being open'* safety alert November 2009
Appendix 8 = Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 9 = Guidance on issuing an apology – NI Ombudsman.

Chief Executive: AB Stevens
Date: July 2012

Author: JR Johnston
Date: July 2012

Appendix 1

NPSA - Seven steps to patient safety.

National Patient Safety Agency. *Seven steps to patient safety. The full reference guide*. 2004.

Appendix 2a

BHSCT – Definitions for grading of Patient Safety Incidents

Insignificant

Incident prevented / Near Miss

Any patient safety incident that had the potential to cause harm but was prevented and no harm was caused to patients receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented Any patient safety incident that occurred but insignificant harm was caused to patients receiving NHS-funded care.

Minor harm

Any patient safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more patients receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, canceling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any patient safety incident that appears to have resulted in permanent harm* to one or more patients receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any patient safety incident that directly resulted in the death* of one or more patients receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.*

Appendix 2b

Grades and consequent actions following Patient Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	Significant but not permanent harm - moderate increase in treatment.	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased patient monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being open'.		**Apply the 'Being open' process Stages I →V.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. 3. No action under the *Being Open* Policy is required.		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Corporate Governance Department (6th Floor, McKinney House, Musgrave Park Hospital. Tel: 02890631085) should be notified immediately and be available to provide support and advice during the *'Being open'* process if required.		

Appendix 3

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by patients and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious patient safety incident indicate that the patients would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

Appendix 4

BENEFITS FOR STAFF

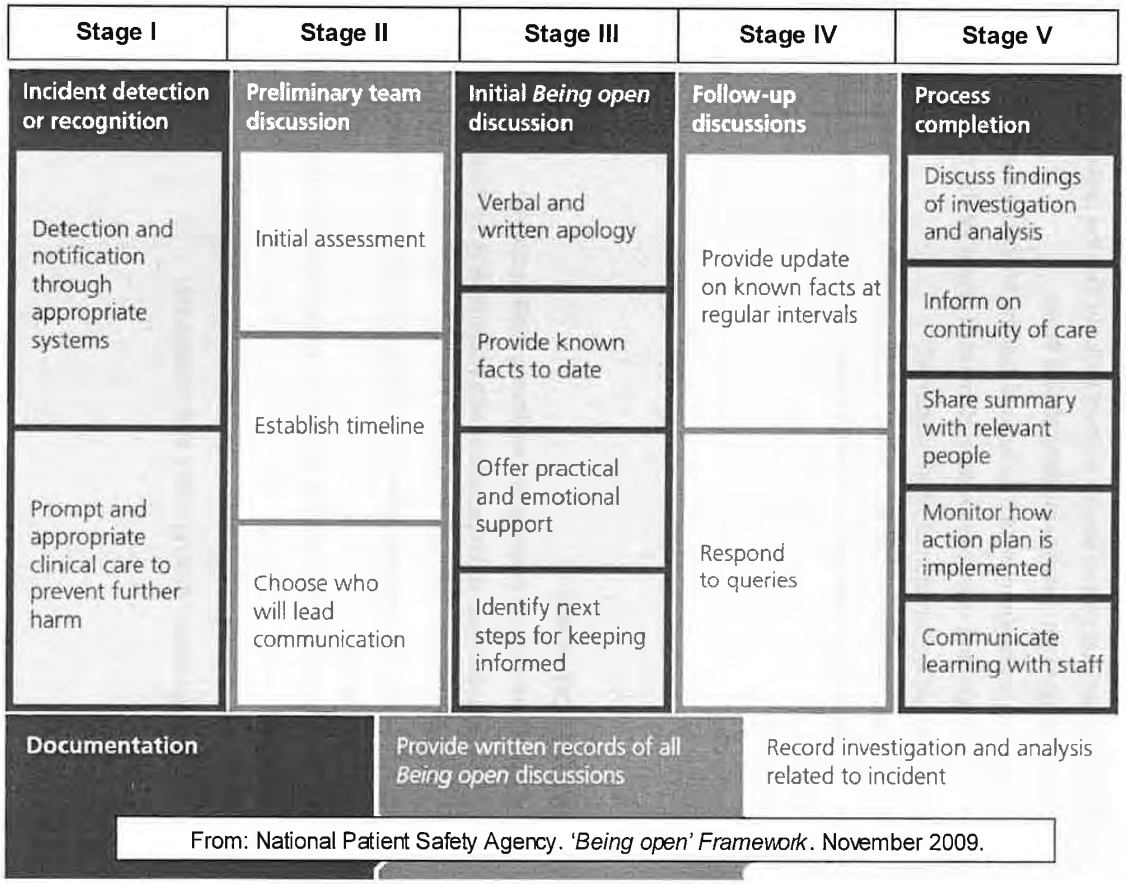
Being open has several benefits for healthcare staff including:

- Satisfaction that communication with patients and /or their carers following a patient safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the patient and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 5

'*BEING OPEN*' PROCESS

'Being open' is a process rather than a one-off event and can be considered in 5 stages with documentation being a constant feature throughout the process.



STAGE I: INCIDENT DETECTION AND RECOGNITION

The *'Being open'* process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a patient safety incident.

Detection of the incident
A patient safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a patient and/or their carers who expresses concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other patients, visitors or non-clinical staff.

Priority
As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse incident criteria , the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB .

Patient safety incidents occurring elsewhere
A patient safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier patient safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the patient safety incident has already been recognized.
- the process of *'Being open'* has commenced.
- incident investigation and analysis is underway.

The *'Being open'* process and the investigation and analysis of a patient safety incident should occur where the incident took place.

Criminal or intentional unsafe act
Patient safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: PRELIMINARY TEAM DISCUSSION

The multidisciplinary team, including the most senior health professional involved in the patient safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts.
- assess the incident to determine the level of immediate response.
- identify who will be responsible for discussion with the patient and/or their carers = '*Being open'* coordinator.
- consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the patient's needs and communicating them back to the healthcare team.
- identify immediate support needs for the healthcare staff involved.
- ensure there is a consistent approach by all team members around discussions with the patient and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm (including prevented patient safety incident)	It is not a requirement of this policy to communicate prevented patient safety incidents and insignificant incidents to patients and/or carers.
Minor harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the patient's care and the patient and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **Apply the principles of 'Being open' – locally.**
Moderate harm, **Major harm** **Death**	A higher level of response is required in these circumstances. The Corporate Governance Department (6th Floor, McKinney House, Musgrave Park Hospital. Tel: 02890631085) should be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the 'Being open' process – Stages I → V.**

Timing of discussion with patient and/or carers
Preliminary discussions with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this and any future '*Being open*' discussions include:

- clinical condition of the patient.
- patient preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being open*' process.
- availability of the patient's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The *'Being open'* coordinator role
It is essential to carefully consider the choice of the individual to communicate with patients and who informs the patient and/or their carers about a patient safety incident. Getting it right at the start of the process will reassure the patient and may lead to a favourable outcome. This should be the most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the patient and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident to be credible to patients, carers and colleagues.
- have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers.
- be able to maintain a medium to long term relationship with the patient and/or their carers, where possible, and to provide continued support and information.
- be culturally aware and informed about the specific needs of the patient and/or their carers.

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute with whom the patient is satisfied should be provided.

Use of a substitute healthcare professional for the 'B*eing open'* discussion
In exceptional circumstances, if the '*Being open*' coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'B*eing open'* discussion
The healthcare professional communicating information about a patient safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being open*' procedures.

Responsibilities of junior healthcare professionals
Junior staff or those in training should not lead the '*Being open*' process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the patient and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a patient safety incident asks to be involved in the '*Being open*' discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate

patient safety information alone or to be delegated the responsibility to lead a *'Being open'* discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Patient safety incidents related to the environment of care
In such cases a senior manager of the relevant service will be responsible for communicating with the patient and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial *'Being open'* discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake
Some patient safety incidents result from errors made by the healthcare staff caring for the patient. In these circumstances the member(s) of staff involved may or may not wish to participate in the *'Being open'* discussion with the patient and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the patient and/or their carers with those of the healthcare professional concerned.

In cases where the healthcare professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the patient and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient and/or their carers during the first *'Being open'* discussion.

STAGE III: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'B*eing open'* discussion

The patient and/or their carers should be advised of the identity and role of all people attending the *'Being open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.

The content of the initial *'Being open'* discussion with the patient, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The patient, their family and/or their carers
  - should be informed that an incident investigation is being carried out.
  - understanding of what happened is taken into consideration, as well as any questions they may have.
  - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the patient's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the patient safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the patient with access to information to assist in making decisions if the patient is unable to participate in decision-making or if the patient has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the patient's instructions.
- Ensure carers are provided with known information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with patients and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to patients, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the patient and the incident should not normally be disclosed to third parties without consent.

STAGE IV: FOLLOW UP DISCUSSIONS

Follow-up discussions with the patient, their family and carers are an important step in the *'Being open'* process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the patient's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the patient and/or their carers to obtain information about the patient safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the patient and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The patient and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the patient and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records.
- The patient should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE V: PROCESS COMPLETION

Communication with the patient, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the patient. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why.*
- details of the patient's, their family's and carers' concerns and complaints.
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident.
- a summary of the factors that contributed to the incident.
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the patient's GP, before discharge, describing what happened. When the patient leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the patient safety incident and the continuing care and treatment;
- the current condition of the patient;
- key investigations that have been carried out to establish the patient's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being open* process it is important to record discussions with the patient, their family and carers as well as the incident investigation.
Written records of the '*Being open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the patient, their family and carers.
- offers of assistance and the patient's, their family's and carers' response.
- questions raised by the patient, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and carers.
- copies of letters sent to the patient, their family and carers, and the GP.
- copies of any statements taken in relation to the patient safety incident.
- a copy of the incident report.

Appendix 6

BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of patient circumstance.

When a patient dies

When a patient safety incident has resulted in a patient's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counseling or assistance at any stage.

"it may be appropriate to wait for the coroner's inquest before holding the '*Being open*' discussion"

Usually, the '*Being open*' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the '*Being open*' discussion with the patient's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event, an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the '*Being open*' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Patients with mental health issues

'*Being open*' for patients with mental health issues should follow standard procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the

express permission of the patient; to do so may constitute an infringement of the patient's Human Rights and/or a breach of Data Protection legislative provisions.

Patients with cognitive impairment
Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The *'Being open'* discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the patient's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients with learning disabilities
Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the patient is not cognitively impaired they should be supported in the *'Being open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the *'Being open'* process, focusing on ensuring that the patient's views are considered and discussed.

Patients with different language or cultural considerations
Reference must be made to the interpreting protocol when booking interpreters.

Patients with different communication needs
A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Patients who do not agree with the information provided
Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the *'Being open'* process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the patient agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the patient has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team.
- Offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution.
- Ensure the patient and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

Appendix 7

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

National Reporting and Learning Service
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Appendix 8

Comparison of BHSCT vs NPSA incident grading matrix.

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 9.

Guidance on Issuing an apology – NI Ombudsman

Guidance on issuing an apology - Ombuds

Belfast Health and Social Care Trust

Reference No: SG 56/11

Title:	*'Being Open'* policy – saying sorry when things go wrong.		
Author(s)	JR Johnston, Co-Chair, Standards and Guidelines Committee. Standards, Quality and Audit Dept, Tel: 02890 636380 [redacted]		
Ownership:	Dr C Jack, Medical Director		
Approval by:	Standards and Guidelines Policy Committee Executive Team Meeting	**Approval date:**	23/10/2014 17/11/2014 19/11/2014
Operational Date:	November 2014	**Next Review:**	November 2017
Version No.	V1.2	**Supercedes**	V1 – November 2011-2013
Key words:	Being Open, Candour, Adverse incident		
Links to other policies	Adverse Incident Reporting and Management Policy BHSCT Procedure for grading an adverse incident		

Date	Version	Author	Comments
Jan 2009	V1.0	Olive Macleod	Initial draft
August 2011	V 0.2	JR Johnston	Formatting: Redrafting
01 Sep 2011	V0.3	C Murphy	Appendix 4a updated to include incident category as per incident reporting policy
22 Sep 2011	V0.4	C Murphy	Correction to 8.6 – Patient Client Council
26/09/2011	V0.5	JRJ & CM	Ombudsman doc. : after ABS and Ann Maginnis comments
27/10/2011	V0.6	JRJ	After Assurance Group comments
27/10/2011	V0.7	JRJ	Final Draft
21/11/2011	V0.8	JRJ	Corporate Governance comments; Implementation and Source changes; + Appendix 8.
14/12/2011	V0.9	CM	Addition of Staff care information, removal of text re: Area Bereavement Councillor on pg 10.
27/02/2012	V0.10	JS-O'D (following consultation by Trade Unions)	Page 4, paragraph 2 word change – seek emotional support – changed to permission will be given to seek emotional support.
25/06/2012	V0.11	JRJ	Approved by Ethics Committee
16/07/2012	V0.12	A McKimm	Up to date NPSA links
17/4/2014	V1.1	JRJ	S+G put into new template
9/10/2014	V1.2	JRJ	Hyperlinks fixed; Francis report

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INTRODUCTION / PURPOSE OF POLICY

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being open' involves:

- acknowledging, apologising and explaining when things go wrong
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT '*Being open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of 'Seven steps to Service user Safety' (appendix 1).

1.1 Background

1.1.1 Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The General Medical Council in their document Good Medical Practice sets out the principles and values on which good practice is founded. It contains a section on: Being open and honest with patients if things go wrong when:-

- If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.
- Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being open*' policies. Their guidance was replaced in November 2009 by Being open: communicating patient safety incidents with patients, their families and carers in response to changes in the healthcare environment and in order to strengthen '*Being open*' throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being open*' policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being open*' at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based on the '*Being open*' Framework document.

1.1.2 **Francis report**

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'.

These were defined as,

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.'

This BHSCT policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy.

1.1.3 **A. Open and fair culture**

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any incident
- organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

B. 'Being Open' policy

A *'Being open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being open'* it is vital that:

- Patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it.

To implement '*Being open*' successfully, the BHSCT will have the following foundations:
A. a culture that is open and fair.
B. a '*Being open*' policy and mechanisms to raise awareness about it.
C. staff and patient support for '*Being open*'.

1.1.4 **Prevented and 'no harm' incidents**

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm patient safety incidents are discussed with patients as this would cause undue and unnecessary anxiety. This does not absolve staff or their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 **Being open**

The main thrust of this 'Being open' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 4). It describes the process of 'Being open' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 **Definitions**

"Harm" is the condition of promoting injury or damage.

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

1.2 Purpose

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind *'Being open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the BHSCT's commitment to *'Being open'* by establishing a culture where:

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.
- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.

- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The BSHCT Adverse Incident Reporting and Management Policy encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

This *'Being Open'* Policy only relates to those incidents that are moderate, major or catastrophic severity as defined in appendix 2a+b and within step 1 of the BHSCT Procedure for grading an adverse incident: incidents that are regarded as insignificant or minor are not within the scope of this policy although the principles can be applied (section 7.3).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies. It sets the scene of openness as a founding principle behind:-

"only relates to those incidents that are Moderate, Major or Catastrophic"

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the concept of this *'Being open'* culture of openness applying throughout the organization.

Trust Board

The Trust Board are responsible

- for actively championing the *'Being open'* process.
- by promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being

empowered to improve patient care by learning from mistakes rather than denying them.

Chief Executive
The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

Executive Directors
Medical Director/Director of Nursing/Director of Primary and Social Care
Overall professional responsibility for managing the *'Being Open'* process.

Service Directors
Responsibility within their own service directorate for managing the *'Being Open'* process.

Managers
- Supporting staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare http://intranet.belfasttrust.local/Pages/News/Staffcare—A-confidential-counselling-service-for-Trust-employees.aspx

- Notifying the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.

  - Medical Director } that the *'Being Open'* process has
    Nursing Director } been initiated for an incident
    Primary and Social Care Director } causing
    Service Director } major or catastrophic harm.

All Healthcare Staff
All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:-
- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.
- recording and documenting discussions with patients and families
- complying with the *'Being Open'* policy.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)
Patient safety incidents will be managed using the principles outlined in this BHSCT *'Being open'* policy. Each incident will trigger a 5 stage process as set

out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a patient's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the patient's illness, its treatment and the factors causing and/or contributing to the patient's death are discussed with the relatives and recorded in the clinical record.

4.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the patient about an incident in a truthful open and timely manner. Information must be based solely on the facts. Patients will not receive conflicting information from different members of staff.

4.5 Patients and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a patient safety incident.

10 principles of 'Being open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 8).

4.6 Support for the Patient

A key part of 'B*eing open'* is considering the patient's needs, or the needs of their carers or family in circumstances where the patient has been involved in

a serious patient safety incident or died. The Trust will ensure early identification of and provision for the patient's practical and emotional needs.

Patients and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a patient safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the patient has agreed that information about their health care can be given. This person (or people) may be different to both the patient's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the patient safety incident. The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the patient identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the patient, using the most appropriate method of communication from the patient's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

Public information statement
'*Being open*' if things go wrong:
We will
- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

It is important to identify at the outset if there are any special restrictions on openness that the patient would like the healthcare team to respect. It is also important to identify whether the patient does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

4.7 Support for Families, Carers

Patients and/or their carers may need considerable practical and emotional help and support after experiencing a patient safety incident. Support may be provided by patients' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the patient needs more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counseling services, e.g. Cruse (the UK's largest bereavement charity).

A patient and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Information on the 'B*eing open'* process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

4.9 **Support for staff**
These guidelines apply to all staff that have a role in providing patient care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a patient safety incident occurs, healthcare professionals involved in the clinical care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for *'Being open'* discussions should be given access to assistance, support and any information they need to fulfill this role.

To **support staff** involved the trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report patient safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the patient safety incident will be available.
- Provide advice and training on the management of patient safety incidents.
- Provide counselling by professional bodies for staff distressed by patient safety incidents. Stress management courses for staff that have responsibilities for leading "Being open" discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with patients and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.10 Patient safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The

'Being Open' policy is part of an integrated approach to addressing patient safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the patient's care. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the *'Being open'* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the *'Being open'* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance framework** in which patient safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of patient safety issues and the value of *'Being open'.*

4.13 Full **confidentiality** of and respect for patients, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating patients. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.14 Patients are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion.

If a patient expresses a preference for their healthcare needs to be taken over by another team, the Trust will make every effort to make the appropriate arrangements unless it is clearly obvious not to be in the patient's best interests

5.0 IMPLEMENTATION OF POLICY

There will be training implications from this policy; from Corporate Governance through to staff working directly with patients.

The NPSA have a *'Being open'* e-learning package which can be accessed at

http://www.nrls.npsa.nhs.uk/beingopen/

5.1 Resources

This should include training, awareness raising, testing of new documentation associated with the policy etc and who is responsible for this

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.

7.0 EVIDENCE BASE / REFERENCES

Legacy Trust Guidance
BSHCT Adverse Incident Reporting and Management Policy
BHSCT Risk Management Strategy 2008-11.
National Patient Safety Agency documents.
Australian Open Disclosure Project - Open Disclosure Policy Directive
Australian Commission on Safety and Quality in Healthcare – Open Disclosure Standard

National Patient Safety Agency
1. Seven steps to patient safety: full reference guide – July 2004.
2. Being open: communicating patient safety incidents with patients, their families and carers
3. 'Being open' Framework – November 2009.

8.0 CONSULTATION PROCESS

Trust Service Group Directors & Staff Side
Standards and Guidelines Committee.
BHSCT Clinical Ethics Committee

9.0 APPENDICES / ATTACHMENTS

Appendix 1 = Benefits for patients
Appendix 2 = Benefits for Staff patients
Appendix 3 = Seven Steps for Safety
Appendix 4a = NPSA grade and definition of patient safety incident
Appendix 4b = Grades and consequent actions following Patient Safety Incidents
Appendix 5 = The '*Being open*' process
Appendix 6 = Being open in particular circumstances
Appendix 7 = NPSA '*Being open*' safety alert November 2009
Appendix 8 = Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 9 = Guidance on issuing an apology – NI Ombudsman.

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).

Date: _____October 2014_____

Date: _____October 2014_____

Appendix 1

NPSA - Seven steps to patient safety.

National Patient Safety Agency. *Seven steps to patient safety. The full reference guide*. 2004.

Appendix 2a

BHSCT – Definitions for grading of Patient Safety Incidents

Insignificant

Incident prevented / Near Miss

Any patient safety incident that had the potential to cause harm but was prevented and no harm was caused to patients receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented Any patient safety incident that occurred but insignificant harm was caused to patients receiving NHS-funded care.

Minor harm

Any patient safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more patients receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, canceling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any patient safety incident that appears to have resulted in permanent harm* to one or more patients receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any patient safety incident that directly resulted in the death* of one or more patients receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.*

Appendix 2b

Grades and consequent actions following Patient Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	**Significant but not permanent harm - moderate increase in treatment.**	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased patient monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being open'.		**Apply the 'Being open' process Stages I →V.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. 3. No action under the *Being Open* Policy is required.		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Corporate Governance Department (6th Floor, McKinney House, Musgrave Park Hospital. Tel: 02890631085) should be notified immediately and be available to provide support and advice during the *'Being open'* process if required.		

Appendix 3

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by patients and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious patient safety incident indicate that the patients would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

Appendix 4

BENEFITS FOR STAFF

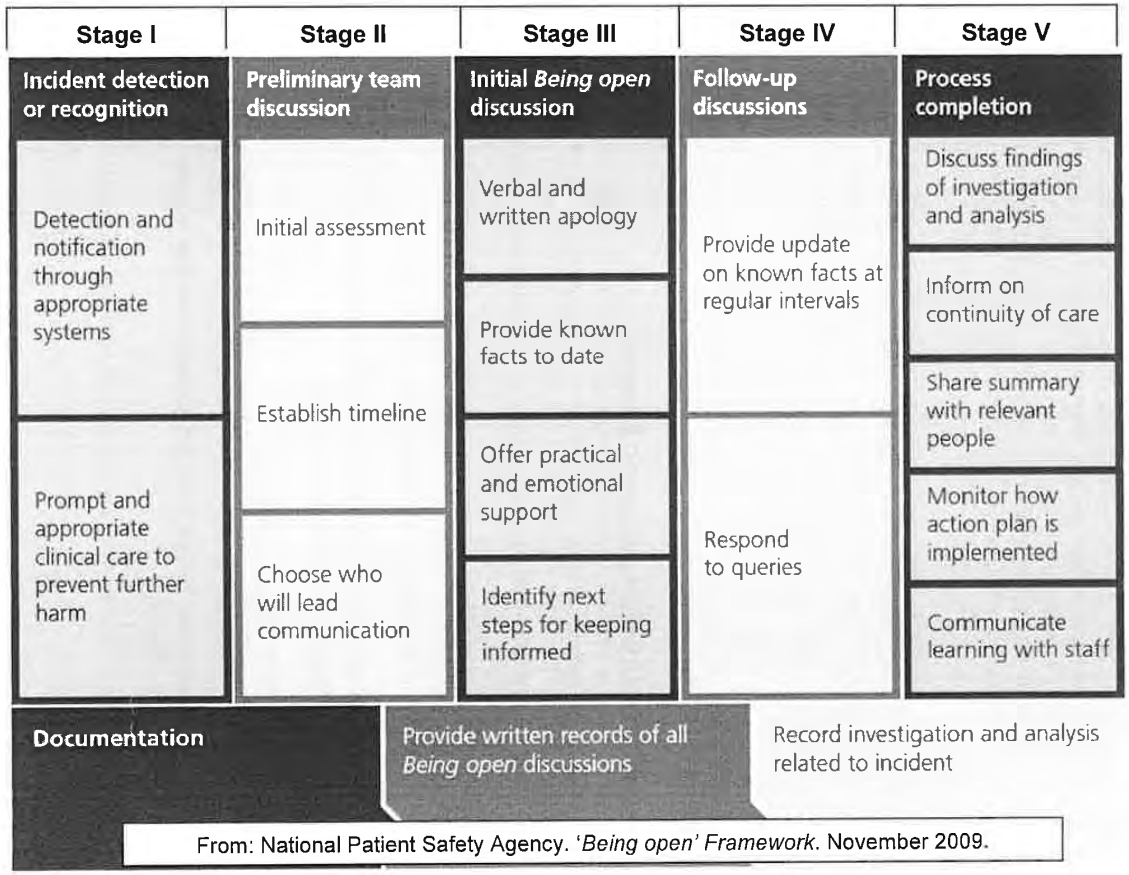
Being open has several benefits for healthcare staff including:

- Satisfaction that communication with patients and /or their carers following a patient safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the patient and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 5

'*BEING OPEN*' PROCESS

'Being open' is a process rather than a one-off event and can be considered in 5 stages with documentation being a constant feature throughout the process.



From: National Patient Safety Agency. '*Being open*' *Framework*. November 2009.

STAGE I: INCIDENT DETECTION AND RECOGNITION

The '*Being open*' process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a patient safety incident.

Detection of the incident

A patient safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a patient and/or their carers who expresses concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other patients, visitors or non-clinical staff.

Priority

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse incident criteria , the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB .

Patient safety incidents occurring elsewhere

A patient safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier patient safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the patient safety incident has already been recognized.
- the process of '*Being open*' has commenced.
- incident investigation and analysis is underway.

The '*Being open*' process and the investigation and analysis of a patient safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Patient safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: PRELIMINARY TEAM DISCUSSION

The multidisciplinary team, including the most senior health professional involved in the patient safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts.
- assess the incident to determine the level of immediate response.
- identify who will be responsible for discussion with the patient and/or their carers = '*Being open'* coordinator.
- consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the patient's needs and communicating them back to the healthcare team.
- identify immediate support needs for the healthcare staff involved.
- ensure there is a consistent approach by all team members around discussions with the patient and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm (including prevented patient safety incident)	It is not a requirement of this policy to communicate prevented patient safety incidents and insignificant incidents to patients and/or carers.
Minor harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the patient's care and the patient and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **Apply the principles of 'Being open' – locally.**
Moderate harm, **Major harm** **Death**	A higher level of response is required in these circumstances. The Corporate Governance Department (6th Floor, McKinney House, Musgrave Park Hospital. Tel: 02890631085) should be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the 'Being open' process – Stages I → V.**

Timing of discussion with patient and/or carers

Preliminary discussions with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this and any future '*Being open*' discussions include:

- clinical condition of the patient.
- patient preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being open*' process.
- availability of the patient's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The *'Being open'* coordinator role

It is essential to carefully consider the choice of the individual to communicate with patients and who informs the patient and/or their carers about a patient safety incident. Getting it right at the start of the process will reassure the patient and may lead to a favourable outcome. This should be the most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the patient and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident to be credible to patients, carers and colleagues.
- have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers.
- be able to maintain a medium to long term relationship with the patient and/or their carers, where possible, and to provide continued support and information.
- be culturally aware and informed about the specific needs of the patient and/or their carers.

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute with whom the patient is satisfied should be provided.

Use of a substitute healthcare professional for the 'B*eing open'* discussion

In exceptional circumstances, if the '*Being open'* coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'B*eing open'* discussion

The healthcare professional communicating information about a patient safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being open*' procedures.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the '*Being open'* process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the patient and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a patient safety incident asks to be involved in the '*Being open'* discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate

patient safety information alone or to be delegated the responsibility to lead a '*Being open*' discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Patient safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the patient and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being open*' discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake

Some patient safety incidents result from errors made by the healthcare staff caring for the patient. In these circumstances the member(s) of staff involved may or may not wish to participate in the '*Being open*' discussion with the patient and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the patient and/or their carers with those of the healthcare professional concerned.

In cases where the healthcare professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the patient and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient and/or their carers during the first '*Being open*' discussion.

STAGE III: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'B*eing open'* discussion

The patient and/or their carers should be advised of the identity and role of all people attending the *'Being open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.

The content of the initial *'Being open'* discussion with the patient, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The patient, their family and/or their carers
    - should be informed that an incident investigation is being carried out.
    - understanding of what happened is taken into consideration, as well as any questions they may have.
    - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the patient's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the patient safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the patient with access to information to assist in making decisions if the patient is unable to participate in decision-making or if the patient has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the patient's instructions.
- Ensure carers are provided with known information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with patients and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to patients, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the patient and the incident should not normally be disclosed to third parties without consent.

STAGE IV: FOLLOW UP DISCUSSIONS

Follow-up discussions with the patient, their family and carers are an important step in the *'Being open'* process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the patient's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the patient and/or their carers to obtain information about the patient safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the patient and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The patient and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the patient and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records.
- The patient should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE V: PROCESS COMPLETION

Communication with the patient, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the patient. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why.*
- details of the patient's, their family's and carers' concerns and complaints.
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident.
- a summary of the factors that contributed to the incident.
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the patient's GP, before discharge, describing what happened. When the patient leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the patient safety incident and the continuing care and treatment;
- the current condition of the patient;
- key investigations that have been carried out to establish the patient's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being open* process it is important to record discussions with the patient, their family and carers as well as the incident investigation.
Written records of the '*Being open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the patient, their family and carers.
- offers of assistance and the patient's, their family's and carers' response.
- questions raised by the patient, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and carers.
- copies of letters sent to the patient, their family and carers, and the GP.
- copies of any statements taken in relation to the patient safety incident.
- a copy of the incident report.

Appendix 6

BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of patient circumstance.

When a patient dies

When a patient safety incident has resulted in a patient's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counseling or assistance at any stage.

"it may be appropriate to wait for the coroner's inquest before holding the '*Being open*' discussion"

Usually, the 'Being open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being open' discussion with the patient's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event, an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being open' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Patients with mental health issues

'Being open' for patients with mental health issues should follow standard procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient; to do so may constitute an infringement of the patient's Human Rights and/or a breach of Data Protection legislative provisions.

Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The *'Being open'* discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the patient's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the patient is not cognitively impaired they should be supported in the *'Being open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the *'Being open'* process, focusing on ensuring that the patient's views are considered and discussed.

Patients with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the *'Being open'* process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the patient agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the patient has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team.
- Offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution.
- Ensure the patient and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

Appendix 7

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

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Appendix 8

Comparison of BHSCT vs NPSA incident grading matrix.

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 9.

Guidance on Issuing an apology – NI Ombudsman

Guidance on issuing an apology - Ombuds

2 027

Belfast Health and Social Care Trust

Reference No: SG 56/11

Title:	*'Being Open'* policy – saying sorry when things go wrong.		
Author(s)	JR Johnston, Co-Chair, Standards and Guidelines Committee. Standards, Quality and Audit Dept, Tel: 02890 636380 [redacted]		
Ownership:	Dr C 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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Date	Version	Author	Comments
17/4/2014	V1.1	JRJ	S+G put into new template
9/10/2014	V1.2	JRJ	Hyperlinks fixed; Francis report
22/01/2015	V1.3	CM	Change to scope and Appendix 2b to reflect application of principles to minor incidents
24/02/2015	V1.4	JRJ	Editing, Duty of candour section 1.1.2
14/04/2015	V1.5	JRJ	Check Hyperlinks, Contents, appendices, 1.1.2

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1.0 INTRODUCTION / PURPOSE OF POLICY

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being open' involves:

- acknowledging, apologising and explaining when things go wrong
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT '*Being open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of 'Seven steps to Service user Safety' (appendix 1).

1.1 Background

1.1.1 Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The General Medical Council in their document Good Medical Practice sets out the principles and values on which good practice is founded. It contains a section on: Being open and honest with patients if things go wrong when:-

- If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.
- Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being open*' policies. Their guidance was replaced in November 2009 by Being open: communicating patient safety incidents with patients, their families and carers in response to changes in the healthcare environment and in order to strengthen '*Being open*' throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being open*' policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being open*' at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based on the '*Being open*' Framework document.

From: Being Open Framework, NPSA, November 2009.

1.1.2 **Francis report**

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'.

These were defined as,

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.'

This BHSCT policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy. The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

1.1.3 **A. Open and fair culture**

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any incident
- organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

B. 'Being Open' policy

A *'Being open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being open'* it is vital that:

- Patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it.

To implement *'Being open'* successfully, the BHSCT will have the following foundations:

A. a culture that is open and fair.
B. a *'Being open'* policy and mechanisms to raise awareness about it.
C. staff and patient support for *'Being open'*.

1.1.4 **Prevented and 'no harm' incidents**

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This

monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm patient safety incidents are discussed with patients as this would cause undue and unnecessary anxiety. This does not absolve staff or their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 **Being open**

The main thrust of this 'Being open' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 2). It describes the process of 'Being open' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 **Definitions**

"Harm" is the condition of promoting injury or damage.

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

1.2 Purpose

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind '*Being open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the BHSCT's commitment to '*Being open'* by establishing a culture where:

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.

- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The BSHCT Adverse Incident Reporting and Management Policy encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The *'Being Open'* principles apply to any incident where any harm has occurred to a patient. The *'Being Open'* process outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in appendix 2a+b and within steps 1+2 of the BHSCT Procedure for grading an adverse incident; incidents that are regarded as insignificant or minor do not require implementation of the Being Open process , although the principles should be applied (section 1.1.4).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies. It sets the scene of openness as a founding principle behind:-

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the concept of this *'Being open'* culture of openness applying throughout the organization.

Trust Board

The Trust Board are responsible

- for actively championing the *'Being open'* process.
- by promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Chief Executive
The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

Executive Directors
Medical Director/Director of Nursing/ Director of Adult Social & Primary Care
Overall professional responsibility for managing the *'Being Open'* process.

Service Directors
Responsibility within their own service directorate for managing the *'Being Open'* process.

Managers
- Ensuring all staff are aware of the "Being Open" policy.

- Supporting staff, particularly those who will have a key role in managing the being open process, in completing Being Open e-learning training available on the HUB http://elearning.belfasttrust.local/

- Supporting staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare.

- Notifying the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.

  - Medical Director } that the *'Being Open'* process has
    Nursing Director } been initiated for an incident
    Primary and Social Care Director } causing
    Service Director } major or catastrophic harm.

All Healthcare Staff
All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:-
- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.
- recording and documenting discussions with patients and families
- complying with the *'Being Open'* policy.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)

Patient safety incidents will be managed using the principles outlined in this BHSCT '*Being open'* policy. Each incident will trigger a 5 stage process as set out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a patient's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the patient's illness, its treatment and the factors causing and/or contributing to the patient's death are discussed with the relatives and recorded in the clinical record.

4.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the patient about an incident in a truthful open and timely manner. Information must be based solely on the facts. Patients will not receive conflicting information from different members of staff.

4.5 Patients and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a patient safety incident.

10 principles of 'Being open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 9).

4.6 Support for the Patient

A key part of '*Being open*' is considering the patient's needs, or the needs of their carers or family in circumstances where the patient has been involved in a serious patient safety incident or died. The Trust will ensure early identification of and provision for the patient's practical and emotional needs.

Patients and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a patient safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the patient has agreed that information about their health care can be given. This person (or people) may be different to both the patient's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the patient safety incident. The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the patient identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the patient, using the most appropriate method of communication from the patient's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

Public information statement
'*Being open*' if things go wrong:
We will
- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

It is important to identify at the outset if there are any special restrictions on openness that the patient would like the healthcare team to respect. It is also important to identify whether the patient does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

4.7 Support for Families, Carers

Patients and/or their carers may need considerable practical and emotional help and support after experiencing a patient safety incident. Support may be provided by patients' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the patient needs more detailed long-term emotional support, advice should be provided on how

to gain access to appropriate counseling services, e.g. Cruse (the UK's largest bereavement charity).

A patient and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Information on the '*Being open'* process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

4.9 **Support for staff**

These guidelines apply to all staff that have a role in providing patient care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a patient safety incident occurs, healthcare professionals involved in the clinical care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for *'Being open'* discussions should be given access to assistance, support and any information they need to fulfill this role.

To **support staff** involved the trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report patient safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the patient safety incident will be available.
- Provide advice and training on the management of patient safety incidents.
- Provide counselling by professional bodies for staff distressed by patient safety incidents. Stress management courses for staff that have responsibilities for leading "Being open" discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with patients and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.10 Patient safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The '*Being Open*' policy is part of an integrated approach to addressing patient safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the patient's care. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the '*Being open'* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the '*Being open'* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance framework** in which patient safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of patient safety issues and the value of '*Being open'*.

4.13 Full **confidentiality** of and respect for patients, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating patients. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.14 Patients are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion.

If a patient expresses a preference for their healthcare needs to be taken over by another team, the Trust will make every effort to make the appropriate arrangements unless it is clearly obvious not to be in the patient's best interests

5.0 IMPLEMENTATION OF POLICY

On line training "Being Open – Saying sorry when things go wrong" is suitable for all staff and is available on the HUB e-learning page at:

http://elearning.belfasttrust.local/

6.0 MONITORING

This policy will be audited through the Audit and Risk & Governance departments.

7.0 EVIDENCE BASE / REFERENCES

Legacy Trust Guidance
BSHCT Adverse Incident Reporting and Management Policy
BHSCT Risk Management Strategy 2008-11.
National Patient Safety Agency documents.
Australian Open Disclosure Framework

National Patient Safety Agency
1. Seven steps to patient safety: full reference guide – July 2004.
2. Being open: communicating patient safety incidents with patients, their families and carers
3. 'Being open' Framework – November 2009.

8.0 CONSULTATION PROCESS

Trust Service Group Directors & Staff Side
Standards and Guidelines Committee.
BHSCT Clinical Ethics Committee

9.0 APPENDICES / ATTACHMENTS

Appendix 1 = Seven Steps for Safety
Appendix 2a = NPSA grade and definition of patient safety incident
Appendix 2b = Grades and consequent actions following Patient Safety Incidents.
Appendix 3 = Benefits for patients
Appendix 4 = Benefits for Staff patients
Appendix 5 = The '*Being open*' process
Appendix 6 = Being open in particular circumstances
Appendix 7 = NPSA '*Being open*' safety alert November 2009
Appendix 8 = Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 9 = Guidance on issuing an apology – NI Ombudsman.

10.0 EQUALITY STATEMENT

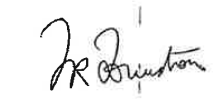
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been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



_____ **Date: _____February 2015_____**

_____ **Date: _____February 2015_____**

Appendix 1

NPSA - Seven steps to patient safety.

National Patient Safety Agency. *Seven steps to patient safety. The full reference guide*. 2004.

Appendix 2a

BHSCT – Definitions for grading of Patient Safety Incidents

Insignificant

Incident prevented / Near Miss

Any patient safety incident that had the potential to cause harm but was prevented and no harm was caused to patients receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented

Any patient safety incident that occurred but insignificant harm was caused to patients receiving NHS-funded care.

Minor harm

Any patient safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more patients receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, canceling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any patient safety incident that appears to have resulted in permanent harm* to one or more patients receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any patient safety incident that directly resulted in the death* of one or more patients receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.*

Appendix 2b

Grades and consequent actions following Patient Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	**Significant but not permanent harm - moderate increase in treatment.**	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased patient monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being open'.		**Apply the 'Being open' process Stages I →V.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. 3. The principles of the 'Being Open' policy apply but no documented actions are required.		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the *'Being open'* process if required.		

Appendix 3

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by patients and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious patient safety incident indicate that the patients would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

Appendix 4

BENEFITS FOR STAFF

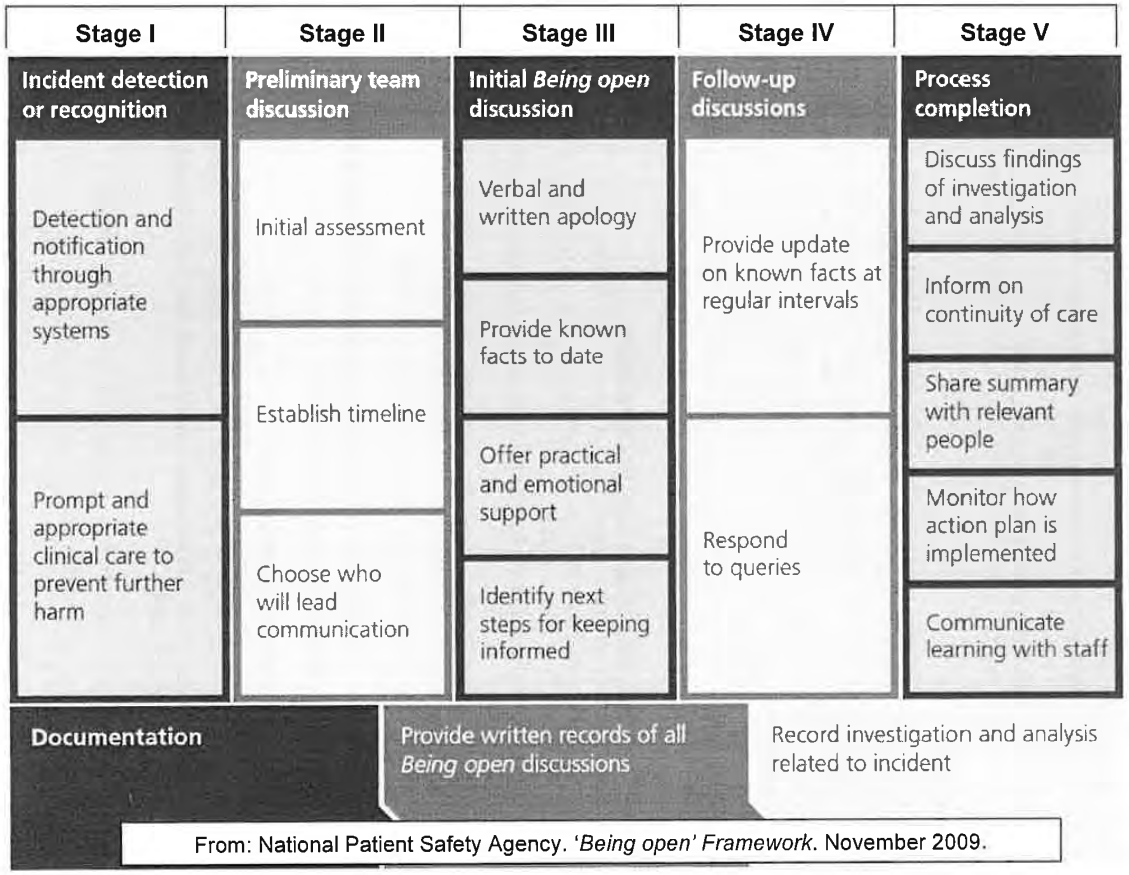
Being open has several benefits for healthcare staff including:

- Satisfaction that communication with patients and /or their carers following a patient safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the patient and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 5

'*BEING OPEN*' PROCESS

'Being open' is a process rather than a one-off event and can be considered in 5 stages with documentation being a constant feature throughout the process.



From: National Patient Safety Agency. '*Being open' Framework*. November 2009.

STAGE I: INCIDENT DETECTION AND RECOGNITION

The '*Being open*' process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a patient safety incident.

Detection of the incident

A patient safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a patient and/or their carers who expresses concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other patients, visitors or non-clinical staff.

Priority

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse incident criteria , the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB .

Patient safety incidents occurring elsewhere

A patient safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier patient safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the patient safety incident has already been recognized.
- the process of '*Being open*' has commenced.
- incident investigation and analysis is underway.

The '*Being open*' process and the investigation and analysis of a patient safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Patient safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: PRELIMINARY TEAM DISCUSSION

The multidisciplinary team, including the most senior health professional involved in the patient safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts.
- assess the incident to determine the level of immediate response.
- identify who will be responsible for discussion with the patient and/or their carers = *'Being open'* coordinator.
- consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the patient's needs and communicating them back to the healthcare team.
- identify immediate support needs for the healthcare staff involved.
- ensure there is a consistent approach by all team members around discussions with the patient and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm (including prevented patient safety incident)	It is not a requirement of this policy to communicate prevented patient safety incidents and insignificant incidents to patients and/or carers.
Minor harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the patient's care and the patient and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **↳ Apply the principles of 'Being open' – locally.**
Moderate harm, Major harm Death	A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the 'Being open' process if required. **↳Apply the 'Being open' process – Stages I → V.**

Timing of discussion with patient and/or carers

Preliminary discussions with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this and any future '*Being open*' discussions include:

- clinical condition of the patient.
- patient preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being open*' process.
- availability of the patient's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The '*Being open*' coordinator role

It is essential to carefully consider the choice of the individual to communicate with patients and who informs the patient and/or their carers about a patient safety incident. Getting it right at the start of the process will reassure the patient and may lead to a favourable outcome. This should be the most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the patient and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident to be credible to patients, carers and colleagues.
- have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers.
- be able to maintain a medium to long term relationship with the patient and/or their carers, where possible, and to provide continued support and information.
- be culturally aware and informed about the specific needs of the patient and/or their carers.

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute with whom the patient is satisfied should be provided.

Use of a substitute healthcare professional for the 'B*eing open*' discussion

In exceptional circumstances, if the '*Being open*' coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'B*eing open*' discussion

The healthcare professional communicating information about a patient safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being open*' procedures.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the '*Being open*' process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the patient and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a patient safety incident asks to be involved in the '*Being open*' discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate

patient safety information alone or to be delegated the responsibility to lead a '*Being open*' discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Patient safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the patient and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being open*' discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake

Some patient safety incidents result from errors made by the healthcare staff caring for the patient. In these circumstances the member(s) of staff involved may or may not wish to participate in the '*Being open*' discussion with the patient and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the patient and/or their carers with those of the healthcare professional concerned.

In cases where the healthcare professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the patient and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient and/or their carers during the first '*Being open*' discussion.

STAGE III: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'B*eing open'* discussion

The patient and/or their carers should be advised of the identity and role of all people attending the '*Being open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.

The content of the initial '*Being open'* discussion with the patient, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The patient, their family and/or their carers
    - should be informed that an incident investigation is being carried out.
    - understanding of what happened is taken into consideration, as well as any questions they may have.
    - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the patient's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the patient safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the patient with access to information to assist in making decisions if the patient is unable to participate in decision-making or if the patient has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the patient's instructions.
- Ensure carers are provided with known information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with patients and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to patients, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the patient and the incident should not normally be disclosed to third parties without consent.

STAGE IV: FOLLOW UP DISCUSSIONS

Follow-up discussions with the patient, their family and carers are an important step in the *'Being open'* process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the patient's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the patient and/or their carers to obtain information about the patient safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the patient and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The patient and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the patient and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records.
- The patient should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE V: PROCESS COMPLETION

Communication with the patient, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the patient. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why*.
- details of the patient's, their family's and carers' concerns and complaints.
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident.
- a summary of the factors that contributed to the incident.
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the patient's GP, before discharge, describing what happened. When the patient leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the patient safety incident and the continuing care and treatment;
- the current condition of the patient;
- key investigations that have been carried out to establish the patient's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being open* process it is important to record discussions with the patient, their family and carers as well as the incident investigation.
Written records of the '*Being open*' discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the patient, their family and carers.
- offers of assistance and the patient's, their family's and carers' response.
- questions raised by the patient, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and carers.
- copies of letters sent to the patient, their family and carers, and the GP.
- copies of any statements taken in relation to the patient safety incident.
- a copy of the incident report.

Appendix 6

BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of patient circumstance.

When a patient dies

When a patient safety incident has resulted in a patient's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counseling or assistance at any stage.

"it may be appropriate to wait for the coroner's inquest before holding the '*Being open*' discussion"

Usually, the 'Being open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being open' discussion with the patient's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event, an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being open' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.
Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Patients with mental health issues

'Being open' for patients with mental health issues should follow standard procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the express permission of the patient; to do so may constitute an infringement of the patient's Human Rights and/or a breach of Data Protection legislative provisions.

Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The '*Being open*' discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the patient's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the patient is not cognitively impaired they should be supported in the '*Being open*' process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the '*Being open*' process, focusing on ensuring that the patient's views are considered and discussed.

Patients with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the '*Being open*' process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the patient agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the patient has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team.
- Offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution.
- Ensure the patient and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

Appendix 7

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open.*
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

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Appendix 8

Comparison of BHSCT vs NPSA incident grading matrix.

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 9.

Guidance on Issuing an apology – NI Ombudsman

Guidance on issuing an apology - Ombuds

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 56/11

Title:	**Being Open policy – saying sorry when things go wrong**		
Author(s)	Eugene Doherty, Medical Devices Coordinator, Corporate Governance		
Ownership:	Dr Cathy Jack, Medical Director		
Approval by:	Standards and Guidelines Committee Policy Committee Executive Team Meeting	**Approval date:**	4th July 2018 1st August 2018 9th August 2018
Operational Date:	July 2018	**Next Review:**	July 2023
Version No.	3 **Supercedes**	v2 April 2015	
Key words:	Being Open, Duty of Candour, Adverse incident, Complaint		
Links to other policies	Adverse Incident Reporting and Management Policy BHSCT Procedure for grading an adverse incident		

Date	Version	Author	Comments
17/4/2014	1.1	JRJ	S+G put into new template
9/10/2014	1.2	JRJ	Hyperlinks fixed; Francis report
22/01/2015	1.3	CM	Change to scope and Appendix 2b to reflect application of principles to minor incidents
24/02/2015	1.4	JRJ	Editing, Duty of candour section 1.1.2
14/04/2015	1.5	JRJ	Check Hyperlinks, Contents, appendices, 1.1.2
24/05/2018	1-4	ED	Original author Dr JR Johnston removed from AUTHOR box Linked Policies hyperlinks removed Contents table updated and repaired Broken hyperlinks corrected Seven steps graphic revised Benefits for Patients & Staff combined Being Open Process Stages table (appendix 5) changed to table as used in BHSCT elearning Appendix 8 – NI ombudsman guidance reproduced in appendix rather than link Appendix 9 – inquiry reports relating to duty of candour, including Francis report section from main body of policy Being open changed to Being Open for consistency Appendices bookmarked Formatting corrected for consistency

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1.0 INTRODUCTION / PURPOSE OF POLICY

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being Open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being Open' involves:

- acknowledging, apologising and explaining when things go wrong
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT '*Being Open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven steps to Patient Safety'* (appendix 1).

1.1 Background

1.1.1 Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

This is supported by *Openness and honesty when things go wrong: the professional duty of candour*, issued by the GMC and NMC in 2015 summarising their position on this and provides guidance on how to follow the principles set out in *Good Medical Practice* (GMC) and *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC)

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being Open'* policies. Their guidance was replaced in November 2009 by *Being Open: communicating patient safety incidents with patients, their families and carers* in response to changes in the

healthcare environment and in order to strengthen '*Being Open'* throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being Open'* policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being Open'* at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy and the '*Being Open'* Framework document..

1.1.2 Recommendations from Inquiry Reports

In recent years there have been a number of reports arising from diverse inquiries into healthcare both in England and Northern Ireland and all of these have included recommendations in regard to Being Open and Duty of candour. The summary of the relevant recommendations are in **appendix 9** and include the Francis Report (2013), the Donaldson Report (2014) and the Hyponatraemia Inquiry (O'Hara 2018)

Although there is currently no statutory duty of candour in Northern Ireland, as recommended by the Donaldson and O'Hara reports, the suggestion has been endorsed by previous Northern Ireland health minsters

1.1.3 BHSCT will have the following foundations to implement '*Being Open'* successfully:

A. Open and fair culture

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any incident
- organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

To implement '*Being Open'* successfully, the BHSCT will have the following foundations:

A. a culture that is open and fair.
B. a '*Being Open'* policy and mechanisms to raise awareness about it.
C. staff and patient support for '*Being Open'.*

B. 'Being Open' policy & associated training

A *'Being Open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

An elearning programme that provides information on the fundamentals of applying the Being Open Process and includes a case study

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being Open'* it is vital that:

- Patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it, and that were appropriate they undertake the Being Open e-learning programme.

1.1.4 Prevented and 'no harm' incidents

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm patient safety incidents are discussed with patients as this would cause undue and unnecessary anxiety. This does not absolve staff or their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 Being Open

The main thrust of this 'Being Open' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 2). It describes the process of 'Being Open' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The Trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While Trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 Definitions

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

1.2 Purpose

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind '*Being Open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the BHSCT's commitment to '*Being Open'* by establishing a culture where:

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.
- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The BSHCT *Adverse Incident Reporting and Management Policy* encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The *'Being Open'* **principles** apply to any incident where any harm has occurred to a patient. The *'Being Open'* **process** outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in appendix 2a+b and within steps 1+2 of the BHSCT Procedure for grading an adverse incident; incidents that are regarded as insignificant or minor do not require implementation of the Being Open process , although the principles should be applied (section 1.1.4).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies. It sets the scene of openness as a founding principle behind:-

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the concept of this *'Being Open'* culture of openness applying throughout the organization.

Trust Board

The Trust Board are responsible

- for actively championing the *'Being Open'* process.
- for promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

Executive Directors

Medical Director/Director of Nursing/ Director of Adult Social & Primary Care

Overall professional responsibility for managing the '*Being Open'* process.

Service Directors

Responsibility within their own service directorate for managing the '*Being Open'* process.

Managers

- Ensure all staff are aware of the "Being Open" policy.
- Support staff, particularly those who will have a key role in managing the being open process, in completing Being Open e-learning training available on the HUB http://elearning.belfasttrust.local/
- Support staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare.
- Notify the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.
  - Medical Director } that the '*Being Open'* process has
    Nursing Director } been initiated for an incident
    Primary and Social Care Director } causing
    Service Director } major or catastrophic harm.

All Healthcare Staff

All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:

- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.
- recording and documenting discussions with patients and families
- complying with the *Being Open* policy
- undertaking the Being Open e-learning programme where appropriate.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)

Patient safety incidents will be managed using the principles outlined in this BHSCT '*Being Open'* policy. Each incident will trigger a 5 stage process as set out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a patient's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the patient's illness, its treatment and the factors causing and/or contributing to the patient's death are discussed with the relatives and recorded in the clinical record.

4.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the patient about an incident in a truthful open and timely manner. Information must be based solely on the facts. Patients will not receive conflicting information from different members of staff.

4.5 Patients and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a patient safety incident.

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

10 principles of 'Being Open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 9).

4.6 Support for the Patient

A key part of 'Being Open*'* is considering the patient's needs, or the needs of their carers or family in circumstances where the patient has been involved in a serious patient safety incident or died. The Trust will ensure early identification of and provision for the patient's practical and emotional needs.

Patients and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a patient safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the patient has agreed that information about their health care can be given. This person (or people) may be different to both the patient's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the patient safety incident.

The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the patient identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the patient, using the most appropriate method of communication from the patient's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

Public information statement
'*Being Open*' if things go wrong:
We will
- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

It is important to identify at the outset if there are any special restrictions on openness that the patient would like the healthcare team to respect. It is also important to identify whether the patient does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

4.7 Support for Families, Carers

Patients and/or their carers may need considerable practical and emotional help and support after experiencing a patient safety incident. Support may be provided by patients' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the patient needs more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counseling services, e.g. Cruse (the UK's largest bereavement charity).

A patient and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Information on the 'Being Open*'* process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

4.9 **Support for staff**

These guidelines apply to all staff that have a role in providing patient care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a patient safety incident occurs, healthcare professionals involved in the clinical care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for '*Being Open'* discussions should be given access to assistance, support and any information they need to fulfill this role.

To **support staff** involved the Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The Trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report patient safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the patient safety incident will be available.
- Provide advice and training on the management of patient safety incidents.
- Provide counselling by professional bodies for staff distressed by patient safety incidents. Stress management courses for staff that have responsibilities for leading "Being Open" discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with patients and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.10 Patient safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The '*Being Open*' policy is part of an integrated approach to addressing patient safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the patient's care. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the '*Being Open'* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the '*Being Open'* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance framework** in which patient safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of patient safety issues and the value of '*Being Open'*.

4.13 Full **confidentiality** of and respect for patients, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating patients. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.14 Patients are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion.

If a patient expresses a preference for their healthcare needs to be taken over by another team, the Trust will make every effort to make the appropriate arrangements unless it is clearly obvious not to be in the patient's best interests.

5.0 IMPLEMENTATION OF POLICY

On-line training "Being Open – Saying sorry when things go wrong" is suitable for all staff and is available on the HUB e-learning page at:

http://elearning.belfasttrust.local/

6.0 MONITORING

This policy will be audited through the Audit and Risk & Governance departments.

7.0 EVIDENCE BASE / REFERENCES

- BSHCT Adverse Incident Reporting and Management Policy

- BHSCT Risk Management Strategy 2017-20.
- National Patient Safety Agency documents.
- Australian Open Disclosure Framework
- *Seven steps to patient safety: full reference guide – (NPSA July 2004).*
- *Being open: communicating patient safety incidents with patients, their families and carers (NPSA, 2009)*
- *'Being Open' Framework* – (NPSA, November 2009).
- Openness & Honesty when things go wrong: the professional duty of candour (NMC/GMC 2015) **https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf**
- The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013),
- Right time, right Place (Donaldson Report) (2014)
- Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)
- Guidance on issuing an apology, NIPSO June 2016, https://nipso.org.uk/site/wp-content/uploads/2018/05/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-June-2016-1.pdf

8.0 CONSULTATION PROCESS

Trust Service Group Directors & Staff Side
Standards and Guidelines Committee.
BHSCT Clinical Ethics Committee

9.0 APPENDICES / ATTACHMENTS

Appendix 1:	Seven steps to patient safety
Appendix 2a:	NPSA grade and definition of patient safety incident
Appendix 2b:	Grades and consequent actions following Patient Safety Incidents.
Appendix 3:	Benefits for Patients & Staff
Appendix 4:	The '*Being Open'* process
Appendix 5:	Being open in particular circumstances
Appendix 6:	NPSA '*Being Open'* safety alert November 2009
Appendix 7:	Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 8:	Guidance on issuing an apology – NI Ombudsman
Appendix 9:	inquiry reports relating to duty of candour

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 ☐

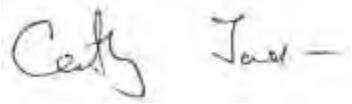
Minor impact ☐

No impact ☒

SIGNATORIES

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

_____ **Date: _____June 2018_____**



_____ **Date: _____ June 2018_____**

Appendix 1

NPSA - Seven steps to patient safety

National Patient Safety Agency. *Seven steps to patient safety*. *The full reference guide*. 2004.

Appendix 2a

BHSCT – Definitions for grading of Patient Safety Incidents

Insignificant

Incident prevented / Near Miss

Any patient safety incident that had the potential to cause harm but was prevented and no harm was caused to patients receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented

Any patient safety incident that occurred but insignificant harm was caused to patients receiving NHS-funded care.

Minor harm

Any patient safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more patients receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, canceling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any patient safety incident that appears to have resulted in permanent harm* to one or more patients receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any patient safety incident that directly resulted in the death* of one or more patients receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.*

Appendix 2b

Grades and consequent actions following Patient Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	**Significant but not permanent harm - moderate increase in treatment.**	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased patient monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being Open'.		**Apply the 'Being Open' process Stages I →VI.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. 3. The principles of the 'Being Open' policy apply but no documented actions are required.		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the '*Being Open'* process if required.		

Appendix 3

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by patients and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious patient safety incident indicate that the patients would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

BENEFITS FOR STAFF

Being open has several benefits for healthcare staff including:

- Satisfaction that communication with patients and /or their carers following a patient safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the patient and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 4

'*BEING OP*EN' PROCESS

'Being Open' is a process rather than a one-off event and can be considered in 6 stages with documentation being a constant feature throughout the process.

Stage I	Stage II		Stage III	Stage IV	Stage V
Patient incident detection and recognition	**Preliminary Team discussion**		**Initial Being Open meeting/ contact**	**Follow-up meetings/ contacts**	**Being Open process completed**
	Inform service user/carer	**Plan further Being Open process**			
Patient safety incident recognised **Prompt care and actions to prevent any further harm** **Incident reporting** **Identify staff and service user support & communication needs**	**Minor** **Initial assessment to determine level of response - grading** **Provide open honest factual information** **Offer initial verbal apology / expression of regret/sympathy** **Offer initial support** **Discuss further contacts**	**Moderate, Major, Catastrophic** **Establish the facts** **Decide the process** **Identify lead person & clarify if this is lead contact** **Agree with SU/Family who will meet with who when and where** **Identify support needed**	**Explain the process** **Offer apology /regret/sympathy & support** **Provide factual details** **Explain learning process** **Invite questions / comments/take notes** **Agree any further contact**	**Confirm meeting in writing and provide written apology** **Keep in touch as agreed at meeting** **Trust investigation process** **Feedback method agreed with SU/family**	**Feedback from the investigation process, learning and actions** **- to service users / family and carers** **- to other Trust staff and partners** **Monitoring**
No Being Open process required for near miss or no harm incidents	End of the Being Open process for low harm incidents		May be end of Being Open process or may agree further contact		End of Being Open process

Documentation

Keep written records of all *Being Open* contacts/discussions:
- **When** (date/time)
- **Who** was involved
- **What** information was given by who

Record incident review process & learning outcomes

Adapted From: National Patient Safety Agency. 'Being Open' Framework. November 2009.

Details of Key Stages of Being Open Process

STAGE I: INCIDENT DETECTION AND MANAGEMENT

The '*Being Open'* process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a patient safety incident.

Detection of the incident

A patient safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a patient and/or their carers who expresses concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other patients, visitors or non-clinical staff.

Priority

As soon as a patient safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the patient and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse incident criteria , the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB .

Patient safety incidents occurring elsewhere

A patient safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier patient safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the patient safety incident has already been recognized.
- the process of '*Being Open'* has commenced.
- incident investigation and analysis is underway.

The '*Being Open'* process and the investigation and analysis of a patient safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Patient safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: INFORM SERVICE USER/CARER

Provide open honest factual information

Offer initial verbal apology / expression of regret /sympathy

An expression of genuine sympathy, regret and an apology for the harm that has occurred.

Appropriate language and terminology are used when speaking to patients, their families and carers.

Offer initial support

Staff should ensure the patient, their family and/or their carers

- are informed that an incident investigation is being carried out if appropriate.
- show understanding of what happened is taken into consideration, as well as any questions they may have.
- are provided with information on the complaints procedure if they wish to have it;

Consideration and formal noting of the patient's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.

Discuss further contacts

An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the patient and the incident should not normally be disclosed to third parties without consent.

Discussions with patients and/or their carers are documented and that information is shared with them;

This is the end of the Being Open process for low harm incidents

STAGE III: PRELIMINARY TEAM DISCUSSION/ Plan further Being Open Process

The multidisciplinary team, including the most senior health professional involved in the patient safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts.
- assess the incident to determine the level of immediate response.
- identify who will be responsible for discussion with the patient and/or their carers = '*Being Open'* coordinator.
- consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the patient's needs and communicating them back to the healthcare team.
- identify immediate support needs for the healthcare staff involved.
- ensure there is a consistent approach by all team members around discussions with the patient and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm **(including prevented patient safety incident)**	It is not a requirement of this policy to communicate prevented patient safety incidents and insignificant incidents to patients and/or carers.
Minor harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the patient's care and the patient and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **↳Apply the principles of 'Being Open' – locally.**
Moderate harm, **Major harm** **Death**	A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the 'Being Open' process if required. **↳Apply the 'Being Open' process – Stages I → VI.**

Timing of discussion with patient and/or carers

Preliminary discussions with the patient and/or their carers should occur as soon as possible after recognition of the patient safety incident. Factors to consider when timing this and any future '*Being Open*' discussions include:

- clinical condition of the patient.
- patient preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being Open'* process.
- availability of the patient's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The *'Being Open'* coordinator role

It is essential to carefully consider the choice of the individual to communicate with patients and who informs the patient and/or their carers about a patient safety incident. Getting it right at the start of the process will reassure the patient and may lead to a favourable outcome. This should be the most senior person responsible for the patient's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the patient and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident to be credible to patients, carers and colleagues.
- have excellent interpersonal skills, including being able to communicate with patients and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- be willing and able to offer an apology, reassurance and feedback to patients and/ or their carers.
- be able to maintain a medium to long term relationship with the patient and/or their carers, where possible, and to provide continued support and information.
- be culturally aware and informed about the specific needs of the patient and/or their carers.

If for any reason it becomes clear during the initial discussion that the patient would prefer to speak to a different healthcare professional, the patient's wishes should be respected. A substitute with whom the patient is satisfied should be provided.

Use of a substitute healthcare professional for the 'Being Open' discussion

In exceptional circumstances, if the '*Being Open'* coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'Being Open' discussion

The healthcare professional communicating information about a patient safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being Open'* procedures.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the '*Being Open'* process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the patient and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a patient safety incident asks to be involved in the '*Being Open'* discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate patient safety information alone or to be delegated the responsibility to lead a '*Being Open'* discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Patient safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the patient and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being Open'* discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake

Some patient safety incidents result from errors made by the healthcare staff caring for the patient. In these circumstances the member(s) of staff involved may or may not wish to participate in the '*Being Open'* discussion with the patient and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the patient and/or their carers with those of the healthcare professional concerned.

In cases where the healthcare professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the patient and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the patient and/or their carers during the first '*Being Open'* discussion.

STAGE IV: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'Being Open' discussion

The patient and/or their carers should be advised of the identity and role of all people attending the '*Being Open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.

The content of the initial '*Being Open'* discussion with the patient, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The patient, their family and/or their carers
    - should be informed that an incident investigation is being carried out.
    - understanding of what happened is taken into consideration, as well as any questions they may have.
    - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the patient's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the patient safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the patient with access to information to assist in making decisions if the patient is unable to participate in decision-making or if the patient has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the patient's instructions.
- Ensure carers are provided with known information, care and support if a patient has died as a result of a patient safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with patients and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to patients, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the patient and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the patient will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the patient and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the patient and the incident should not normally be disclosed to third parties without consent.

STAGE V: FOLLOW UP DISCUSSIONS

Follow-up discussions with the patient, their family and carers are an important step in the *'Being Open'* process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the patient's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the patient and/or their carers to obtain information about the patient safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the patient and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The patient and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the patient and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the patient and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the patient's records.
- The patient should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE VI: PROCESS COMPLETION

Communication with the patient, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the patient. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why.*
- details of the patient's, their family's and carers' concerns and complaints.
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety incident.
- a summary of the factors that contributed to the incident.
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the patient's GP, before discharge, describing what happened. When the patient leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the patient safety incident and the continuing care and treatment;
- the current condition of the patient;
- key investigations that have been carried out to establish the patient's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being Open* process it is important to record discussions with the patient, their family and carers as well as the incident investigation.
Written records of the '*Being Open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the patient, their family and carers.
- offers of assistance and the patient's, their family's and carers' response.
- questions raised by the patient, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the patient, their family and carers.
- copies of letters sent to the patient, their family and carers, and the GP.
- copies of any statements taken in relation to the patient safety incident.
- a copy of the incident report.

Appendix 05

BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the patient's personal circumstances. The following gives guidance on how to manage different categories of patient circumstance.

When a patient dies

When a patient safety incident has resulted in a patient's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counseling or assistance at any stage.

Usually, the 'Being Open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being Open' discussion with the patient's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the patient's death. In any event, an apology should be issued as soon as possible after the patient's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

> "it may be appropriate to wait for the coroner's inquest before holding the '*Being Open'* discussion"

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being Open' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Patients with mental health issues

'Being Open' for patients with mental health issues should follow standard procedures, unless the patient also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the

express permission of the patient; to do so may constitute an infringement of the patient's Human Rights and/or a breach of Data Protection legislative provisions.

Patients with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The '*Being Open'* discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the patient's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the patient as a whole and not simply their medical interests. However, the patient with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients with learning disabilities

Where a patient has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the patient is not cognitively impaired they should be supported in the '*Being Open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the patient, should be appointed. Appropriate advocates may include carers, family or friends of the patient. The advocate should assist the patient during the '*Being Open'* process, focusing on ensuring that the patient's views are considered and discussed.

Patients with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Patients who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the patient and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the '*Being Open'* process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the patient agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the patient has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the patient expressing their concerns to other members of the clinical team.
- Offer the patient and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution.
- Ensure the patient and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the patient and/or their carer disagree with and reassure them you will follow up these issues.

Appendix 06

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

National Reporting and Learning Service
National Patient Safety Agency
4-8 Maple Street, London, W1T 5HD
T: 020 7927 9500 F: 020 7927 9501
www.nrls.npsa.nhs.uk

Appendix 07

Comparison of BHSCT vs NPSA incident grading matrix

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 08

GUIDANCE ON ISSUING AN APOLOGY

When the Ombudsman investigates a complaint and finds maladministration, she may recommend that the public service provider offers an apology. In these circumstances the complainant may have been waiting a considerable period of time for the organisation to provide a full explanation as to what went wrong and to acknowledge any failings.

What is an apology?

An apology can be defined as a 'regretful acknowledgement of an offence or failure'. Mistakes can be made by one member of staff, a whole team or there may be systemic failures within an organisation. When things do go wrong, most people who have had a bad experience may simply seek an acknowledgement and, if appropriate, to be given an explanation and an apology.

Why apologise?

In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. The value of this approach should not be underestimated. A prompt acknowledgement and apology, where appropriate, can often prevent the complaint escalating. It can help restore dignity and trust in the public service provider and can be the first step in putting things right.

What are the implications of an apology?

Although there is no legislation in this area of law which applies specifically to Northern Ireland, the Compensation Act 2006 governing England and Wales states that 'an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or statutory duty.' The timely provision of a full apology may in fact reduce the chances of litigation.

What is a meaningful apology?

Each complaint is unique so your apology will need to be based on the individual circumstances. It is important when you are making an apology, you understand how and why the person making the complaint believes they were failed and what they want in order to put things right. Failing to acknowledge the complainant's whole experience is only a partial apology and therefore less effective.
To make an apology meaningful you should:

- Accept you have done wrong. You should include identifying the failure along with a description of the relevant action or omission to which the apology

applies. This should include any failings that the Ombudsman identified in her investigation that warrant an apology. Your description must be specific to show that you understand the effect your act or omission has had on the complainant. It must also acknowledge if appropriate, that the affected person has suffered disappointment, hurt, anxiety, upset or loss.

- Clearly explain why the failure happened and include that the failure was not intentional or personal. If there is no explanation, however, one should not be offered. Care should be taken to provide full explanations rather than excuses.
- Demonstrate that you are sincerely sorry. An apology should be an expression of sorrow or at the very least an expression of regret. The nature of the harm done will determine whether the expression of regret should be made in person as well as being reinforced in writing; or simply in writing.
- Reassure the complainant that you will not repeat the failure. This may include a statement of the steps that have been taken, or will be taken, to address the failure, and, if possible, to prevent a reoccurrence.
- Provide the complainant with a statement of specific steps proposed to address the grievance or problem, by mitigating the harm or offering a remedy.

How should I make an apology?

There is no 'one size fits all' apology but the following points reflect some general good practice:

1. The timing of an apology is very important. Once you establish that you have done wrong, apologise. If you delay, you may lose your opportunity to apologise.
2. The language you use should be clear, plain and direct.
3. Your apology should not be conditional by qualifying the apology by saying for example: 'I apologise if you feel that the service provided to you was not acceptable' or 'if mistakes have been made, I apologise'.
4. To make an apology meaningful, do not distance yourself from the apology.

   Generalised apologies such as 'I am sorry for what occurred' or 'mistakes were made' do not sound natural or sincere. It is much better to accept responsibility by stating 'It was my fault'.
5. Avoid enforced apologies such as 'I have received the Investigation report from the Ombudsman and am therefore carrying out her recommendations by apologising to you for the shortcomings identified in her report.'
6. It is also very important to apologise to the right person or the right people.

Who should apologise?

If, in her Investigation report, the Ombudsman has made a recommendation that an apology should be provided to the complainant, then we would expect to see the Chief Executive, Director or Head of Department of the public service provider involved making the apology.

Who should receive the apology?

The apology should be sent directly to the complainant who is named in the Ombudsman's Investigation report. We will not, as a matter of course, review apologies prior to them being issued. However, in order to monitor compliance with the Ombudsman's recommendations, we would expect to receive a copy of the apology letter within the time required by the Ombudsman.

The benefits to organisations of apologising

It is important to remember that an apology is not a sign of weakness or an encouragement to take legal action. An apology can be a sign of confidence and competence and demonstrates a willingness to learn from mistakes and a commitment to put things right. To apologise in a fulsome and timely manner is good administrative practice and is an important part of effectively managing complaints.

Contact Details

You can contact us in the following ways:

Freepost: Freepost NIPSO

or The Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

Telephone: 028 9023 3821 **or Freephone:** 0800 34 34 24

Text Phone: 028 9089 7789

Email: nipso@nipso.org.uk

or By calling, 9.00am & 5.00pm, Monday to Friday,
at the above address.

June 2016

Appendix 09

Miscellaneous Inquiry Recommendations Relating to Being Open and A Duty Of Candour

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'

These were defined as,

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.'

Right time, right Place (Donaldson Report) (2014)

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement of governance arrangements across the HSC. This was subsequently published in January 2015 by his successor, Jim Wells

Amongst the recommendation within this was that there should the introduction of a Duty of Candour, in Northern Ireland in line with the *Making Amends* that examined the handling of complaints, incidents and medical negligence claims in a whole systems manner for England

The Review Team considered that priority in Northern Ireland should be given to the areas covered by its recommendations and this included:

"a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom"

Furthermore he suggested that:

> *".In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an*

organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators."

p36, § **4.5.3 Duty of candour**

Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018):

The Inquiry into Hyponatraemia-related deaths in Northern Ireland was established in 2004 and chaired by Lord Justice O'Hara. His report, published in 2018, found that there had been significant failings both in the care of five children in Northern Ireland's hospitals, leading to their deaths, and in the subsequent dealings with their families.
Amongst the many recommendations in the report were those relating to the issue of candour and openness.

Candour

1. A statutory duty of candour should now be enacted in Northern Ireland so that:
    i. Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public.
    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.
    iii. Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).
    iv. Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.
    v. Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.
    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.
    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.
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
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.

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.
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.
6. Support and protection should be given to those who properly fulfil their duty of candour.
7. Trusts should monitor compliance and take disciplinary action against breach.
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.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 80/11

Title:	***Being Open* Policy – saying sorry when things go wrong**		
Author(s)	Eugene Doherty, Medical Devices Coordinator, Risk & Governance Tel: [redacted] Gillian Harkness, Governance Manager, Corporate Governance Tel: [redacted]		
Ownership:	Mr Chris Hagan, Medical Director		
Approval by:	Policy Committee Executive Team Meeting	**Approval date:**	04 June 2020 10 June 2020
Operational Date:	June 2020	**Next Review:**	June 2025
Version No.	V4 **Supercedes** V3 July 2018		
Key words:	Being Open, Duty of Candour, Adverse Incident, Complaint		
Links to other policies	BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 BHSCT Procedure for grading an adverse incident (2018) TP 95/14 BHSCT Serious Adverse Incident (SAI) Procedure (2016) TP 97/14 BHSCT Risk Management Strategy 2017 – 2020 (2019) TP 58/08 BHSCT Memorandum of Understanding – Investigating Service User Safety Incidents		

Date	Version	Author	Comments
17/04/2014	1.1	Julian R Johnston	S+G put into new template
09/10/2014	1.2	Julian R Johnston	Hyperlinks fixed; Francis report
22/01/2015	1.3	CM	Change to scope and Appendix 2b to reflect application of principles to minor incidents
24/02/2015	1.4	Julian R Johnston	Editing, Duty of candour section 1.1.2
14/04/2015	1.5	Julian R Johnston	Check Hyperlinks, Contents, appendices, 1.1.2
24/05/2018	1-4	Eugene Doherty	Linked Policies hyperlinks removed. Contents table updated and repaired. Broken hyperlinks corrected. Seven steps graphic revised. Benefits for Patients & Staff combined. Being Open Process Stages

			table (appendix 5) changed to table as used in BHSCT e learning. Appendix 8 – NI ombudsman guidance reproduced in appendix rather than link. Appendix 9 – inquiry reports relating to duty of candour, including Francis report section from main body of policy. Being open changed to Being Open for consistency. Appendices bookmarked. Formatting corrected for consistency.
13/05/2020	3.1	Gillian Harkness	Comparison review to Being Open Policy v3 and regional policy template for being Open issued by HSCB. Amendments made as follows: • Ownership changed from Dr Cathy Jack to Mr Chris Hagan, Medical Director • 1.1.6 Definition of Service User added as per HSCB Policy • Wording 'Patient' or 'Patients' changed to 'Service User' or Service Users' throughout in line with HSCB policy terminology. • Automatic Table of Contents (TOC) has been added and Headings and Sub-Headings formatted.

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1.0 INTRODUCTION / PURPOSE OF POLICY

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being Open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being Open' involves:

- acknowledging, apologising and explaining when things go wrong
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT '*Being Open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven steps to Patient Safety'* (appendix 1).

1.1 Background

1.1.1 Openness, Transparency and Candour

Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

This is supported by *Openness and honesty when things go wrong: the professional duty of candour*, issued by the GMC and NMC in 2015 summarising their position on this and provides guidance on how to follow the principles set out in *Good Medical Practice* (GMC) and *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC)

In September 2005, the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being Open'* policies. Their guidance was

replaced in November 2009 by *Being Open: communicating patient safety incidents with patients, their families and carers* in response to changes in the healthcare environment and in order to strengthen '*Being Open'* throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the *Seven steps to patient safety* (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being Open'* policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being Open'* at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy and the '*Being Open'* Framework document.

1.1.2 Recommendations from Inquiry Reports

In recent years there have been a number of reports arising from diverse inquiries into healthcare both in England and Northern Ireland and all of these have included recommendations in regard to Being Open and Duty of candour. The summary of the relevant recommendations are in **appendix 9** and include the Francis Report (2013), the Donaldson Report (2014) and the Hyponatraemia Inquiry (O'Hara 2018)

Although there is currently no statutory duty of candour in Northern Ireland, as recommended by the Donaldson and O'Hara reports, the suggestion has been endorsed by previous Northern Ireland health minsters

1.1.3 Culture, Policy and Support

BHSCT will have the following foundations to implement '*Being Open'* successfully:

To implement '*Being Open'* successfully, the BHSCT will have the following foundations:
A. a culture that is open and fair.
B. a '*Being Open'* policy and mechanisms to raise awareness about it.
C. staff and patient support for '*Being Open'.*

A. Open and fair culture

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any incident
- organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

B. 'Being Open' policy & associated training

A *'Being Open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

An elearning programme that provides information on the fundamentals of applying the Being Open Process and includes a case study

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being Open'* it is vital that:

- Patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it, and were appropriate they undertake the Being Open e-learning programme.

1.1.4 Prevented and 'no harm' incidents

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that no harm patient safety incidents are discussed with patients as this would cause undue and

unnecessary anxiety. This does not absolve staff of their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 Being Open

The main thrust of this 'Being Open' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 2). It describes the process of 'Being Open' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The Trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While Trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 Definitions

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances, it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

Service User[1] refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

1.2 Purpose

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind '*Being Open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the BHSCT's commitment to '*Being Open'* by establishing a culture where:

[1] As per the draft statement of what you should expect in relation to a Serious Adverse Incident (SAI) Review, January 2019.

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.
- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The BHSCT Adverse Incident Reporting and Management Policy encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The *'Being Open'* **principles** apply to any incident where any harm has occurred to a patient. The *'Being Open'* **process** outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in appendix 2 a+b and within steps 1+2 of the BHSCT Procedure for grading an adverse incident; incidents that are regarded as insignificant or minor do not require implementation of the Being Open process , although the principles should be applied (section 1.1.4).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies. It sets the scene of openness as a founding principle behind:-

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the

concept of this *'Being Open'* culture of openness applying throughout the organization.

3.1 Trust Board

The Trust Board are responsible

- for actively championing the *'Being Open'* process.
- for promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

3.2 Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

3.3 Executive Directors

Medical Director/Director of Nursing/ Director of Adult Social & Primary Care

Overall professional responsibility for managing the '*Being Open'* process.

Service Directors

Responsibility within their own service directorate for managing the '*Being Open'* process.

3.4 Managers

- Ensure all staff are aware of the "Being Open" policy.
- Support staff, particularly those who will have a key role in managing the Being Open process, in completing Being Open e-learning training available on the HUB http://elearning.belfasttrust.local/
- Support staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare.
- Notify the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.
  - Medical Director } that the '*Being Open'* process has
    Nursing Director } been initiated for an incident
    Primary and Social Care Director } causing
    Service Director } major or catastrophic harm.

3.5 All Healthcare Staff

All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:

- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.

- recording and documenting discussions with patients and families
- complying with the *Being Open* policy
- undertaking the Being Open e-learning programme where appropriate.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)

Patient safety incidents will be managed using the principles outlined in this BHSCT '*Being Open'* policy. Each incident will trigger a 5 stage process as set out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a service user's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

10 principles of 'Being Open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the service user's illness, its treatment and the factors causing and/or contributing to the service user's death are discussed with the relatives and recorded in the clinical record.

4.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the service user about an incident in a truthful open and timely manner. Information must be based solely on the facts. Service users will not receive conflicting information from different members of staff.

4.5 Service users and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a service user safety incident.

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 9).

4.6 Support for the Service Users

A key part of 'Being Open*'* is considering the service user's needs, or the needs of their carers or family in circumstances where the service user has been involved in a serious service user safety incident or died. The Trust will ensure early identification of and provision for the service user's practical and emotional needs.

Service users and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a service user safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the service user has agreed that information about their health care can be given. This person (or people) may be different to both the service user's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the service user safety incident.

The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the service user identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the service user, using the most appropriate method of communication from the perspective of the service user and/or their carer(s). Their role is to provide both practical and emotional support in a timely manner.

It is important to identify at the outset if there are any special restrictions on openness that the service user would like the healthcare team to respect. It is also important to identify whether the service user does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

Public information statement
'*Being Open*' if things go wrong:
We will

- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

4.7 Support for Families, Carers

Service users and/or their carers may need considerable practical and emotional help and support after experiencing a service user safety incident. Support may be provided by service users' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the service user needs more detailed long-term emotional support, advice should

be provided on how to gain access to appropriate counselling services, e.g. Cruse (the UK's largest bereavement charity).

A service user and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Information for Service Users, Families and Carers

Information on the 'Being Open*'* process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

When a Serious Adverse Incident (SAI) has occurred service users, families and/or carers will be made aware of the incident and have opportunity to engage in the review process in line with the Regional HSCB Procedure for Reporting & Follow-Up of SAIs.

An SAI Information leaflet will be provided explaining what an SAI is, how it will be investigated and how they can contribute to the process including opportunity for expressing their concerns and sharing their experiences. On completion of the SAI Review, a copy of the final report will be shared detailing the outcomes and learning identified.

4.9 Support for staff

These guidelines apply to all staff that have a role in providing service user care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a service user safety incident occurs, healthcare professionals involved in the clinical care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for '*Being Open'* discussions should be given access to assistance, support and any information they need to fulfil this role.

To **support staff** involved the Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The Trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report service user safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the service user safety incident will be available.

- Provide advice and training on the management of service user safety incidents.
- Provide counselling by professional bodies for staff distressed by service user safety incidents. Stress management courses for staff that have responsibilities for leading “Being Open” discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with service users and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.10 Service user safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The ‘*Being Open*’ policy is part of an integrated approach to addressing service user safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the service user’s care. This should be reflected in the way that service users, their families and carers are communicated with when things go wrong. This will ensure that the ‘*Being Open’* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the ‘*Being Open’* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance** framework in which service user safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of service user safety issues and the value of ‘*Being Open’*.

4.13 Full **confidentiality** of and respect for service users, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating service users. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.14 Service users are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion.

If a service user expresses a preference for their healthcare needs to be taken over by another team, the Trust will make every effort to make the

appropriate arrangements unless it is clearly obvious not to be in the service user's best interests.

5.0 IMPLEMENTATION OF POLICY

On-line training "Being Open – Saying sorry when things go wrong" is suitable for all staff and is available on the HUB e-learning page at:

http://elearning.belfasttrust.local/

6.0 MONITORING

This policy will be audited through the Risk & Governance Departments.

7.0 EVIDENCE BASE / REFERENCES

- BSHCT Adverse Incident Reporting and Management Policy
- BHSCT Risk Management Strategy 2017-20.
- National Patient Safety Agency documents.
- Australian Open Disclosure Framework
- *Seven steps to patient safety: full reference guide – (NPSA July 2004).*
- *Being open: communicating patient safety incidents with patients, their families and carers (NPSA, 2009)*
- *'Being Open' Framework* – (NPSA, November 2009).
- Openness & Honesty when things go wrong: the professional duty of candour (NMC/GMC 2015) **https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf**
- The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013),
- Right time, right Place (Donaldson Report) (2014)
- Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)
- Guidance on issuing an apology, NIPSO June 2016, https://nipso.org.uk/site/wp-content/uploads/2018/05/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-June-2016-1.pdf

8.0 CONSULTATION PROCESS

- Trust Service Directors & Staff Side
- Standards and Guidelines Committee.
- BHSCT Clinical Ethics Committee

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Seven steps to Patient Safety
Appendix 2a: NPSA grade and definition of patient safety incident

Appendix 2b: Grades and consequent actions following Service User Safety Incidents.
Appendix 3: Benefits for Service Users & Staff
Appendix 4: The '*Being Open'* process
Appendix 5: Being open in particular circumstances
Appendix 6: NPSA '*Being Open'* safety alert November 2009
Appendix 7: Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 8: Guidance on issuing an apology – NI Ombudsman
Appendix 9: Inquiry reports relating to duty of candour

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. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☒

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

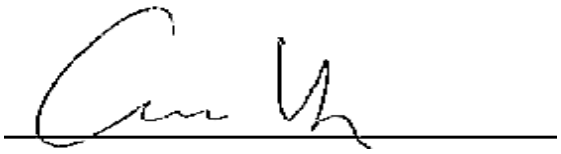
12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services. It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES



17/08/2020

Date: _____

Chris Hagan
Medical Director

18/08/2020

Date: _____

Cathy Jack
Chief Executive

Appendix 1: NPSA - Seven Steps to Patient Safety

National Patient Safety Agency. *Seven steps to patient safety. The full reference guide*. 2004.

Appendix 2a: BHSCT – definitions for grading of Service User Safety Incidents

Insignificant

Incident prevented / Near Miss

Any service user safety incident that had the potential to cause harm but was prevented and no harm was caused to service users receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented

Any service user safety incident that occurred but insignificant harm was caused to service users receiving NHS-funded care.

Minor harm

Any service user safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any service user safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more service users receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any service user safety incident that appears to have resulted in permanent harm* to one or more service users receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the service user's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any service user safety incident that directly resulted in the death* of one or more service users receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.*

Appendix 2b: Grades and consequent actions following Service User Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	**Significant but not permanent harm - moderate increase in treatment.**	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased service user monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being Open'.		**Apply the 'Being Open' process Stages I →VI.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. **3.** The principles of the 'Being Open' policy apply but no documented actions are required**.**		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the '*Being Open'* process if required.		

Appendix 3 – Benefits for Service Users and Staff

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by service users and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious service user safety incident indicate that the service users would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

BENEFITS FOR STAFF

Being open has several benefits for healthcare staff including:

- Satisfaction that communication with services users and /or their carers following a service user safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the service user and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 4 – Being Open Process

'Being Open' is a process rather than a one-off event and can be considered in 6 stages with documentation being a constant feature throughout the process.

Stage I	Stage II		Stage III	Stage IV	Stage V
Service User incident detection and recognition	**Preliminary Team discussion**		**Initial Being Open meeting/ contact**	**Follow-up meetings/ contacts**	**Being Open process completed**
	Inform service user/carer	**Plan further Being Open process**			
Service user safety incident recognised **Prompt care and actions to prevent any further harm** **Incident reporting** **Identify staff and service user support & communication needs**	**Minor** **Initial assessment to determine level of response - grading** **Provide open honest factual information** **Offer initial verbal apology / expression of regret/sympathy** **Offer initial support** **Discuss further contacts**	**Moderate, Major, Catastrophic** **Establish the facts** **Decide the process** **Identify lead person & clarify if this is lead contact** **Agree with SU/Family who will meet with who when and where** **Identify support needed**	**Explain the process** **Offer apology /regret/sympathy & support** **Provide factual details** **Explain learning process** **Invite questions / comments/take notes** **Agree any further contact**	**Confirm meeting in writing and provide written apology** **Keep in touch as agreed at meeting** **Trust investigation process** **Feedback method agreed with SU/family**	**Feedback from the investigation process, learning and actions** **- to service users / family and carers** **- to other Trust staff and partners** **Monitoring**
No Being Open process required for near miss or no harm incidents	**End of the Being Open process for low harm incidents**		**May be end of Being Open process or may agree further contact**		**End of Being Open process**

Documentation

Keep written records of all *Being Open* contacts/discussions:
- **When** (date/time)
- **Who** was involved
- **What** information was given by who

Record incident review process & learning outcomes

Adapted From: National Patient Safety Agency. 'Being Open' Framework. November 2009.

Details of Key Stages of Being Open Process

STAGE I: INCIDENT DETECTION AND MANAGEMENT

The '*Being Open'* process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a service user safety incident.

Detection of the incident

A service user safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a service user and/or their carers who expresses concern or dissatisfaction with the service user's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other service users, visitors or non-clinical staff.

Priority

As soon as a service user safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the service user and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse Incident (SAI) criteria, the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB.

Service user safety incidents occurring elsewhere

A service user safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier service user safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the service user safety incident has already been recognized.
- the process of '*Being Open'* has commenced.
- incident investigation and analysis is underway.

The '*Being Open'* process and the investigation and analysis of a service user safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Service user safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: INFORM SERVICE USER/CARER

Provide open honest factual information

Offer initial verbal apology / expression of regret /sympathy

An expression of genuine sympathy, regret and an apology for the harm that has occurred.

Appropriate language and terminology are used when speaking to service users, their families and carers.

Offer initial support

Staff should ensure the service user, their family and/or their carers

- are informed that an incident investigation is being carried out if appropriate.
- show understanding of what happened is taken into consideration, as well as any questions they may have.
- are provided with information on the complaints procedure if they wish to have it;

Consideration and formal noting of the views and concerns of the service user, their family and carer(s), and demonstration that these are being heard and taken seriously.

Discuss further contacts

An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

Discussions with service users and/or their carers are documented and that information is shared with them;

This is the end of the Being Open process for low harm incidents

STAGE III: PRELIMINARY TEAM DISCUSSION/ Plan further Being Open Process

The multidisciplinary team, including the most senior health professional involved in the service user safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts.
- assess the incident to determine the level of immediate response.
- identify who will be responsible for discussion with the service user and/or their carers = '*Being Open'* coordinator.
- consider the appropriateness of engaging service user support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the service user's needs and communicating them back to the healthcare team.
- identify immediate support needs for the healthcare staff involved.
- ensure there is a consistent approach by all team members around discussions with the service user and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm **(including prevented patient safety incident)**	It is not a requirement of this policy to communicate prevented service user safety incidents and insignificant incidents to service users and/or carers.
Minor harm	Unless there are specific indications or the service user requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the service user's care and the service user and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **↳Apply the principles of 'Being Open' – locally.**
Moderate harm, **Major harm** **Death**	A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the 'Being Open' process if required. **↳Apply the 'Being Open' process – Stages I → VI.**

Timing of discussion with patient and/or carers

Preliminary discussions with the service user and/or their carers should occur as soon as possible after recognition of the service user safety incident. Factors to consider when timing this and any future '*Being Open*' discussions include:

- clinical condition of the service user.
- service user preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being Open'* process.
- availability of the service user's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The *'Being Open'* coordinator role

It is essential to carefully consider the choice of the individual to communicate with service users and who informs the service user and/or their carers about a service user safety incident. Getting it right at the start of the process will reassure the service user and may lead to a favourable outcome.
This should be the most senior person responsible for the service user's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the service user and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of service user safety incident to be credible to patients, carers and colleagues.
- have excellent interpersonal skills, including being able to communicate with service users and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- be willing and able to offer an apology, reassurance and feedback to service users and/ or their carers.
- be able to maintain a medium to long term relationship with the service user and/or their carers, where possible, and to provide continued support and information.
- be culturally aware and informed about the specific needs of the service user and/or their carers.

If for any reason it becomes clear during the initial discussion that the service user would prefer to speak to a different healthcare professional, the service user's wishes should be respected. A substitute with whom the service user is satisfied should be provided.

Use of a substitute healthcare professional for the 'Being Open' discussion

In exceptional circumstances, if the '*Being Open'* coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'Being Open' discussion

The healthcare professional communicating information about a service user safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being Open'* procedures.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the '*Being Open'* process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the service user and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a service user safety incident asks to be involved in the '*Being Open'* discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate patient safety information alone or to be delegated the responsibility to lead a '*Being Open'* discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Service user safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the service user and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being Open'* discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake

Some service user safety incidents result from errors made by the healthcare staff caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the '*Being Open'* discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the healthcare professional concerned.

In cases where the healthcare professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the service user and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the service user and/or their carers during the first '*Being Open'* discussion.

STAGE IV: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'Being Open' discussion

The service user and/or their carers should be advised of the identity and role of all people attending the '*Being Open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.

The content of the initial '*Being Open'* discussion with the service user, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The service user, their family and/or their carers
    - should be informed that an incident investigation is being carried out.
    - understanding of what happened is taken into consideration, as well as any questions they may have.
    - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the views and concerns of the service user, their family and carers, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the service user safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the service user with access to information to assist in making decisions if the service user is unable to participate in decision-making or if the service user has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the service user's instructions.
- Ensure carers are provided with known information, care and support if a service user has died as a result of a service user safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with service users and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to service users, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the service user and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the service user will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the service user and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

STAGE V: FOLLOW UP DISCUSSIONS

Follow-up discussions with the service user, their family and carers are an important step in the
'Being Open' process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the service user's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the service user and/or their carers to obtain information about the service user safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the service user and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The service user and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the service user and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the service user and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the service user's records.
- The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE VI: PROCESS COMPLETION

Communication with the service user, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why.*
- details of the concerns and complaints of the service user'], their family and carer(s).
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the service user safety incident.
- a summary of the factors that contributed to the incident.
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the service user's GP, before discharge, describing what happened. When the service user leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the service user safety incident and the continuing care and treatment;
- the current condition of the service user;
- key investigations that have been carried out to establish the service user's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being Open* process it is important to record discussions with the service user, their family and carers as well as the incident investigation. Written records of the '*Being Open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the service user, their family and carers.
- offers of assistance and the response of the service users, their family and carers.
- questions raised by the service user, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user, their family and carers.
- copies of letters sent to the service user, their family and carers, and the GP.
- copies of any statements taken in relation to the service user safety incident.
- a copy of the incident report.

Appendix 5: BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the service user's personal circumstances. The following gives guidance on how to manage different categories of service user circumstance.

When a service user dies

When a service user safety incident has resulted in a service user's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The service user's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

> "it may be appropriate to wait for the coroner's inquest before holding the '*Being Open'* discussion"

Usually, the 'Being Open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being Open' discussion with the service user's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the service user's death. In any event, an apology should be issued as soon as possible after the service user's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being Open' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Service users with mental health issues

'Being Open' for service users with mental health issues should follow standard procedures, unless the service user also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold service user safety incident information from a mentally ill service user is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the service user. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the express permission of the service user; to do so may constitute an infringement of the service user's Human Rights and/or a breach of Data Protection legislative provisions.

Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The '*Being Open'* discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the service user's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the service user as a whole and not simply their medical interests. However, the service user with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the service user to assist in the communication process.

Service users with learning disabilities

Where a service user has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the service user is not cognitively impaired they should be supported in the '*Being Open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the service user, should be appointed. Appropriate advocates may include carers, family or friends of the service user. The advocate should assist the patient during the '*Being Open'* process, focusing on ensuring that the service user's views are considered and discussed.

Service users with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Service users with different communication needs

A number of service users will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Service users who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the service user and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the '*Being Open'* process.

In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the service user agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the service user has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the service user expressing their concerns to other members of the clinical team.
- Offer the service user and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the service user, and to look for a mutually agreeable solution.
- Ensure the service user and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the service user and/or their carer disagree with and reassure them you will follow up these issues.

Appendix 6: National Patient Safety Agency - Being Open

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency
National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

National Reporting and Learning Service
National Patient Safety Agency
4-8 Maple Street, London, W1T 5HD
T: 020 7927 9500 F: 020 7927 9501
www.nrls.npsa.nhs.uk

Appendix 7: Comparison of BHSCT vs NPSA Incident Grading Matrix

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 8: NI Public Services Ombudsman – Guidance on Issuing an Apology.

GUIDANCE ON ISSUING AN APOLOGY

When the Ombudsman investigates a complaint and finds maladministration, she may recommend that the public service provider offers an apology. In these circumstances the complainant may have been waiting a considerable period of time for the organisation to provide a full explanation as to what went wrong and to acknowledge any failings.

What is an apology?

An apology can be defined as a 'regretful acknowledgement of an offence or failure'. Mistakes can be made by one member of staff, a whole team or there may be systemic failures within an organisation. When things do go wrong, most people who have had a bad experience may simply seek an acknowledgement and, if appropriate, to be given an explanation and an apology.

Why apologise?

In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. The value of this approach should not be underestimated. A prompt acknowledgement and apology, where appropriate, can often prevent the complaint escalating. It can help restore dignity and trust in the public service provider and can be the first step in putting things right.

What are the implications of an apology?

Although there is no legislation in this area of law which applies specifically to Northern Ireland, the Compensation Act 2006 governing England and Wales states that 'an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or statutory duty.' The timely provision of a full apology may in fact reduce the chances of litigation.

What is a meaningful apology?

Each complaint is unique so your apology will need to be based on the individual circumstances. It is important when you are making an apology, you understand how and why the person making the complaint believes they were failed and what they want in order to put things right. Failing to acknowledge the complainant's whole experience is only a partial apology and therefore less effective.
To make an apology meaningful you should:

- Accept you have done wrong. You should include identifying the failure along with a description of the relevant action or omission to which the apology applies. This should include any failings that the Ombudsman identified in her investigation that warrant an apology. Your description must be specific to show that you understand the effect your act or omission has had on the complainant. It must also acknowledge if appropriate, that the affected person has suffered disappointment, hurt, anxiety, upset or loss.
- Clearly explain why the failure happened and include that the failure was not intentional or personal. If there is no explanation, however, one should not be offered. Care should be taken to provide full explanations rather than excuses.
- Demonstrate that you are sincerely sorry. An apology should be an expression of sorrow or at the very least an expression of regret. The nature of the harm done will determine whether the expression of regret should be made in person as well as being reinforced in writing; or simply in writing.
- Reassure the complainant that you will not repeat the failure. This may include a statement of the steps that have been taken, or will be taken, to address the failure, and, if possible, to prevent a reoccurrence.
- Provide the complainant with a statement of specific steps proposed to address the grievance or problem, by mitigating the harm or offering a remedy.

How should I make an apology?

There is no ‘one size fits all’ apology but the following points reflect some general good practice:

1. The timing of an apology is very important. Once you establish that you have done wrong, apologise. If you delay, you may lose your opportunity to apologise.
2. The language you use should be clear, plain and direct.
3. Your apology should not be conditional by qualifying the apology by saying for example: ‘I apologise if you feel that the service provided to you was not acceptable’ or ‘if mistakes have been made, I apologise’.
4. To make an apology meaningful, do not distance yourself from the apology.

   Generalised apologies such as ‘I am sorry for what occurred’ or ‘mistakes were made’ do not sound natural or sincere. It is much better to accept responsibility by stating ‘It was my fault’.
5. Avoid enforced apologies such as ‘I have received the Investigation report from the Ombudsman and am therefore carrying out her recommendations by apologising to you for the shortcomings identified in her report.’
6. It is also very important to apologise to the right person or the right people.

Who should apologise?

If, in her Investigation report, the Ombudsman has made a recommendation that an apology should be provided to the complainant, then we would expect to see the

Chief Executive, Director or Head of Department of the public service provider involved making the apology.

Who should receive the apology?

The apology should be sent directly to the complainant who is named in the Ombudsman's Investigation report. We will not, as a matter of course, review apologies prior to them being issued. However, in order to monitor compliance with the Ombudsman's recommendations, we would expect to receive a copy of the apology letter within the time required by the Ombudsman.

The benefits to organisations of apologising

It is important to remember that an apology is not a sign of weakness or an encouragement to take legal action. An apology can be a sign of confidence and competence and demonstrates a willingness to learn from mistakes and a commitment to put things right. To apologise in a fulsome and timely manner is good administrative practice and is an important part of effectively managing complaints.

Contact Details

You can contact us in the following ways:

Freepost: Freepost NIPSO

or The Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

Telephone: 028 9023 3821 **or Freephone:** 0800 34 34 24

Text Phone: 028 9089 7789

Email: nipso@nipso.org.uk

or By calling, 9.00am & 5.00pm, Monday to Friday,
at the above address.

June 2016

Appendix 9: Inquiry Reports relating to Duty of Candour

Miscellaneous Inquiry Recommendations Relating to Being Open and A Duty of Candour

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'

These were defined as,

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, service users and the public;
- Candour: ensuring that service users harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.'

Right time, right Place (Donaldson Report) (2014)

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement of governance arrangements across the HSC. This was subsequently published in January 2015 by his successor, Jim Wells

Amongst the recommendation within this was that there should the introduction of a Duty of Candour, in Northern Ireland in line with the *Making Amends* that examined the handling of complaints, incidents and medical negligence claims in a whole systems manner for England

The Review Team considered that priority in Northern Ireland should be given to the areas covered by its recommendations and this included:

"a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom"

Furthermore he suggested that:

> *".In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an*

organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators."

p36, § **4.5.3 Duty of candour**

Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018):

The Inquiry into Hyponatraemia-related deaths in Northern Ireland was established in 2004 and chaired by Lord Justice O'Hara. His report, published in 2018, found that there had been significant failings both in the care of five children in Northern Ireland's hospitals, leading to their deaths, and in the subsequent dealings with their families

Amongst the many recommendations in the report were those relating to the issue of candour and openness

Candour

1. A statutory duty of candour should now be enacted in Northern Ireland so that:
    i. Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with service users and the public.
    ii. Where death or serious harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.
    iii. Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).
    iv. Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.
    v. Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.
    vi. Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a service user must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.
    vii. Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a service user by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the service user, must report their belief or suspicion to their employer as soon as is reasonably practicable.
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
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.

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.
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.
6. Support and protection should be given to those who properly fulfil their duty of candour.
7. Trusts should monitor compliance and take disciplinary action against breach.
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.

Belfast Health and Social Care Trust

TYPE OF DOCUMENT	Trust Policy for approval by Trust Policy Committee
TITLE	Belfast Health and Social Care Trust General Health and Safety Policy
Summary	The Trust recognises that it has a duty to ensure, so far as is reasonably practicable, the health safety and welfare of all its staff, patients, clients, contractors, visitors, volunteers and members of the public. It is necessary for management and staff to work together positively to achieve an environment where the provision of proper services to patients is compatible with reducing the potential for injuries to staff and others and loss or damage to plant, equipment and premises to a minimum. The Trust will do all that is reasonably practicable to achieve such a situation.
Purpose	This policy & procedural arrangement is designed to provide Managers and Staff with clear guidelines on their general health and safety responsibilities. The Belfast Health & Social Care Trust, in complying with the requirements of all relevant Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, and all relevant legislation and guidance, has produced this General Health and Safety policy for the information and guidance of all staff.
Operational date	1st November 2009
Review date	31st October 2012
Version Number	V2
Supersedes previous	Belfast Health & Social Care Trust Health & Safety Policy, Version 2.
Director Responsible	Dr Anthony Stevens, Medical Director
Lead Authors	Ann Johnston, Senior Manager, Corporate Risk Services Karen Cunningham, Health & Safety Manager
Lead Author, Position	Senior Manager, Corporate Risk Services
Additional Author(s)	Health & Safety Managers
Department / Service Group	Medical Directors Office
Contact details	*Ann Johnston, Senior Manager Corporate Risk Services* [redacted] *tel:* [redacted] *Karen Cunningham, Health & Safety Manager* [redacted] *tel:* [redacted]

Reference Number	TP050/08
Supersedes	Version 2, Operational Date June 2008

Date	Version	Author	Comments
25/5/09	2.1	Karen Cunningham	Annual Review of Belfast Trust Health & Safety Policy with comments from the consultation process
18/8/09	2.2	Karen Cunningham Ann Johnston	Additional points following comparison against relevant standards

Policy Record

		Date	Version
Author (s)	Approval		
Director Responsible	Approval		

Approval Process – Trust Policies

Policy Committee	Approval	09.11.09	V2
Executive Team	Authorise	11.11.09	V2
Chief Executive	Sign Off	11.11.09	V2

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Approval		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Summary

Reference No:	TPO50/08
Title:	
Belfast Health & Social Care Trust General Health & Safety Policy	
Purpose: This policy & procedural arrangement is designed to provide managers and staff with clear guidelines on their general health and safety responsibilities. The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff.	
Objectives: • To ensure, so far as is reasonably practicable, the health safety and welfare of all its staff, patients, clients, contractors, visitors, volunteers and members of the public, and promote a positive health and safety culture throughout the Trust. • To advise, inform and instruct in a straightforward way the basic principles in health and safety management. • To ensure that managers undertake the relevant risk assessments relating to the delivery of their services, to identify and implement relevant controls and associated Approved Codes of practice. • To ensure that the relevant human and financial resources are identified and prioritised as part of the risk assessment process. • To implement the Trust's Mandatory Training Matrix and to identify training specific to the work activity as part of the risk assessment process. • To ensure that the Trust complies with the relevant health and safety legislation and guidance. • To monitor the adequacy of safety and health communication and awareness in the workplace through the analysis of trends in accident/incidents, investigation of accidents/incidents, during audits, inspections and observation of working practices, staff awareness of risk assessments associated with their work activities and their compliance with Trust and Service Group Policies and Procedures. • To ensure that Service Groups disseminate and communicate health and safety information as part of their assurance arrangements. Corporate health & safety policies, procedures and risk assessment documentation is available via the Trust's Intranet • To ensure staff, trade union side and professional body health & safety representatives are consulted on health & safety matters. • To ensure that the management of Health & Safety is monitored through the organisations performance management and assurance frameworks. • To include specific reference to health & safety issues in local induction programmes.	
Policy Statement(s): • It is recognised that the people employed by the Trust are its most important asset and that this is reflected in a commitment to ensuring their health, safety and welfare. • The Trust Board and Trust Directors have overall responsibility for workplace health and safety. The executive team and service group management are responsible for ensuring the undertakings outlined in this policy are adhered to throughout the Belfast Health and Social Care Trust. • Health and safety is an integral part of management responsibilities, inseparable	

from all Trust Objectives. It is an essential component in the provision of high quality health care.

- The Trust will link with Health & Safety Inspectors from HSENI during the reporting and investigation of RIDDOR reportable incidents, during routine inspections and when it is necessary to request advice and assistance. The Trust will also link with Health & Safety Inspectors on health and safety matters raised at local seminars, conferences and best practice meetings.
- This policy will be supported by organisational arrangements for health and safety within the Trust (Appendix 3).
- The organisational arrangements described in this document place health and safety at the centre of the Belfast Health and Social Care Trust arrangements for wider health care governance. Health and safety is incorporated within the Belfast Health and Social Care Trust wider governance strategy at both corporate and service group levels.

Medical Director
11 November 2009

Chief Executive
11 November 2009

Full Description

Reference No:	TP050/08
1.	**Title:**
	Belfast Health & Social Care Trust Policy & Procedural Arrangements relating to the General Statement of Policy Health & Safety
2.	**Introduction:**
	This provides the Belfast Health & Social Care Trust with a clear sense of direction for the organisation identifying objectives, responsibilities including the need to achieve continual improvement in its health & safety performance and providing a structure for its health & safety management system..
3.	**Purpose:**
	This policy & procedural arrangement is designed to provide managers and staff with clear guidelines on their general health and safety responsibilities. The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff.
4.	**The scope:**
	This is a corporate policy to advise, inform and instruct Directors, Managers, Staff and contracted services who work within the Belfast Trust, of their duties, to ensure the health, safety and welfare of all patients, clients, staff, visitors and contractors.
5.	**Objectives:**
	• To ensure, so far as is reasonably practicable, the health safety and welfare of all its staff, patients, clients, contractors, visitors, volunteers and members of the public, and promote a positive health and safety culture throughout the Trust. • To advise, inform and instruct in a straightforward way the basic principles in health and safety management. • To ensure that managers undertake the relevant risk assessments relating to the delivery of their services, to identify and implement relevant controls and associated Approved Codes of practice. • To ensure that the relevant human and financial resources are identified and prioritised as part of the risk assessment process. • To implement the Trust's Mandatory Training Matrix and to identify training specific to the work activity as part of the risk assessment process. • To ensure that the Trust complies with the relevant health and safety legislation and guidance. • To monitor the adequacy of safety and health communication and awareness in the workplace through the analysis of trends in accident/incidents, investigation of accidents/incidents, during audits, inspections and observation of working practices, staff awareness of risk assessments associated with their work activities and their compliance with Trust and Service Group Policies and Procedures. • To ensure that Service Groups disseminate and communicate health and safety information as part of their assurance arrangements. Corporate health & safety policies, procedures and risk assessment documentation is available via the Trust's Intranet

	• To ensure staff, trade union side and professional body health & safety representatives are consulted on health & safety matters. • To ensure that the management of Health & Safety is monitored through the organisations performance management and assurance frameworks. • To include specific reference to health & safety issues in local induction programmes.
6.	**Roles and Responsibilities:**
	The ultimate responsibility for ensuring the health, safety & welfare of our staff and others who may be affected by the Trust's work activities rests with the Chief Executive. The Medical Director (as Lead Director for Health & Safety and Managing Aggression) is responsible for co-ordinating compliance with the requirements in this Policy in conjunction with the Director of Human Resources. The responsibility cascades down through the line management structure to Co-Directors, Senior Managers and Ward, Department & Facility Managers and to all staff who should familiarise themselves with this Policy and the impact of such on their work activities. **A. The responsibilities of the Board of Directors are as follows:** The Trust Board Directors together with the Chief Executive have the ultimate responsibility to ensure compliance, in the Trust's undertakings, with the statutory obligations described in health and safety legislation. The Board will: 1. Issue a policy statement under the chief executive officer's signature, detailing the Trust's policy and organisational arrangements for the effective management of health and safety. 2. The Assurance Committee will monitor and review the organisation's performance in health and safety management. **B. The responsibilities of the Executive Team are as follows:** The executive team will be responsible for the implementation of the health and safety policy. It will: Ensure that the organisational arrangements contained within the health and safety policy and its associated procedures are implemented. 1. Monitor and review the overall health and safety performance and receive an annual health and safety report. 2. Set corporate objectives for health and safety management and develop performance indicators. 3. Consider health and safety issues affecting the organisation's undertakings, as they arise. 4. Ensure health and safety management is integrated within the Trust's performance management and assurance framework. 5. Promote positive health and safety culture through all activities of the Trust. **C. The responsibilities of the Chief Executive are as follows:** The Chief Executive is the Accountable Officer. The Chief Executive is responsible to the Trust Board for the effective management of health and safety and for achieving the aims of the health and safety policy. The Chief Executive will:

1. Report at regular intervals to the board of directors on health and safety performance.
2. Set targets for health and safety performance, assisted by the Health and Safety Committee.

The Chief Executive has delegated these executive functions to the Medical Director.

D. The responsibilities of the Medical Director are as follows:

The Medical Director has responsibility for co-ordinating and monitoring health and safety activity throughout all the Belfast Health and Social Care Trust undertakings. The Medical Director will report to the executive team and joint health and safety committee in all matters relating to health and safety. The Medical Director will work directly with line management and safety representatives to encourage and facilitate the implementation of the health and safety policy.

The Medical Director will:

1. Advise on suitable organisational arrangements for the management of health and safety.
2. Advise on the development and review of health and safety policy.
3. Develop and maintain systems to monitor health and safety performance within the organisation.
4. Provide guidance to the executive team on health and safety legislation and issues, as they affect the organisation's undertakings.
5. Ensure that management are aware of their health and safety responsibilities as contained in legislation and authoritative guidance.
6. Advise on priorities for the prevention or control of health and safety risks.
7. Promote and maintain a Health & Safety Culture.
8. Promote and maintain consultation with staff side and employees.
9. Ensure adequate arrangements to meet their health and safety training needs.
10. Ensure that the Trust has access to competent persons for the purposes of the Management of Health and Safety at Work Regulations (Northern Ireland) 2000 (see section I relating to Specialist Advisors).
11. Is responsible for compliance with the requirements of the RIDDOR regulations

E. The responsibilities of the Director of Planning and Redevelopment are as follows:

The Planning and Redevelopment Director has responsibilities for the maintenance and management of work place plant and equipment. The Director of Planning and Redevelopment will be a member of the Belfast Health and Social Care Trust Joint Health and Safety Committee.

The Planning and Redevelopment Director will:

1. Ensure compliance with statutory provisions and other authoritative guidance, as they affect work place plant and equipment.

2. Be responsible to the Chief Executive for fire safety for the whole site.

F. The Responsibilities of the Director of Human Resources are as follows:

The Director of Human Resources will be responsible for:

1. Ensuring that all new staff (including permanent, temporary, honorary and volunteers) have a health assessment to determine their suitability
2. Ensuring that all new and current staff have access to a copy of the health and safety policy.
3. Ensuring that all new staff have Corporate induction training that includes an explanation of the Trust's arrangements for managing health and safety.

G. The responsibilities of the Service Group Directors are as follows:

The Service Group Directors are responsible to the Chief Executive for implementation of the health and safety policy within their service group. They are responsible for making such health and safety arrangements as are appropriate, having regard to the nature of the service group activities, for the effective planning, organisation, control monitoring, review of preventative and protective measures. Service Groups will each establish suitable arrangements for governance. These arrangements must provide a focus for health and safety management within the service group and will ensure the implementation of the Belfast Health and Social Care Trust health and safety policy.

Service Group Directors must ensure that adequate health and safety arrangements are in place, having regard to the nature of their activities and size, for the effective planning, organisation, control, monitoring and review of preventative and protective measures.

Service Groups require access to competent assistance in applying the provisions of health and safety legislation. This is available through the Trust's Joint Health and Safety Committee, Corporate Risk - Health and Safety Managers & Ergonomics Advisors, Fire Officers and Radiation Protection Advisors/Supervisors.

The responsibilities of each Service Group are to:

1. Ensure that the Service Groups' undertakings are carried out in compliance with health and safety legislation, the health and safety policy and other relevant guidelines.
2. Ensure that all staff are aware of the health and safety policy and their own responsibilities under the policy.
3. Make suitable arrangements for the training and education of staff to ensure that they are competent to carry out their duties safely and without risk to health. This includes mandatory training, training identified as a result of a risk assessment, local induction and the ways in which health & safety information is communicated and disseminated.
4. Ensure that comprehensive risk assessments are completed and maintained.
5. Ensure that reasonable measures are taken to prevent or control identified risk to health, including
6. Ensure that the required human and financial resources are identified and prioritised through the risk assessment process.

7. Develop local policies/procedures and safe systems of work where these are required by the individual undertakings and circumstances of the Service Group in line with the Trust's Health and Safety Policy.
8. Ensure that the Belfast Health and Social Care Trust's procedures for the reporting of adverse incidents are adhered to, that all such events are investigated and that appropriate preventative action is taken.
9. Co-operate with the Joint Health and Safety Committee in the monitoring of health and safety performance.
10. Report to the Joint Health and Safety Committee and Executive Team any matters of concern with regard to health and safety.

H. The responsibilities of the Senior Manager – Corporate Risk Services are as follows:

The Senior Manager will support the Medical Director in meeting his responsibility for health and safety management. The senior manager will be a member of the Joint Health and Safety Committee.

The Senior Manager will:

1. Promote a positive health and safety culture and compliance with statutory obligations.
2. Contribute to planning for health and safety.
3. Promote procedures for the reporting, recording and analysis of serious incidents.
4. Make arrangements for the investigation of serious incidents.
5. Provide administrative support to the joint health and safety committee, acting as committee secretary.
6. Provide incident reports to Joint Health and Safety Committee and Executive Team.
7. Develop and maintain health and safety audit systems and related procedures, that are appropriate to the organisation.
8. Assist managers in hazard identification, conducting risk assessments and establishing and reviewing control measures.
9. Ensure that the Belfast Health and Social Care Trust has access to competent advice and information on health and safety matters.
10. To liaise with the Occupational Health Service on health matters and relevant health & safety issues.

I. The responsibilities of the Trust's Specialist Advisers are as follows:

Specialist Advisers include the Health and Safety Managers/Advisers, Radiation Protection Advisers, Fire Officers, Genetic Modification Safety Officer, Infection Control Advisers, Occupational Health Professionals, Decontamination Managers and Ergonomics Advisers.

In addition to the professional and technical work inherent in their posts they will:

1. Provide specialist advice to all levels of management on those health and safety issues in which they have expertise such as workplace risk assessments, workplace visits and COSHH advice.
2. In conjunction with the Joint Health and Safety Committee develop and maintain policies and procedures on health and safety issues for which they have responsibility.
3. Monitor and report on aspects of health and safety performance as they relate to their area of expertise and responsibility.
4. Contribute to training and education programmes relating to their area of expertise.
5. Collate the required evidence for the relevant Controls Assurance Standards.
6. The Occupational Health Service will undertake the required health surveillance programmes as identified by managers through the completion of local risk assessments.
7. To maintain statistical information on incidents and ill health occurring within the organisation.

J. The responsibilities of Service Group Managers / Heads of Department / Line Managers within each Service Group are as follows:

1. Ensure that they are familiar with the health and safety policy and the arrangements laid out therein for the management of health and safety.
2. Ensure that a suitable and sufficient assessment is made of the risk to the health and safety of employees and agency, locum, contractors, students, visiting members of the public and other persons not in their employment arising out of, or in connection with, the activities within their departments. Risk assessments should be undertaken by competent departmental managers or appointed assessors. The risk assessment process will be co-ordinated at service group level as far as is reasonably practicable.
3. Ensure that the requirements of the Disability Discrimination Act (reasonable adjustment for example) are considered where relevant in risk assessments.
4. Ensure that measures are taken to avoid or control any risk including human and financial resources are identified and prioritised through the risk assessment process. Where this is beyond the competence, authority or resources of the manager, he/she must advise his/her senior manager.
5. Ensure that all personnel under their control know and accept the responsibilities under the health and safety policy and that they are equipped to play their part.
6. Operate within all legal and other requirements applicable to the work within their area of responsibility.
7. Ensure that systems of work are safe and without risk to health are agreed and implemented in liaison with the relevant members of staff.
8. Ensure employees are properly trained and competent to perform their work safely and without risk to health. This includes attendance at mandatory training, training identified as a result of a risk assessment, local induction and the ways in which health & safety information is communicated and disseminated.
9. Ensure investigation and reporting procedures for adverse incidents are carried out and that corrective action where indicated is taken, as identified through risk assessment.

10. To inform the Occupational Health Service to undertake the required health surveillance programmes, for the protection of the member of staff for the duration of their employment with the Trust. The need for health surveillance should be identified by managers through the completion of local risk assessment.
11. To refer staff to the Occupational Health Service where a concern exists about their heath in relation to health and safety or in relation to suspected work-related injury/disease.
12. Ensure that personal protective equipment, where required, is appropriate, readily available and properly maintained.
13. Ensure that staff who are required to use personal protective equipment are appropriately trained in its use, maintenance and where appropriate fit tested for respiratory protective equipment use.
14. Ensure that all work place equipment is properly maintained and fit for purpose, logged and services (where appropriate).
15. To liaise with the Occupational Health Service on health matters and relevant health & safety issues.
16. To provide this policy in other languages and formats when requested, a manager should refer to:-

www.centralservicesagency.n-i.nhs.uk/display/ni_translation_contract for further information on translation services or contact the Health and Social Inequalities Manager assigned to your service group.

K. The responsibilities of Supervisory Staff are as follows:

Supervisory staff have a responsibility for carrying out duties determined by heads of department / line managers to ensure that the objectives of the health and safety policy are achieved.

They will:

1. Assist the heads of department/line managers in ensuring that all personnel within their department know and understand the responsibilities under the health and safety policy and that they are fully trained and equipped to play their part.
2. Operate within all legal and other requirements appropriate to their workplace.
3. Ensure that they understand the risk assessment process, the outcomes/requirements that a risk assessment may identify, and the preventative control measures to be implemented within the department.
4. Check and ensure that all plant, tools and equipment are available and safe to use, and that safe and easy access to all places of work are maintained.
5. Ensure that all safe operating procedures and instructions are known and observed and maintained.
6. Know the accident and untoward incident reporting procedures and ensure that they take the action required.
7. Assist with the training of employees and ensure that they are capable of carrying out their duties safely and identify any weakness/gaps in training. This includes attendance at mandatory training, training identified as a result of a risk

assessment, local induction and the ways in which health & safety information is communicated and disseminated.

8. Ensure that all personal protective equipment and other safety equipment is used at all appropriate times as identified by risk assessment.
9. Advise the heads of department/line managers of any problems that occur in the implementation of the health and safety policy.

L. The responsibilities of all Staff are as follows:

All staff including managers are held accountable in law, not to commit acts in breach of Health and Safety Legislation. Staff have a duty under the Health and Safety at Work Order (NI) 1978 to take reasonable care of their own health and safety and that of others who may be affected by their acts or omissions. It is each employee's duty to co-operate with management to enable the employer to comply with statutory duties for health and safety.

All staff must:

1. Use any machinery, equipment, dangerous substances, transport and safety device provided by his employer in accordance with their training and safety instructions.
2. Conform to rules and procedures regarding health and safe working practices.
3. Report to management unsafe plant, tools, equipment, practices and methods of work and any other hazards.
4. Use correct method of work and not improvise by using methods, tools of equipment which entail unnecessary risk.
5. Co-operate in the work of any committees and in any inspections of the work place.
6. Report and assist in the investigation of incidents.
7. Ensure that any ill health or medical condition which may affect their ability to work safely to reported to their manager or the Occupational Health Service.
8. Is required as part of the risk assessment process, to participate in health surveillance programmes and exposure monitoring (refer the Health Surveillance and COSHH Policies for further details).
9. Wear and use the necessary personal protective equipment specified by risk assessment.
10. If required, to use Respiratory Protective Equipment of the required standard to comply with the Trust's Fit Testing Policy.

M. The responsibilities of Other Persons on Trust Premises are as follows:

Any employees of organisations other than the Belfast Health and Social Care Trust who operate on Trust premises will be expected to abide by the Trust's Health and Safety Policy. They must therefore be informed in writing, by the Senior Manager who has permitted their access to the site, of the relevant Trust health and safety standards and the health and safety risks to which they may be exposed by the Trust's activities. Furthermore they must inform the Trust of any risks to the Trust, its clients, its staff and members of the public which may occur due to the operation of such contractors on site and comply with the relevant permit to work arrangements and method statements.

	Any staff ie. agency, students, not directly employed by the Trust, but working on Trust premises, are subject to the health and safety requirements established for Trust staff. Trust staff. Trust staff with responsibilities for overseeing such staff must ensure that they are familiarised with the Trust health and safety policies, procedures, committees and groups with health and safety responsibilities. **N. The responsibilities of Safety Representatives are as follows:** Trade Union side safety representatives are nominated via the staff side organisation. Their function is laid down within the Safety Representative & Safety Committee Regulations (NI) and also by the health and safety procedural agreement (Appendix 2). **O. The responsibilities of the Trust Joint Health and Safety Committee are as follows:** The Joint Health and Safety Committee is constituted and works according to the requirements laid down by the Health and Safety at Work Order (NI) 1978 and the Safety Representative and Safety Committee Regulations (NI) which facilitates consultation on all health and safety matters. Its terms of reference and membership are laid down in a procedural agreement between the Belfast Health & Social Care Trust and the trade union side organisation (See Appendix 2 for further details). **P. The responsibilities of the Assurance Group are as follows:** The Assurance Group is responsible for co-ordinating the activities of expert groups. Of the various expert groups reporting through the assurance group the following have an identified health and safety remit: • Infection Prevention and Control Committee • Controls Assurance Steering Group • Employers' Liability and Occupiers' Liability Advisory Group • Radiation Protection Committee • Genetic Modification Safety Committee • Business Continuity / Emergency Planning Committee • Inter-professional Learning and Development Committee • Medical Devices Management Group including decontamination • Blood and Blood Products Committee • Drugs and Therapeutics Committee (See Appendix 1 for further details).
7.	**The definition and background of the policy or guidelines:**
	The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff. Assessment and Control of Risk The Management of Health & Safety at Work Regulations (NI) 2000 requires suitable and sufficient assessments of the risk to the health and safety of employees and others arising from the activities of the Trust. This responsibility falls to individual Service

	Groups, Department Managers and Line Managers. Risk assessments should form the basis of health and safety management within each department/ward. A regularly reviewed and dated record of each assessment must be maintained within each Service Group. The risk assessments will provide a basis for line managers to make health and safety arrangements for the planning, organisation, control, monitoring and review of preventative and protective measures. Risk Assessment should contribute to the populations of the Service Groups Risk Register. Further details on the Risk Register can be obtained from the Trust's Risk Management Strategy. The risk assessment must include details of avoidance or control measures required, safe systems of work, training/communication needs and where appropriate, health surveillance. The details of risk assessments must be communicated to staff to assist in ensuring they are competent to carry out their duties safely. Staff and trade union representatives should have access to completed risk assessments, RIDDOR reports and reports from the Health & Safety Executive. All risk assessments must be reviewed at least every 2 years or upon significant change (Regulation 3, Management of Health & Safety at Work Regulations (NI) 2000. Some important aspects of work and work activities requiring the completion of specific risk assessments are:- Client/Patient & Load Handling, Chemicals/Drugs/Dusts, Biological Agents and Display Screen Equipment. The General Health and Safety Risk Assessment Form can be used for risk assessments relating to the workplace and work equipment, lone working, slips, trips and falls etc.
8.	**Policy / Guideline description:**
	This policy describes how the health, safety & welfare issues should be identified, assessed and managed within the Belfast Trust.
9.	**Policy statements:**
	• It is recognised that the people employed by the Trust are its most important asset and that this is reflected in a commitment to ensuring their health, safety and welfare. • The Trust Board and Trust Directors have overall responsibility for workplace health and safety. The executive team and service group management are responsible for ensuring the undertakings outlined in this policy are adhered to throughout the Belfast Health and Social Care Trust. • Health and safety is an integral part of management responsibilities, inseparable from all Trust Objectives. It is an essential component in the provision of high quality health care.

	• The Trust will link with Health & Safety Inspectors from HSENI during the reporting and investigation of RIDDOR reportable incidents, during routine inspections and when it is necessary to request advice and assistance. The Trust will also link with Health & Safety Inspectors on health and safety matters raised at local seminars, conferences and best practice meetings. • This policy will be supported by organisational arrangements for health and safety within the Trust (Appendix 3). • The organisational arrangements described in this document place health and safety at the centre of the Belfast Health and Social Care Trust arrangements for wider health care governance. Health and safety is incorporated within the Belfast Health and Social Care Trust wider governance strategy at both corporate and service group levels.
10.	**Implementation / Resource requirements:**
	This Policy is required to be implemented by all Service Groups. All staff are required to comply with this Policy, in particular those individuals and Departments with specific responsibilities, as detailed.
11.	**Source(s) / Evidence Base:**
	This policy is based on legislation and ACOPS and guidance as detailed in section 13 1 references.
12.	**Links with other Trust Policies**
	Belfast Trust policies relating to: • Lone Working • Zero Tolerance Approach to the Prevention • Prevention & Management of Alcohol & Drugs in the Workplace • Manual Handling • Display Screen Equipment • Control of Substances Hazardous to Health • New & Expectant Mothers • Driving for Work • Management of Stress, Health & Well Being • Health Surveillance Policy and associated Procedures • Fit Testing (Respiratory Protective Equipment) and other Belfast Trust policies under development.
13.	**References, including relevant external guidelines:**
	Health & Safety at Work (NI) Order 1978, as amended, set our duties on the Trust to ensure the Health, Safety and Welfare of their staff whilst they are at work. Safety Representatives & Safety Committee (NI) Regulations 1978. Health & Safety (Consultation with Employees) Regulations (NI) 1996. Management of Health & Safety at Work (NI) Regulations 2000, requires the Trust to undertake suitable and sufficient risk assessments of the risks to staff and others associated with the work activity. HSENI Publication – Safety Representatives & Safety Committee (available from HSENI, Ladas Drive, Belfast).

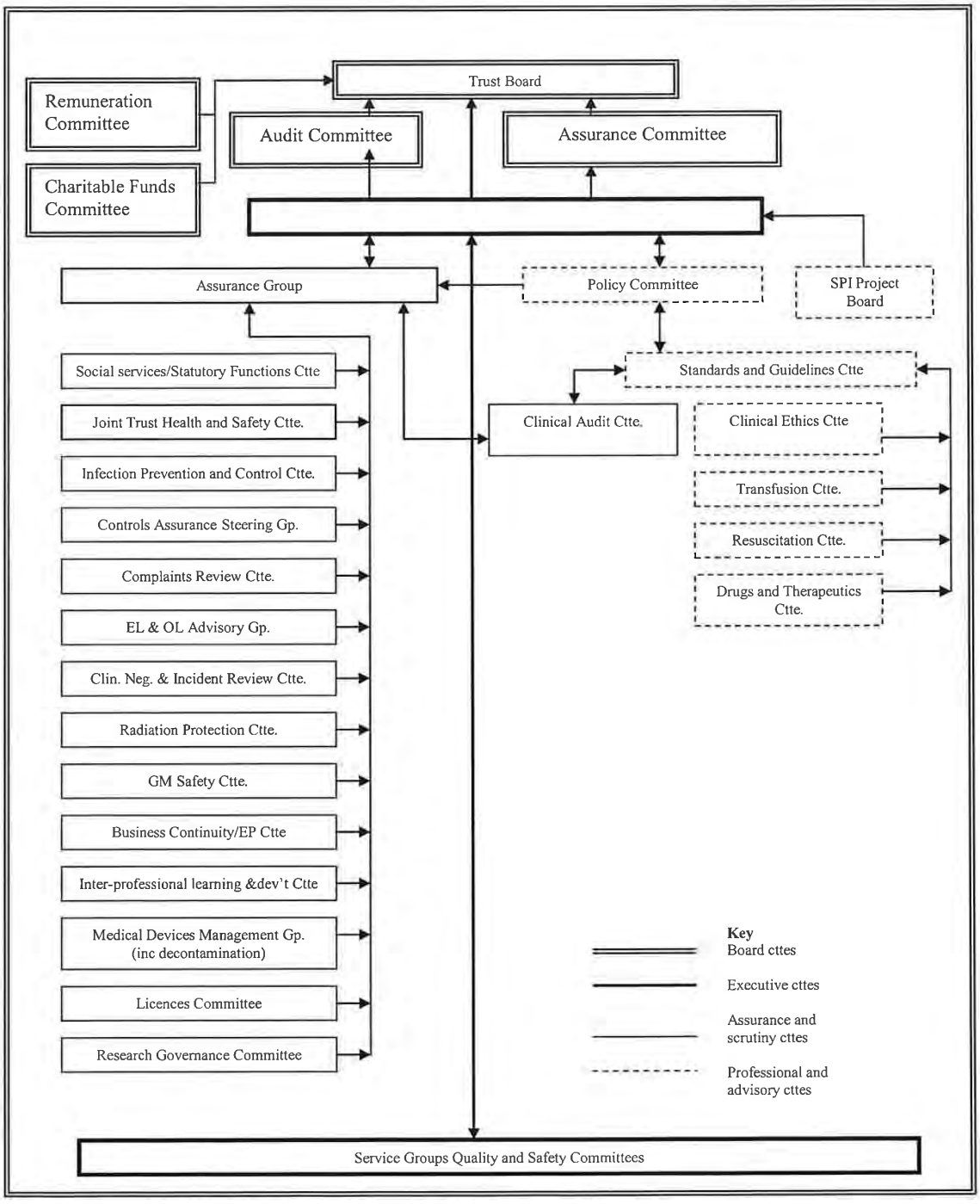
14.	**Consultation Process:**
	This policy has been revised in collaboration with the Trust's Health & Safety Managers, Joint Health & Safety Committee, Co-Directors and Senior Managers throughout the Trust. Consultation with staff and their trade union representatives during development and introduction of a policy is a legal requirement and it will also help to enhance employee relations, ref: Health & Safety (Consultation with Staff) Regulations (NI) 1966 and The Safety Representatives and Safety Committee Regulations (NI) 1979.
15.	**Equality and Human Rights screening carried out:**
	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, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.
	√ Screening completed No action required. ☐ Full impact assessment to be carried out.
16.	**Procedures:**
	These procedures are included as part of the responsibilities section above and within Appendix 2 attached.

Medical Director
11 November 2009

Chief Executive
11 November 2009

Appendix 1

ORGANISATIONAL ARRANGEMENTS FOR HEALTH AND SAFETY



Trust Policy Committee - General Health and Safety Policy – V2 – Dec 2009

Appendix 2

Belfast Health and Social Care Trust

Trust Health & Safety Committee - Terms of Reference

1.0 Rationale

In recognition of the responsibility of the Belfast Health & Social Care Trust for the health, safety and welfare of its, staff, patients and visitors and to restate its responsibilities under the Health and Safety at Work Order (Northern Ireland) 1978, Safety Representatives and Safety Committee (NI) Regulations 1979, Health & Safety (Consultation with Employees) Regulations (Northern Ireland) 1996 and other relevant legislation. The Trust Management and the trade union side representative agree to set out arrangements relating to the conduct of the management of health and safety within the Belfast Health & Social Care Trust's Joint Health & Safety Committee.

2.0 Objectives

To promote co-operation and consultation between the Trust and staff in instigating, developing and carrying out measures to ensure the health, safety and welfare of all staff, patients, clients, visitors, contractors, volunteers and members of the public.

3.0 Introduction

The Trust believes that the health, safety and well being of their employees are vital to the provision of a quality service. It is of mutual benefit to the Trust and its staff, to be represented by trade union side / professional bodies. The Trust also believes that fully representative staff trade union / professional bodies are an integral part in the management of health and safety.

The Trust and trade union side / professional bodies will work in co-operation, to encourage and promote a culture of partnership in relation to the management of health and safety, throughout the organisation. Arrangements that are reached between the Trust and the trade union side / professional bodies will be binding for non union members within the trust.

4.0 Principles

The trade union side / professional bodies recognise management's responsibility to plan, organise and manage the activities of the Trust according to the objectives of the board of directors.

The Trust recognises that trade union side / professional bodies have the right and responsibility to represent the health and safety interests of their members and non trade union staff and to work to achieve improvements in their health, safety and well being.

The Trust accepts the right of trade union side / professional bodies to brief their members in respect of health and safety issues using agreed procedures.

The Trust agrees to disclose to the Health and Safety Committee information in accordance with their statutory responsibility for health and safety management.

The Trust, trade union side and professional bodies recognise the importance of working in an atmosphere of mutual trust and partnership and also recognise the importance of confidentiality of certain information and that specific information may be identified as confidential.

It is not the intention of this agreement to exclude the right of trade union side / professional bodies to represent their members or to prevent local agreements concerning health and safety issues within service groups providing such locally based agreements are without prejudice to collective negotiations within the trust.

Day to day operational health and safety issues will be resolved, where possible at service group level with the trade unions / professional bodies directly affected.

5.0 Functions

a. Promote and encourage a multidisciplinary health and safety culture within the Trust, which will secure implementation of policies and programmes for effective health and safety management.
b. Review of the efficiency and effectiveness of the trust wide structures for health and safety
c. Measure and review health and safety performance.
d. Assist in the development, introduction, monitoring and review of Trust policies and procedures.
e. Ensure the Trusts Health and Safety policy is effectively implemented and reviewed.
f. Health and safety training and development.
g. Assistance in the development of works safety rules and safe systems of work.
h. The study of accidents, incidents and notifiable disease statistics and trends, so that reports can be made to management on unsafe and unhealthy conditions and practices, together with recommendations for corrective action.
i. Assistance in the production of the trust annual health and safety report.
j. Examination of safety audit reports and to make recommendations to the Chief Executive.
k. Consideration of reports which safety representatives may wish to submit.
l. Analysis of information and reports provided by inspectors of the relevant enforcing authority.
m. Endorsement of the Trusts compliance with the requirements of the health and safety Controls Assurance standard.
n. Receiving reports from service group health and safety committees and making recommendation as appropriate.
o. Monitoring amendments to existing and any new legislation or other authoritative guidance and advising on its application and implementation within the trust.

6.0 Membership

The health and safety committee shall consist of representatives as follows:

a. Up to ten management representatives, including the Chief Executive or his nominated deputy.
b. Up to ten trade union side health and safety representatives to be nominated by trade union side / professional staff organisations accredited by the Trust.
c. Management and trade union side will each appoint a committee secretary.
d. The Chief Executive or his nominated deputy will normally chair meetings. The trade union side committee secretary will otherwise chair meetings.
e. The committee may decide to request individuals with specialist or expert knowledge to attend meetings. In these instances the individuals would be co-opted for only those meetings at which the subjects on which they have expertise are to be discussed.
f. Membership shall be regarded as part of the member's normal work and no member shall suffer any pecuniary loss or suffer any detriment because of their membership.

7.0 Meetings

a. Meetings of the health and safety committee shall be held as often as required but at least quarterly. This will not preclude the convening of a meeting at any other time for a special purpose.
b. Attendance of at least 6 members is required to run each meeting.
c. Draft minutes of the meetings will be prepared by the management's secretary and agreed with the trade union side secretary.
d. The agenda and previous minutes will be distributed at least 2 weeks prior to each meeting.
e. Management's secretary will be responsible for arranging venues and agreeing dates.
f. Items not included on the agenda may be raised under any other business only by agreement of both secretaries before the start of the meeting.
g. Responses to actions assigned to individual members in the previous minutes should be received prior to the meeting if the member is unable to attend the meeting in person.
h. Non-attendances/apologies at 3 consecutive meetings will result in a new nomination being sought from Director or Trade Union Side /Professional Body.

8.0 Meeting Agenda

The agenda will include:

- Members present
- Apologies for absence
- Minutes of the previous meeting
- Matters arising from the previous minutes
- Matters raised by HSENI and other inspecting authority
- Matters raised by internal Trust inspections/audits
- Adverse incident reports and accidents and notifiable diseases reported and investigated since last meeting
- Trade Union side business
- Chairperson's business
- New legislation, codes of practice etc.
- Training, education and communication regarding health and safety
- Any other relevant business
- Date and time of next meeting

9.0 Representation/ Facilities

In order to stand for election as a health and safety representative, an employee must be employed within the Trust, and be elected in accordance with the rules of the trade union side / professional body concerned and in accordance with the legislation detailed above. The trade union side / professional bodies accept that it is in the interests of both sides that representatives are familiar with the working practices of the trust and are conversant with the duties required of them to represent their constituents.

Written notification of the names of elected health and safety representatives will be made to the trust in keeping with relevant legislation.

10.0 Time Off / Facilities

Accredited health and safety representatives will be given reasonable time off with pay to perform trade union side health and safety duties including those associated with the business of the committee.

The Trust will assist accredited health and safety representatives to discharge their responsibilities by allowing reasonable time off with pay for health and safety representatives to undergo relevant training which has been approved by their own trade union / professional body. On each occasion the health and safety representative must seek prior permission from the departmental manager at least two weeks in advance, where possible, and provide a copy of the syllabus or prospectus indicating the content of the training course.

The Trust will make available to the trade union side committee such facilities as are necessary for the purpose of carrying out agreed health and safety functions.

11.0 Review

This agreement will be reviewed in within twelve months from the date of operation.

Belfast Health and Social Care Trust

Policy No. TP050/08

Title:	**General Health & Safety Policy**		
Author(s)	Karen Cunningham, Lead Health & Safety Manager Tel: [redacted], email: [redacted]		
Ownership:	Dr Anthony Stevens, Medical Director		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	19 Nov 2012 28 Nov 2012
Operational Date:	1st November 2009	**Next Review:**	31st October 2015
Version No.	3	**Supercedes**	Version 2, 1st November 2009 – 31st October 2012
Links to other policies	All other Health & Safety Policies as listed in the Risk & Governance section of the HUB		

Date	Version	Author	Comments
03/09/12	Draft 3.1	Karen Cunningham	3 yearly review of Belfast Trust General Health & Safety Policy
09/10/12	Draft 3.2	Karen Cunningham	Incorporating comments from Health & Safety Team
07/11/12	Draft 3.3	Karen Cunningham	Incorporating comments from Trust Wide consultation

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This policy provides the Belfast Health & Social Care Trust with a clear sense of direction for the organisation identifying objectives, responsibilities including the need to achieve continual improvement in its health & safety performance and providing a structure for its health & safety management system.

1.2 Purpose

This policy & procedural arrangement is designed to provide managers and staff with clear guidelines on their general health and safety responsibilities. The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff.

- To ensure, so far as is reasonably practicable, the health safety and welfare of all its staff, service users, contractors, visitors, students, volunteers and members of the public, and promote a positive health and safety culture throughout the Trust.
- To advise, inform and instruct in a straightforward way the basic principles in health and safety management.
- To ensure that managers undertake and review the relevant risk assessments relating to the delivery of their services, to identify and implement relevant controls and associated Approved Codes of practice.
- To ensure that the relevant human and financial resources are identified and prioritised as part of the risk assessment process.
- To implement the Trust's Mandatory Training Matrix and to identify training specific to the work activity as part of the risk assessment process.
- To ensure that the Trust complies with the relevant health and safety legislation and guidance.
- To monitor the adequacy of safety and health communication and awareness in the workplace through the analysis of trends in accident/incidents, investigation of accidents/incidents, during audits, inspections and observation of working practices, staff awareness of risk assessments associated with their work activities and their compliance with Trust and Directorate Policies and Procedures.
- To ensure that Directorates disseminate and communicate health and safety information as part of their assurance arrangements. Corporate health & safety policies, procedures and risk assessment documentation is available via the Trust's Intranet
- To ensure staff, trade union side and professional body health & safety representatives are consulted on health & safety matters.
- To ensure that the management of Health & Safety is monitored through the organisations performance management and assurance frameworks.
- To include specific reference to health & safety issues in local induction programmes.

2.0 DEFINITIONS/SCOPE OF THE POLICY

This is a corporate policy to advise, inform and instruct Directors, Managers, Staff and contracted services who work within the Belfast Trust, of their duties, to ensure the health, safety and welfare of all staff, service users, contractors, visitors, students, volunteers and members of the public.

3.0 ROLES/RESPONSIBILITIES

The ultimate responsibility for ensuring the health, safety & welfare of our staff and others who may be affected by the Trust's work activities rests with the Chief Executive.

The Medical Director (as Lead Director for Health & Safety is responsible for co-ordinating compliance with the requirements in this Policy in conjunction with the Director of Human Resources.

The responsibility cascades down through the line management structure to Co-Directors, Senior Managers and Ward, Department & Facility Managers and to all staff who should familiarise themselves with this Policy and the impact of such on their work activities.

A. The responsibilities of the Board of Directors are as follows:

The Trust Board Directors together with the Chief Executive have the ultimate responsibility to ensure compliance, in the Trust's undertakings, with the statutory obligations described in health and safety legislation. The Board will:

1. Issue a policy statement under the Chief Executive officer's signature, detailing the Trust's policy and organisational arrangements for the effective management of health and safety.
2. Monitor and review the organisation's performance in health and safety management through the Assurance Committee, in particular the way in which the Trust's activities are managed and organised, taking cognisance of the requirements of the Corporate Manslaughter and Corporate Homicide Act 2007.

B. The responsibilities of the Executive Team are as follows:

The Executive Team will be responsible for the implementation of the health and safety policy. It will:

1. Ensure that the organisational arrangements contained within the health and safety policy and its associated procedures are implemented.
2. Monitor and review the overall health and safety performance and receive an annual health and safety report.
3. Set corporate objectives for health and safety management and agree key performance indicators.
4. Consider health and safety issues affecting the organisation's undertakings, as they arise.
5. Ensure health and safety management is integrated within the Trust's performance management and assurance framework.

6. Promote positive health and safety culture through all activities of the Trust.

C. The responsibilities of the Chief Executive are as follows:

The Chief Executive is the Accountable Officer. The Chief Executive is responsible to the Trust Board for the effective management of health and safety and for achieving the aims of the health and safety policy.

The Chief Executive will:

1. Report at regular intervals to the Board of Directors on health and safety performance.
2. Set targets for health and safety performance, assisted by the Joint Health and Safety Committee.

The Chief Executive has delegated these executive functions to the Medical Director.

D. The responsibilities of the Medical Director are as follows:

The Medical Director has responsibility for co-ordinating and monitoring health and safety activity throughout all the Belfast Health and Social Care Trust undertakings. The Medical Director will report to the Executive Team and joint health and safety committee in all matters relating to health and safety. The Medical Director will work directly with line management and safety representatives to encourage and facilitate the implementation of the health and safety policy.

The Medical Director is responsible for providing suitable organisational arrangements for the management of health and safety and ensuring that Directorates have access to competent advice and assistance from Specialist Advisors for the purposes of the Management of Health & Safety at Work Regulations (NI) 2000. (See Definitions for further details). The Medical Director will:

1. Advise on the development and review of health and safety policies and procedures.
2. Develop and maintain systems to monitor health and safety performance within the organisation.
3. Provide guidance to the Executive Team on health and safety legislation and issues, as they affect the organisation's undertakings.
4. Ensure that management are aware of their health and safety responsibilities as contained in legislation and authoritative guidance.
5. Advise on priorities for the prevention or control of health and safety risks.
6. Promote and maintain a health & safety culture.
7. Promote and maintain consultation with Trade union and Employee Representatives and employees.
8. Ensure adequate arrangements to meet their health and safety training needs.
9. Ensure compliance with the requirements of the RIDDOR regulations

E. The responsibilities of the Director of Finance & Estates are as follows:

The Director of Finance has responsibilities for the maintenance and management of work place plant and equipment. The Estates Manager has been delegated to attend the Joint Health and Safety Committee.

The Finance & Estates Director will:

1. Ensure compliance with statutory provisions and other authoritative guidance, as they affect work place plant and equipment.
2. Be responsible to the Chief Executive for fire safety for the Belfast Trust.

F. The responsibilities of the Director of Human Resources are as follows:

The Director of Human Resources will;

1. Ensure that all new staff (including permanent, temporary, honorary and volunteers) have a health assessment to determine their suitability for employment.
2. Ensure that all new and current staff have access to a copy of the health and safety policy.
3. Ensure that all new staff have Corporate induction training that includes an explanation of the Trust's arrangements for managing health and safety.

G. The responsibilities of the Directors are as follows:

The Directors are responsible to the Chief Executive for implementation of the health and safety policy within their Directorate. They are responsible for making such health and safety arrangements as are appropriate, having regard to the nature of the Directorate activities, for the effective planning, organisation, control monitoring, review of preventative and protective measures. Directorates will each establish suitable arrangements for governance. These arrangements must provide a focus for health and safety management within the Directorate and will ensure the implementation of the Belfast Health and Social Care Trust health and safety policy.

The responsibilities of each Directorate are to:

1. Ensure that the Directorate's undertakings are carried out in compliance with health and safety legislation, the health and safety policy and other relevant guidelines.
2. Ensure that all staff are aware of the health and safety policy and their own responsibilities under the policy.
3. Make suitable arrangements for the training and education of staff to ensure that they are competent to carry out their duties safely and without risk to health. This includes mandatory training, training identified as a result of a risk assessment,

local induction and the ways in which health & safety information is communicated and disseminated.

4. Ensure that comprehensive risk assessments are completed and maintained.
5. Ensure that reasonable measures are taken to prevent or control identified risk to health
6. Ensure that the required human and financial resources are identified and prioritised through the risk assessment process.
7. Develop local policies/procedures and safe systems of work where these are required by the individual undertakings and circumstances of the Directorate in line with the Trust's Health and Safety Policy.
8. Ensure that the Trust's procedures for the reporting of adverse incidents are adhered to, that all such events are investigated and that appropriate preventative action is taken.
9. Co-operate with the Joint Health and Safety Committee in the monitoring of health and safety performance.
10. Report to the Joint Health and Safety Committee and Executive Team any matters of concern with regard to health and safety.
11. Ensure the level of compliance for health & safety is measured and monitored through the completion of the Health & Safety Controls Assurance Process and the Belfast Risk, Audit and Assessment Tool (BRAAT).

H. The responsibilities of the Risk & Governance Department is as follows:

The Co-director and Senior Managers will support the Medical Director in meeting his responsibility for health and safety management.

The Senior Manager for Regulation & Improvement will:

1. Promote a positive health and safety culture and compliance with statutory obligations.
2. To present the Annual Health & Safety Report to the Medical Director and Joint Health & Safety Committee.
3. Provide administrative support to the Joint Health and Safety Committee.
4. Provide incident reports to Joint Health and Safety Committee and Governance Steering Group.
5. Promote the completion of BRAAT.
6. Ensure arrangements are in place to assist managers in hazard identification, conducting risk assessments and establishing and reviewing control measures.
7. Ensure that Managers have access to competent advice and information on health and safety matters.
8. To liaise with the Occupational Health Service and other specialist advisors on health matters and relevant health & safety issues.

The Senior Manager Corporate Governance will promote procedures for the reporting, recording and analysis of adverse incidents and will make arrangements for the investigation of serious incidents.

The Trust's Health & Safety Team will in addition to the professional and technical work inherent in their posts:

1. Provide specialist advice to all levels of management on those health and safety issues in which they have expertise.
2. In conjunction with the Joint Health and Safety Committee develop and maintain policies and procedures on health and safety issues for which they have responsibility.
3. To develop and implement an Annual Health & Safety Plan.
4. To develop an Annual Health & Safety Report in conjunction with the Joint Health & Safety Committee.
5. To promote and advise on the completion of BRAAT and actions arising from such.
6. Contribute to training and education programmes relating to their area of expertise.
7. Collate the required evidence for the Health & Safety Controls Assurance Standards.
8. To maintain statistical information on staff incidents and RIDDOR Reportable Incidents occurring within the organisation.

I. The responsibilities of the Trust's Specialist Advisors

1. To provide advice and guidance & monitor and report on aspects of health and safety performance as they relate to their area of expertise and responsibility. Specialist Advisors may include Radiation Protection Advisers, Fire Officers, Genetic Modification Safety Officer, Infection Prevention & Control Advisers, Occupational Health Professionals, Decontamination Managers, Ergonomics Advisors and Dangerous Goods Safety Advisors.

J. The responsibilities of Directorate Managers / Heads of Department / Line Managers within each Directorate are as follows:

1. Ensure that they are familiar with the health and safety policy and the arrangements laid out therein for the management of health and safety.
2. Ensure that a suitable and sufficient assessment is made of the risk to the health and safety of employees and agency, locum, contractors, students, visitors, members of the public and other persons not in their employment arising out of, or in connection with, the activities within their departments. Risk assessments should be undertaken by competent departmental managers or appointed assessors. The risk assessment process will be co-ordinated at Directorate level as far as is reasonably practicable.
3. Ensure that the requirements of the Disability Discrimination Act (reasonable adjustment for example) are considered where relevant in risk assessments.

4. Ensure that measures are taken to avoid or control any risk including human and financial resources are identified and prioritised through the risk assessment process. Where this is beyond the competence, authority or resources of the manager, he/she must advise his/her senior manager.
5. Ensure that all personnel under their control know and accept the responsibilities under the health and safety policy and that they are equipped to play their part.
6. Operate within all legal and other requirements applicable to the work within their area of responsibility.
7. Ensure that systems of work are safe and without risk to health are agreed and implemented in liaison with the relevant members of staff.
8. Ensure employees are properly trained and competent to perform their work safely and without risk to health. This includes attendance at mandatory training, training identified as a result of a risk assessment, local induction and the ways in which health & safety information is communicated and disseminated.
9. Ensure investigation and reporting procedures for adverse incidents are carried out and that corrective action where indicated is taken, as identified through risk assessment.
10. To inform the Occupational Health Service to undertake the required health surveillance programmes, for the protection of the member of staff for the duration of their employment with the Trust. The need for health surveillance should be identified by managers through the completion of local risk assessment.
11. To refer staff to the Occupational Health Service where a concern exists about their heath in relation to health and safety or in relation to suspected work-related injury/disease.
12. Ensure that personal protective equipment, where required, is appropriate, readily available and properly maintained.
13. Ensure that staff who are required to use personal protective equipment are appropriately trained in its use, maintenance and where appropriate fit tested for respiratory protective equipment use.
14. Ensure that all work place equipment is properly maintained and fit for purpose, logged and serviced (where appropriate).
15. To demonstrate compliance with the relevant Trust Health & Safety Policies, statutory and mandatory requirements by implementing the standards within the Belfast Risk Audit & Assessment Tool (BRAAT) in accordance with the guidance on completion.
16. To provide this policy in other languages and formats when requested, a manager should refer to:- the Procurement & Logistics Service (PALS) in relation to requests for interpreting or translation services. For further information on translation services contact the Health and Social Inequalities Manager assigned to your Directorate.

K. The responsibilities of Supervisory Staff are as follows:

Supervisory staff have a responsibility for carrying out duties determined by heads of department / line managers to ensure that the objectives of the health and safety policy are achieved.

They will:

1. Assist the heads of department/line managers in ensuring that all personnel within their department know and understand the responsibilities under the health and safety policy and that they are fully trained and equipped to play their part.
2. Operate within all legal and other requirements appropriate to their workplace.
3. Ensure that they understand the risk assessment process, the outcomes/requirements that a risk assessment may identify, and the preventative control measures to be implemented within the department.
4. Check and ensure that all plant, tools and equipment are available and safe to use, and that safe and easy access to all places of work are maintained.
5. Ensure that all safe operating procedures and instructions are known and observed and maintained.
6. Know the accident and untoward incident reporting procedures and ensure that they take the action required.
7. Assist with the training of employees and ensure that they are capable of carrying out their duties safely and identify any weakness/gaps in training. This includes attendance at mandatory training, training identified as a result of a risk assessment, local induction and the ways in which health & safety information is communicated and disseminated.
8. Ensure that all personal protective equipment and other safety equipment is used at all appropriate times as identified by risk assessment.
9. Advise the heads of department/line managers of any problems that occur in the implementation of the health and safety policy.
10. To assist with the completion of BRAAT.

L. The responsibilities of all Staff are as follows:

All staff including managers are held accountable in law, not to commit acts in breach of Health and Safety Legislation. Staff have a duty under the Health and Safety at Work Order (NI) 1978 to take reasonable care of their own health and safety and that of others who may be affected by their acts or omissions. It is each employee's duty to co-operate with management to enable the employer to comply with statutory duties for health and safety.

All staff must:

1. Use any machinery, equipment, dangerous substances, transport and safety device provided by the Trust in accordance with their training and safety instructions.
2. Conform to rules and procedures regarding health and safe working practices.
3. Report to management unsafe plant, tools, equipment, practices and methods of work and any other hazards.
4. Use correct method of work and not improvise by using methods, tools of equipment which entail unnecessary risk.
5. Co-operate in the work of any committees and in any inspections of the work place.
6. Report and assist in the investigation of incidents.
7. Ensure that any ill health or medical condition which may affect their ability to work safely to reported to their manager or the Occupational Health Service.
8. Is required as part of the risk assessment process, to participate in health surveillance programmes and exposure monitoring (refer the Health Surveillance and COSHH Policies for further details).
9. Wear and use the necessary personal protective equipment specified by risk assessment.
10. If required, to use Respiratory Protective Equipment of the required standard to comply with the Trust's Fit Testing Policy.
11. To contribute to the completion of BRAAT.

M. The responsibilities of Other Persons on Trust Premises are as follows:

Any employees of organisations other than the Belfast Health and Social Care Trust who operate on Trust premises will be expected to abide by the Trust's Health and Safety Policy. They must therefore be informed in writing, by the Senior Manager who has permitted their access to the site, of the relevant Trust health and safety standards and the health and safety risks to which they may be exposed by the Trust's activities. Furthermore they must inform the Trust of any risks to the Trust, its service users, its staff and members of the public which may occur due to the operation of such contractors on site and comply with the relevant permit to work arrangements and method statements.

Any staff i.e. agency, students, not directly employed by the Trust, but working on Trust premises, are subject to the health and safety requirements established for Trust staff. Trust staff. Trust staff with responsibilities for overseeing such staff must ensure that they are familiarised with the Trust health and safety policies, procedures, committees and groups with health and safety responsibilities.

N. The responsibilities of Trade Unions, Professional Bodies and Employee Health & Safety Representatives are as follows:

The role of the Health & Safety representatives nominated by their Trade Union or Professional Body is laid down within the Safety Representative & Safety Committee Regulations (NI), Health & Safety (Consultation with Employees) Regulations (Northern Ireland) 1996 and also by the Joint Health & Safety Committee's Terms of Reference (Appendix 1).

O. The responsibilities of the Trust Joint Health and Safety Committee are as follows:

The Joint Health and Safety Committee is constituted and works according to the requirements laid down by the Health and Safety at Work Order (NI) 1978 and the Safety Representative and Safety Committee Regulations (NI) 1979 which facilitates consultation on all health and safety matters. Its terms of reference and membership are outlined in Appendix 1.

P. The responsibilities of the Assurance Group are as follows:

The Assurance Group is responsible for co-ordinating the activities of expert groups. Of the various expert groups reporting through the assurance group the following have an identified health and safety remit:

- Infection Prevention and Environment Control Committee
- Radiation Protection Committee
- Governance Steering Group
- Medicines Management Group
- Transfusion Committee
- Standards & Guidelines Committee
- Safety & Quality Steering Group
- Safety Improvement Team
- SAI Review Board
- Joint Health & Safety Committee

(See Appendix 2 for further details).

4.0 KEY POLICY PRINCIPLES

The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff.

- The Management of Health & Safety at Work Regulations (NI) 2000 requires suitable and sufficient assessments of the risk to the health and safety of employees and others arising from the activities of the Trust. This responsibility falls to individual Directorates, Department Managers and Line Managers.

Sample risk assessments are available on the Hub, for reference.

- Risk assessments should form the basis of health and safety management within each department/ward or facility. A regularly reviewed and dated record of each assessment must be maintained within each Directorate. The risk assessments will provide a basis for line managers to make health and safety arrangements for the planning, organisation, control, monitoring and review of preventative and protective measures.
- Risk Assessment should contribute to the population of the Directorate Risk Registers. Further details on Risk Registers can be obtained from the Trust's Risk Management Strategy.
- The risk assessment must include details of avoidance or control measures required, safe systems of work, training/communication needs and where appropriate, health surveillance.
- The details of risk assessments must be communicated to staff to assist in ensuring they are competent to carry out their duties safely. Staff and trade union side representatives should have access to completed risk assessments, RIDDOR reports and reports from the Health & Safety Executive for NI / Local Councils.
- All risk assessments must be reviewed at least every 2 years or upon significant change.
- This policy describes how the health, safety & welfare issues should be identified, assessed and managed within the Belfast Trust.
- It is recognised that the people employed by the Trust are its most important asset and that this is reflected in a commitment to ensuring their health, safety and welfare.
- The Trust Board and Trust Directors have overall responsibility for workplace health and safety. The executive team and service group management are responsible for ensuring the undertakings outlined in this policy are adhered to throughout the Belfast Health and Social Care Trust.
- Health and safety is an integral part of management responsibilities, inseparable from all Trust Corporate Objectives. It is an essential component in the provision of high quality health care.
- The Trust will link with Health & Safety Inspectors from HSENI during the reporting and investigation of RIDDOR reportable incidents, during routine inspections and when it is necessary to request advice and assistance. The Trust will also link with Health & Safety Inspectors on health and safety matters raised at local seminars, conferences and best practice meetings.
- The organisational arrangements described in this document place health and safety at the centre of the Belfast Health and Social Care Trust arrangements for wider health & social care governance. Health and safety is incorporated within the Belfast Health and Social Care Trust wider governance strategy at both corporate and Directorate levels.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy is required to be implemented by all Directorates. All managers and staff are required to comply with this Policy, in particular those individuals and Departments with specific responsibilities, as detailed in Section 3.

5.2 Resources

Responsibility for training and risk assessments associated with this policy are detailed in Section 3 – Roles & Responsibilities.

5.3 Exceptions

There are no exceptions.

6.0 MONITORING

It is the responsibility of line managers to monitor the completion and review of relevant risk assessments, staff training, incidents reporting and investigation and the completion of audit tools. Other specific monitoring responsibilities are detailed in Section 3. The Trust's Health & Safety Management System will be monitored through BRAAT scoring returns, validation visits, compliance with the Controls Assurance Standards and by Internal/External Audit.

7.0 EVIDENCE BASE / REFERENCES

Health & Safety at Work (NI) Order 1978, as amended, set our duties on the Trust to ensure the Health, Safety and Welfare of their staff whilst they are at work.

Safety Representatives & Safety Committee (NI) Regulations 1998.

Health & Safety (Consultation with Employees) Regulations (NI) 1996.

Management of Health & Safety at Work (NI) Regulations 2000, requires the Trust to undertake suitable and sufficient risk assessments of the risks to staff and others associated with the work activity.

HSENI Publication – Safety Representatives & Safety Committee (available from HSENI, Ladas Drive, Belfast).

Corporate Manslaughter & Corporate Homicide Act 2007 relates to the organisation being found guilty of Corporate Manslaughter as a result of serious management failures resulting in gross breach of a duty of care

Belfast Trust policies relating to:

- Lone Working
- Zero Tolerance Approach to the Prevention & Management of Violence and Aggression in the Workplace
- Prevention & Management of Alcohol & Drugs in the Workplace
- Manual Handling
- Display Screen Equipment

- Control of Substances Hazardous to Health
- New & Expectant Mothers
- Driving for Work
- Management of Stress, Health & Well Being
- Noise
- Vibration
- Work at Height
- Safety Spectacles
- Sharps Injuries & Blood & body Fluid Exposures
- First Aid at Work
- Radiation Protection Policy
- Health Surveillance
- Respiratory Health Surveillance
- Fit Testing

and other Belfast Trust policies.

8.0 CONSULTATION PROCESS

This policy has been revised in collaboration with the Trust's Health & Safety Managers, Joint Health & Safety Committee, Co-Directors and Senior Managers throughout the Trust.

Consultation with staff and their trade union representatives during development and introduction of a policy is a legal requirement and it will also help to enhance employee relations, ref: Health & Safety (Consultation with Staff) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

9.0 APPENDICES / ATTACHMENTS

Appendix I – Trust Health & Safety Committee - Terms of Reference
Also refer to:

1. Assurance Committee Sub Committee Structure for organisational arrangements relating to Health & Safety – this is available from the Hub.
2. Also refer to the Guidance on General Health & Safety Risk Assessment Process.

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).

Name Dr Tony Stevens
Title Medical Director

Date: 28 November 2012

Name Colm Donaghy
Title Chief Executive

Date: 28 November 2012

Appendix 1

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	Joint Trust Health and Safety Committee
PURPOSE	As a sub-committee of the Assurance Framework the purpose of the Joint Trust Health and Safety Committee is to promote co-operation and consultation between the Trust and staff in instigating, developing and carrying out measures to ensure the health, safety and welfare of all staff, clients, patients and visitors and provide evidence to the Governance Steering Group that any risks identified are managed. In recognition of the responsibility of the Belfast Health & Social Care Trust for the health, safety and welfare of its employees, patients and visitors and to restate its responsibilities under the Health and Safety at Work Order (Northern Ireland) 1978, Safety Representatives and Safety Committee (NI) Regulations 1979, Health & Safety (Consultation with Employees) Regulations (Northern Ireland) 1996 and relevant European legislation, the Trust management and the staff side organisation agree to set out arrangements relating to the conduct of the management of health and safety within the Belfast Health & Social Care Trust.
MEMBERSHIP	**Chair:** Medical Director **Membership:** The Joint Trust Health and Safety Committee shall consist of representatives as follows: Up to ten management representatives, including the Medical Director, or his nominated deputy. Up to ten staff-side health and safety representatives to be nominated by the trade unions / professional staff organisations accredited by the Trust. Management and staff side will each appoint a Committee Secretary The Medical Director, or his nominated deputy, will normally chair meetings. The Chair of Staff Side will otherwise chair meetings. The committee may decide to request individuals with specialist or expert knowledge to attend meetings. In these instances the individuals would be co-opted for only those meetings at which the subjects on which they have expertise are to be discussed. Membership shall be regarded as part of the member's normal work and no member shall suffer any pecuniary loss or detriment because of their membership. **In attendance:** Any Director, Senior Professional, Senior

	Manager, or Health & Safety Manager of the Trust will, where appropriate, be invited to attend. **Secretary:** The committee will be supported by Corporate Risk & Governance Department. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair. **Member Appointments** The membership of the committee shall be determined by the Governance Steering Group based on the recommendations of the Chair, taking into account the skills and expertise necessary to deliver the Joint Trust Health & Safety Committee's remit.
DUTIES	The Committee will in respect of its provision monitor the process for managing Health and Safety and will: • Promote and encourage a multi-disciplinary health and safety culture within the Trust, which will secure implementation of policies and programmes for effective health and safety management; • Review of the efficiency and effectiveness of Trust-wide structures for health and safety; • Measure and review health and safety performance; • Assist in the development, introduction, monitoring and review of Trust policies and procedures; • Ensure the Trust's Health and Safety policy is effectively implemented and reviewed; • Identify health and safety training needs of staff in the Trust and ensure they are met; • Assistance in the development of works safety rules and safe systems of work; • The study of accidents, incidents and notifiable disease statistics and trends, so that reports can be made to management on unsafe and unhealthy conditions and practices, together with recommendations for corrective action; • Assistance in the production of the Trust annual health and safety report; • Examination of safety audit reports and to make recommendations to the Chief Executive; • Consideration of reports which safety representatives may wish to submit; • Analysis of information and reports provided by inspectors of the relevant enforcing authority; • Endorsement of the Trust's compliance with the requirements of the Health and Safety Controls Assurance standard; • Receiving reports from service group health and safety

	committees and making recommendation as appropriate; • Contribute to the quarterly and annual reporting arrangements to the Assurance Committee.
AUTHORITY	The Joint Trust Health and Safety Committee is authorised by the Governance Steering Group to review any activity within its terms of reference. In doing so, the Committee shall have the right to inspect records or documents of the Trust relevant to the Joint Trust Health and Safety Committee's remit, ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any: • Employee (and all employees are directed to co-operate with any reasonable request made by the Committee); • Other Committee, subcommittees or group established within the Assurance Framework to assist in the delivery of its functions.
MEETINGS	**Quorum** The quorum for the meeting will be the Chair (or deputy) plus no fewer than 6 members and must include both management and staff-side representatives. **Frequency of Meetings** Meetings of the Joint Trust Health and Safety Committee shall be held as often as required, but at least quarterly. This will not preclude the convening of a meeting at any other time for a special purpose. Management's secretary will be responsible for arranging venues and agreeing dates. Items not included on the agenda may be raised under any other business only by agreement with the Chair before the start of the meeting. Responses to actions assigned to individual members in the previous minutes should be received prior to the meeting if the member is unable to attend the meeting in person; Non-attendances/apologies at three consecutive meetings will result in a new nomination being sought from Director or Trade Union/Professional Body. **Papers and Agendas** Draft minutes of the meetings will be prepared by the management's secretary and agreed with the Chair Agenda and papers will be disseminated to Committee members at a minimum of seven working days before the date of the meeting and, wherever possible, electronically.

	The agenda will include: • Members present; • Apologies for absence; • Minutes of the previous meeting; • Matters arising from the previous minutes; • Matters raised by HSENI and other inspecting authority; • Matters raised by in-Trust inspections; • Adverse incident reports, accidents and notifiable diseases reported and investigated since last meeting; • Trade Union-side business; • Chair's business; • New legislation, codes of practice, etc; • Training, education and communication regarding health and safety; • Any other relevant business; • Date and time of next meeting. **Withdrawal of individuals in attendance** The Chair of the Committee may ask any or all of those who may attend but who are not members to withdraw to facilitate open and frank discussion of a particular matter.
REPORTING	The Joint Trust Health & Safety Committee is directly accountable to the Governance Steering Group for its performance in exercising the functions set out in these Terms of Reference. The Joint Trust Health & Safety Committee, through its Chair and members, shall work closely with the Assurance Framework's other Steering Groups and Committees, to provide advice and assurance to the Assurance Group through the: • Joint planning and co-ordination of Assurance Framework business; • Sharing of information. In doing so, the Joint Trust Health & Safety Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Trust's overall risk and assurance framework. The Joint Trust Health & Safety Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business. The Joint Trust Health & Safety Committee Chair shall: • Report formally, regularly and on a timely basis to the Governance Steering Group on its activities. This

	includes verbal updates on activity, the submission of minutes and written reports; • Bring to the Governance Steering Group's specific attention any significant matter under consideration of the Committee; • Ensure appropriate escalation arrangements are in place to alert the Executive Team or Chairs of other relevant Committees or Steering Groups of any urgent/critical matters that may compromise patient/client care and affect the operation and/or reputation of the Trust. The Senior Manager for Corporate Governance, on behalf of the Chair of the Assurance Group shall oversee a process of regular self-submission of minutes and written reports, including that of any sub-committees established.
CONFLICT/ DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting of the Joint Trust Health & Safety Committee.
REVIEW	These Terms of Reference and operating arrangements will be reviewed on at least an annual basis by the Joint Trust Health & Safety Committee.

Final Version

April 2012

Date of Review April 2013

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 50/08

Title:	**General Health & Safety Policy**		
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Ownership:	Dr Cathy Jack, Medical Director		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	11 April 2016 20 April 2016
Operational Date:	May 2016	**Next Review:**	May 2019
Version No.	V4	**Supercedes**	V3 - November 2012 - 2015
Key words:	Health, Safety, Responsibilities		
Links to other policies	All other Trust Health & Safety Policies as listed in the Risk & Governance section of the HUB. Also see relevant Trust OHS & HR Policies.		

Date	Version	Author	Comments
03/09/12	V3.1	Karen Cunningham	3 yearly review of Belfast Trust General Health & Safety Policy
09/10/12	V3.2	Karen Cunningham	Incorporating comments from Health & Safety Team
07/11/12	V3.3	Karen Cunningham	Incorporating comments from Trust Wide consultation
11/08/15	V3.4	Karen Cunningham	3 yearly review of Version 3.
05/01/16	V3.5	Karen Cunningham	Health & Safety Team comments.
04/02/16	V4	Karen Cunningham	Add further changes arising from Trust Wide consultation including the Joint Health & Safety Committee

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This policy provides the Belfast Health & Social Care Trust with a clear sense of direction for the organisation identifying objectives, responsibilities including the need to achieve continual improvement in its health & safety performance and providing a structure for its health & safety management system.

1.2 Purpose

This policy & procedural arrangement is designed to provide managers and staff with clear guidelines on their general health and safety responsibilities. The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff.

1.3 Objectives

- To ensure, so far as is reasonably practicable, the health safety and welfare of all its staff, service users, contractors, visitors, placements, students, volunteers and members of the public, and promote a positive health and safety culture throughout the Trust.
- To advise, inform and instruct in a straightforward way the basic principles in health and safety management.
- To ensure that managers undertake and review the relevant risk assessments relating to the delivery of their services, to identify and implement relevant controls and associated Approved Codes of practice.
- To ensure that the relevant human and financial resources are identified and prioritised as part of the risk assessment process.
- To implement the Trust's Statutory/Mandatory Training Matrix in relation to Health & Safety Training and to identify training specific to the work activity as part of the risk assessment process.
- To ensure that the Trust complies with the relevant health and safety legislation and guidance.
- To monitor the adequacy of safety and health communication and awareness in the workplace through the analysis of trends in incidents, investigation of incidents, during audits, inspections and observation of working practices, staff awareness of risk assessments associated with their work activities and their compliance with Trust and Directorate Policies and Procedures.
- To ensure that Directorates disseminate and communicate health and safety information as part of their assurance arrangements. Corporate health & safety policies, procedures and risk assessment documentation is available via the Trust's HUB.
- To ensure staff, trade union side and professional body health & safety representatives are consulted on health & safety matters.
- To ensure that the management of Health & Safety is monitored through the organisations performance management and assurance frameworks.
- To include specific reference to health & safety issues in local induction programmes.

2.0 SCOPE OF THE POLICY

This is a corporate policy to advise, inform and instruct Directors, Managers, Staff and contracted services who work within the Belfast Trust, of their duties, to ensure the health, safety and welfare of all staff, service users, contractors, visitors, students, volunteers and members of the public.

3.0 ROLES/RESPONSIBILITIES

The ultimate responsibility for ensuring the health, safety & welfare of our staff and others who may be affected by the Trust's work activities rests with the Chief Executive.

The Medical Director (as Lead Director for Health & Safety) is responsible for co-coordinating compliance with the requirements in this Policy in conjunction with the Director of Human Resources.
The responsibility cascades down through the line management structure to Co-Directors, Senior Managers and Ward, Department & Facility Managers and to all staff who should familiarise themselves with this Policy and the impact of such on their work activities.

A. The responsibilities of the Board of Directors are as follows:

The Trust Board Directors together with the Chief Executive have the ultimate responsibility to ensure compliance, in the Trust's undertakings, with the statutory obligations described in health and safety legislation. The Board will:

1. Issue a policy statement under the Chief Executive officer's signature, detailing the Trust's policy and organisational arrangements for the effective management of health and safety.
2. Monitor and review the organisation's performance in health and safety management through the Assurance Committee, in particular the way in which the Trust's activities are managed and organised, taking cognisance of the requirements of the Corporate Manslaughter and Corporate Homicide Act 2007.

B. The responsibilities of the Executive Team are as follows:

The Executive Team will be responsible for the implementation of the health and safety policy. It will:

1. Ensure that the organisational arrangements contained within the health and safety policy and its associated procedures are implemented.
2. Monitor and review the overall health and safety performance and receive an annual health and safety report.
3. Consider health and safety issues affecting the organisation's undertakings, as they arise.
4. Ensure health and safety management is integrated within the Trust's performance management and assurance framework.
5. Promote positive health and safety culture through all activities of the Trust.
6. Ensure that the Directorate's Trusts undertakings are carried out in compliance with health and safety legislation, the health and safety policy and other relevant guidelines.

C. The responsibilities of the Chief Executive are as follows:

The Chief Executive is the Accountable Officer. The Chief Executive is responsible to the Trust Board for the effective management of health and safety and for achieving the aims of the health and safety policy.
The Chief Executive will:

1. Report at regular intervals to the Board of Directors on health and safety performance.
2. Set targets for health and safety performance, assisted by the Joint Health and Safety Committee.

The Chief Executive has delegated these executive functions to the Medical Director.

D. The responsibilities of the Medical Director are as follows:

The Medical Director has responsibility for co-ordinating and monitoring health and safety activity throughout all the Belfast Health and Social Care Trust undertakings. The Medical Director will report to the Executive Team and Joint Health and Safety Committee in all matters relating to health and safety. The Medical Director will work directly with line management and safety representatives to encourage and facilitate the implementation of the Trusts health and safety policies.

The Medical Director is responsible for providing suitable organisational arrangements for the management of health and safety and ensuring that Directorates have access to competent advice and assistance from Specialist Advisors for the purposes of the Management of Health & Safety at Work Regulations (NI) 2000. (See Definitions for further details). The Medical Director will provide guidance to the Executive Team on health and safety legislation and issues, as they affect the organisation's undertakings.

1. Ensure adequate arrangements to meet their health and safety training needs.
2. Ensure compliance with the requirements of the RIDDOR regulations.

E. The responsibilities of the Director of Finance are as follows:

The Director of Finance has responsibilities for the maintenance and management of work place plant and equipment. The Estates Co-Director has been delegated to attend the Joint Health and Safety Committee.

The Finance Director will:

1. Ensure compliance with statutory provisions and other authoritative guidance, as they affect workplace plant and equipment.
2. Be responsible to the Chief Executive for the management of fire safety within the Belfast Trust.

F. The responsibilities of the Director of Human Resources are as follows:

The Director of Human Resources will;

1. Ensure that all new staff (including permanent, temporary, placement and volunteers) have a health assessment to determine their suitability for employment.
2. Ensure that all new staff attend the Corporate Welcome that includes an explanation of the Trust's arrangements for managing health and safety.

G. The responsibilities of the Directors are as follows:

The Directors are responsible to the Chief Executive for implementation of the Trust Health and Safety Policies within their Directorate. They are responsible for making such health and safety arrangements as are appropriate, having regard to the nature of the Directorate activities, for the effective planning, organisation, control monitoring, review of preventative and protective measures. Directorates will each establish suitable arrangements for the management of health & safety risks associated with their Services. Any concerns of Corporate interest should be reported through their Directorate representative on the Joint Health & Safety Committee and reported in their quarterly Health and Safety reports to this Committee.

H. The Senior Manager for Licensing and Regulation will:

1. Promote a positive health and safety culture and compliance with statutory obligations.
2. Agree corporate objectives for Health & Safety Performance.
3. Develop and maintain systems to monitor health & safety performance within the organisation.
4. Support the Joint Health & Safety committee and provide quarterly reports to the Trust's Assurance Committee.
5. Establish and Chair relevant Groups to promote a reduction in incidents.
6. Promote compliance with statutory/mandatory health & safety training and ensure adequate records of such are retained.
7. Set corporate objectives for health and safety management.
8. Agree key performance indicators.
8. Develop and maintain systems to monitor health and safety performance within the organisation.
9. To report to the Joint Health and Safety Committee and Executive Team any matters of concern with regard to health and safety.

I. The Lead Health & Safety Manager will:

1. Promote a positive health and safety culture and compliance with statutory obligations.
2. To present the Annual Health & Safety Report to the Medical Director and Joint Health & Safety Committee.
3. Manage the arrangements for the Joint Health & Safety Committee Meetings, which forms part of the Trusts Assurance Sub-Committee Structure.
4. To Provide RIDDOR and Health & Safety Reports to Joint Health & Safety Committee.

5. To promote the completion and implementation of the Belfast Risk Audit & Assessment tool (BRAAT) and to keep it under review.
6. To provide the relevant Health & Safety reports to the Assurance Committees.
7. To ensure arrangements are in place to assist managers in hazard identification, undertake risk assessments and establish and review control measures.
8. To ensure that Managers have access to competent advice and information on health and safety matters.
9. To liaise with the Occupational Health Service and other Specialist Advisors on relevant health & safety issues.
10. To develop an Annual Health and Safety Work Plan.
11. To ensure compliance with the requirements of the RIDDOR regulations.
12. To ensure the level of compliance for health & safety is measured and monitored through the completion of the Health & Safety Controls Assurance Process and the Belfast Risk, Audit and Assessment Tool (BRAAT) and other Key Performance Indicators.
13. To ensure arrangements are in place in relation to Health & Safety training (as per Statutory/Mandatory Training).
14. To liaise with external Statutory Bodies (HSENI, Local Councils), as required.

J. The Senior Manager Corporate Governance will promote procedures for the reporting, recording and analysis of adverse incidents, will make arrangements for the management of serious incidents and maintain accurate records of risks affecting the delivery of the Trust's objectives.

K. The Trust's Health & Safety Team will in addition to the professional and technical work inherent in their posts:

1. Provide specialist advice to all levels of management on those health and safety issues in which they have expertise and to maintain adequate records of such.
2. In conjunction with the Joint Health and Safety Committee develop and maintain policies and procedures on health and safety issues for which they have responsibility.
3. Implement the Annual Health & Safety Plan.
4. To develop an Annual Health & Safety Report in conjunction with the Joint Health & Safety Committee.
5. To promote and advise on the completion of BRAAT and actions arising from such.
6. Contribute to training and education programmes relating to their area of expertise.
7. Collate the required evidence for the Health & Safety Controls Assurance Standards.
8. Maintain adequate records on RIDDOR Reportable Incidents occurring within the organisation.
9. To liaise with external Statutory Bodies (HSENI, Local Councils) as required.

L. The responsibilities of the Trust's Specialist Advisors

1. To provide advice and guidance & monitor and report on aspects of health and safety performance as they relate to their area of expertise and responsibility. Specialist Advisors may include:
   - Radiation Protection Advisers
   - Fire Officers
   - Genetic Modification Safety Officer
   - Infection Prevention & Control Advisers
   - Occupational Health Professionals
   - Decontamination Managers
   - Ergonomics Advisors
   - Dangerous Goods Safety Advisors

M. The responsibilities of Directorate Managers / Heads of Department / Line Managers within each Directorate are as follows:

1. To ensure that they are familiar with the Trusts health and safety policies and the responsibilities laid out therein for the management of health and safety.
2. To ensure that a suitable and sufficient assessment is completed, reviewed and records maintained of the risk to the health and safety of employees and agency, locum, contractors, students, visitors, members of the public and other persons not in their employment arising out of, or in connection with, the activities within their Services. Risk assessments should be undertaken by competent departmental managers or appointed assessors. The risk assessment process should be co-ordinated within Service Areas.
3. To ensure that the requirements of the Disability Discrimination Act (reasonable adjustment for example) are considered where relevant in risk assessments.
4. To ensure that measures are taken to avoid or control risks and that human and financial resources are identified and prioritised through the risk assessment process. Where this is beyond the competence, authority or resources of the manager, he/she must advise his/her senior manager.
5. To ensure that all staff know and accept their responsibilities under the Trust health and safety policies.
6. To operate within all legal and other requirements applicable to the work within their area of responsibility.
7. To ensure that reasonable measures are taken to prevent or control identified risk to health.
8. To ensure that systems of work are safe and without risk to health are agreed and implemented in conjunction with the relevant members of staff and staff practices regularly observed.
9. To ensure employees are properly trained and competent to perform their work safely and without risk to health. This includes attendance at statutory/mandatory training, training identified as a result of a risk assessment, local induction and communication and dissemination of health and safety information from newsletters, safety meetings, inspections/audits and the Trusts HUB.
10. To inform the Occupational Health Service of the relevant staff required to attend health surveillance programmes, for the protection of the member of staff for the duration of their employment with the Trust. The need for health

surveillance should be identified by managers through the completion of local risk assessment.

11. To refer staff to the Occupational Health Service where a concern exists about their health, safety, or in relation to a work-related injury/disease.
12. To ensure that personal protective equipment, where required, is appropriate, readily available and properly maintained.
13. To ensure that staff who are required to use personal protective equipment are appropriately trained in its use, maintenance and where appropriate fit tested for respiratory protective equipment use.
14. To ensure that all work place equipment is properly maintained, fit for purpose, serviced and appropriate records of such retained and staff trained in its use.
15. To demonstrate substantive compliance with the relevant Trust Health & Safety Policies, statutory and mandatory requirements by implementing the relevant standards within the Belfast Risk Audit & Assessment Tool (BRAAT) in accordance with the guidance on completion.
16. To develop Service Area policies/procedures and safe systems of work where these are required, in relation to particular work activities.
17. Ensure that the Trust's procedures for the reporting of adverse incidents are adhered to, that all such events are investigated and that appropriate preventative action is taken.
18. To provide support or alternative formats in terms of communication support or linguistic needs, if required, to communicate the policy.
19. Check and ensure that all plant, tools and equipment are available and safe to use, and that safe and easy access to all places of work are maintained.
20. Ensure that all new and current staff have access to a copy of the health and safety policy.

N. The responsibilities of all Staff are as follows:

All staff including managers are held accountable in law, not to commit acts in breach of Health and Safety Legislation. Staff have a duty under the Health and Safety at Work Order (NI) 1978 to take reasonable care of their own health and safety and that of others who may be affected by their acts or omissions. It is each employee's duty to co-operate with management to enable the employer to comply with statutory duties for health and safety.

All staff must:

1. Use any machinery, equipment, dangerous substances, transport and safety device provided by the Trust in accordance with their training and safety instructions.
2. Conform to rules and procedures regarding health and safe working practices.
3. Report to management unsafe plant, tools, equipment, practices and methods of work and any other hazards.
4. Use correct method of work and not improvise by using methods, tools of equipment which entail unnecessary risk.
5. Co-operate in the work of any committees and in any inspections of the work place.

6. Report and assist in the investigation of incidents.
7. Ensure that any ill health or medical condition which may affect their ability to work safely to reported to their manager or the Occupational Health Service.
8. To participate in health surveillance programmes and exposure monitoring (refer to the Health Surveillance and COSHH Policies for further details), identified as part of the risk assessment process.
9. To wear and use the necessary personal protective equipment specified by the relevant risk assessments.
10. If required, to use Respiratory Protective Equipment of the required standard, to comply with the Trust's Fit Testing Policy.
11. To contribute to the completion of the Belfast Risk Audit & Assessment Tool (BRAAT).

O. The responsibilities of Other Persons on Trust Premises are as follows:

Any employees of organisations other than the Belfast Health and Social Care Trust who operate on Trust premises will be expected to abide by the Trust's Health and Safety Policy. They must therefore be informed in writing, by the Senior Manager who has permitted their access to the site, of the relevant Trust health and safety standards and the health and safety risks to which they may be exposed by the Trust's activities. Furthermore they must inform the Trust of any risks to the Trust, its service users, its staff and members of the public which may occur due to the operation of such contractors on site and comply with the relevant permit to work arrangements and method statements.

Any staff i.e. agency, students, not directly employed by the Trust, but working on Trust premises, are subject to the health and safety requirements established for Trust staff. Trust staff. Trust staff with responsibilities for overseeing such staff must ensure that they are familiarised with the Trust health and safety policies, procedures, committees and groups with health and safety responsibilities.

P. The responsibilities of Trade Unions, Professional Bodies and Employee Health & Safety Representatives are as follows:

The role of the Health & Safety representatives nominated by their Trade Union or Professional Body is laid down within the Safety Representative & Safety Committee Regulations (NI) 1979, Health & Safety (Consultation with Employees) Regulations (Northern Ireland) 1996 and also by the Joint Health & Safety Committee's Terms of Reference (Appendix 1).

Q. The responsibilities of the Trust Joint Health and Safety Committee are as follows:

The Joint Health and Safety Committee is constituted and works according to the requirements laid down by the Health and Safety at Work Order (NI) 1978 and the Safety Representative and Safety Committee Regulations (NI) 1979 which facilitates consultation on all health and safety matters. Its terms of reference and membership are outlined in Appendix 1.

1. To advise on the development and review of health and safety policies and procedures.
2. To ensure that management are aware of their health and safety responsibilities as contained in legislation and authoritative guidance.
3. To advise on priorities for the prevention or control of health and safety risks.
4. To promote and maintain a health & safety culture.
5. To promote and maintain consultation with Trade union and Employee Representatives and employees.

R. The responsibilities of the Assurance Group are as follows:

The Assurance Group is responsible for co-ordinating the activities of the various expert groups reporting through the Assurance Group the following have an identified health and safety remit:

- Joint Health & Safety Committee
- Infection Prevention and Control Committee
- Radiation Protection Committee
- Governance Steering Group
- Medicines Management Group
- Safety & Quality Steering Group
- Safety Improvement Team
- SAI Group

Other relevant Committees include Policy Committee, Standards & Guidelines Committee, SIT and Patient Falls Forum.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

The Belfast Health & Social Care Trust in complying with the requirements of the Health & Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS(NI) guidance has produced this General Health and Safety Policy for the information and guidance of all staff.

4.2 Policy Principles

- The Management of Health & Safety at Work Regulations (NI) 2000 requires suitable and sufficient assessments of the risk to the health and safety of employees and others arising from the activities of the Trust. This responsibility falls to individual Directorates, Department Managers and Line Managers.
  Sample risk assessments are available on the Hub, for reference.
- Risk assessments should form the basis of health and safety management within each department/ward or facility. A regularly reviewed and dated record of each assessment must be maintained within each Directorate. The risk assessments will provide a basis for line managers to make health and

safety arrangements for the planning, organisation, control, monitoring and review of preventative and protective measures.

- Risk Assessment should contribute to the population of the Directorate Risk Registers. Further details on Risk Registers can be obtained from the Trust's Risk Management Strategy.
- The risk assessment must include details of avoidance or control measures required, safe systems of work, training/communication needs and where appropriate, health surveillance.
- The details of risk assessments must be communicated to staff to assist in ensuring they are competent to carry out their duties safely. Staff and trade union side representatives should have access to completed risk assessments, RIDDOR reports and reports from the Health & Safety Executive for NI.
- All risk assessments must be reviewed at least every 2 years or upon significant change.
- This policy describes how the health, safety & welfare issues should be identified, assessed and managed within the Belfast Trust.
- It is recognised that the people employed by the Trust are its most important asset and that this is reflected in a commitment to ensuring their health, safety and welfare.
- The Trust Board and Trust Directors have overall responsibility for workplace health and safety. The Executive Team and Directorate management are responsible for ensuring the undertakings outlined in this policy are adhered to throughout the Belfast Health and Social Care Trust.
- Health and safety is an integral part of management responsibilities, inseparable from all Trust Corporate Objectives. It is an essential component in the provision of high quality health care.
- The Trust will link with Health & Safety Inspectors from HSENI during the reporting and investigation of RIDDOR reportable incidents, during routine inspections and when it is necessary to request advice and assistance. The Trust will also link with Health & Safety Inspectors on health and safety matters raised at local seminars, conferences and best practice meetings.
- The organisational arrangements described in this document place health and safety at the centre of the Belfast Health and Social Care Trust arrangements for wider health & social care governance. Health and safety is incorporated within the Belfast Health and Social Care Trust wider governance strategy at both corporate and Directorate levels.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy is required to be implemented by all Directorates. All managers and staff are required to comply with this Policy, in particular those individuals and Departments with specific responsibilities, as detailed in Section 3.
If support or alternative formats are required in terms of communication in relation to the policy, this will be provided.

5.2 Resources

Responsibility for training and risk assessments associated with this policy are detailed in Section 3 – Roles & Responsibilities.

5.3 Exceptions

There are no exceptions.

6.0 MONITORING

It is the responsibility of line managers to monitor the completion and review of relevant risk assessments, staff training, incidents reporting and investigation and the completion of audit tools. Other specific monitoring responsibilities are detailed in Section 3. The Trust's Health & Safety Management System will be monitored through BRAAT scoring returns, validation visits, compliance with the Controls Assurance Standards and by Internal/External Audit.

7.0 EVIDENCE BASE / REFERENCES

Health & Safety at Work (NI) Order 1978, as amended, set our duties on the Trust to ensure the Health, Safety and Welfare of their staff whilst they are at work.

Safety Representatives & Safety Committee (NI) Regulations 1979.

Health & Safety (Consultation with Employees) Regulations (NI) 1996.

Management of Health & Safety at Work (NI) Regulations 2000, requires the Trust to undertake suitable and sufficient risk assessments of the risks to staff and others associated with the work activity.

HSENI Publication – Safety Representatives & Safety Committee (available from HSENI, Ladas Drive, Belfast).

Corporate Manslaughter & Corporate Homicide Act 2007 relates to the organisation being found guilty of Corporate Manslaughter as a result of serious management failures resulting in gross breach of a duty of care

Relevant Belfast Trust policies relating to:

- Lone Working
- Zero Tolerance Approach to the Prevention & Management of Violence and Aggression in the Workplace
- Prevention & Management of Alcohol & Drugs in the Workplace
- Manual Handling
- Display Screen Equipment
- Control of Substances Hazardous to Health
- New & Expectant Mothers
- Driving for Work
- Management of Stress, Health & Well Being
- Noise
- Vibration

- Work at Height
- Safety Spectacles
- Sharps Injuries & Blood & body Fluid Exposures
- First Aid at Work
- Prevention and Management of Latex Sensitisation
- Radiation Protection Policy
- Health Surveillance
- Respiratory Health Surveillance
- Fit Testing

and other relevant Belfast Trust policies.

All policies are accessible from the Trust's HUB.

8.0 CONSULTATION PROCESS

This policy has been revised in collaboration with the Trust's Health & Safety Managers, Joint Health & Safety Committee, Co-Directors and Senior Managers throughout the Trust.

Consultation with staff and their trade union representatives during development and introduction of a policy is a legal requirement and it will also help to enhance employee relations, ref: Health & Safety (Consultation with Staff) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

9.0 APPENDICES / ATTACHMENTS

Appendix I – Trust Health & Safety Committee - Terms of Reference
Also refer to:

1. Assurance Committee Sub Committee Structure for organisational arrangements relating to Health & Safety – this is available from the Hub.
2. The Guidance on General Health & Safety Risk Assessment Process.

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).

Cathy Jack

Name: Dr Cathy Jack
Title: Medical Director

Date: 20 April 2016

Name: Dr Michael McBride
Title: Chief Executive

Date: 20 April 2016

Appendix 1

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	Joint Trust Health and Safety Committee
PURPOSE	As a sub-Committee of the Assurance Framework the purpose of the Joint Trust Health and Safety Committee is to promote co-operation and consultation between the Trust and staff to investigate, develop and carry out measures to ensure the health, safety and welfare of all staff, clients, patients and visitors and provide evidence to the Governance Steering Group that any risks identified are managed. In recognition of the responsibility of the Belfast Health & Social Care Trust for the health, safety and welfare of its employees, patients and visitors and to restate its responsibilities under the Health and Safety at Work Order (Northern Ireland) 1978, Safety Representatives and Safety Committee (NI) Regulations 1979, Health & Safety (Consultation with Employees) Regulations (Northern Ireland) 1996 the Trust management and the Trade Union side agree to set out arrangements relating to the conduct of the management of health and safety within the Belfast Health & Social Care Trust.
MEMBERSHIP	**Chair** Medical Director/ Chair (Staff Side)) **Membership** The Joint Trust Health and Safety Committee shall consist of representatives as follows: Up to ten management representatives, including the Medical Director, or her nominated deputy. Up to ten Trade Union side health and safety representatives to be nominated by the trade unions / professional staff organisations accredited by the Trust. Management and Trade Union side will each appoint a Committee Secretary The Medical Director, or her nominated deputy, will normally chair meetings. The Chair of Trade Union Side will otherwise chair meetings. The Committee may decide to request individuals with specialist or expert knowledge to attend meetings. In these instances the individuals would be co-opted for the specific meetings at which the subjects on which they have expertise are to be discussed.

	Membership shall be regarded as part of the member's normal work and no member shall suffer any pecuniary loss or detriment because of their membership. **In attendance** Any Director, Senior Professional, Senior Manager, or Health & Safety Manager of the Trust will, where appropriate, be invited to attend. **Secretary** The Committee will be supported by the Health & Safety Department. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair. **Member Appointments** The membership of the Committee shall be determined by the Governance Steering Group based on the recommendations of the Chair, taking into account the skills and expertise necessary to deliver the Joint Trust Health & Safety Committee's remit.
DUTIES	The Committee will in respect of its provision monitor the process for managing Health and Safety and will: • Promote and encourage a multi-disciplinary health and safety culture within the Trust, which will secure implementation of policies and programmes for effective health and safety management; • To monitor Directorates implementation of the Trust's health and safety management system; • To monitor Directorates compliance with key Performance Indicators (KPIs), and increased compliance with BRAAT standard scores in Phase 2 in comparison to Phase 1.again we do not currently do this and not sure that this is our remit, it's for managers of each area to do. • To participate in the development, consultation, monitoring and review of Trust Health & Safety policies • Assist with the identification of health and safety training needs of staff in the Trust and they are met. • Assistance in the development of works safety rules and safe systems of work; • To study incidents and RIDDOR reportable including trends and patterns, so that reports can be made to management on areas of concerns requiring action and inclusion on risk registers • Assistance in the production of the Trust annual health and safety report; • To receive progress reports on actions required as a

	result of visits, & inspections, incident investigations and enforcement action from relevant enforcing authorities and other external agencies consideration of reports which safety representatives may wish to submit; • Endorsement of the Trust's compliance with the requirements of the Health and Safety Controls Assurance standard; • Receiving quarterly Health & Safety Reports from Directorates, Occupational Health Service and Health and Safety and making recommendation as appropriate; • Contribute to the quarterly and annual reporting arrangements to the Assurance Committee. • To discuss the impact of new health & safety legislation and guidance on the delivery of Trust Services • To support and promote the Health and Wellbeing at Work Group initiatives to prevent and manage work related stress and Health Fairs to participate in the European week of Health & Safety • To receive reports on the implementation of the Belfast Risk Audit and Assessment Tool Phase 2 and to encourage completion and compliance with the relevant audit standards • To participate in the consultation on the draft Trust's Annual Health & Safety Report
AUTHORITY	The Joint Trust Health and Safety Committee is authorised by the Governance Steering Group to review any activity within its terms of reference. In doing so, the Committee shall have the right to inspect records or documents of the Trust relevant to the Joint Trust Health and Safety Committee's remit, ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any: • Employee (and all employees are directed to co-operate with any reasonable request made by the Committee); • Other Committee, sub Committees or group established within the Assurance Framework to assist in the delivery of its functions.
MEETINGS	**Quorum** The quorum for the meeting will be the Chair (or deputy) plus no fewer than 6 members and must include both management and staff-side representatives with at least two non-corporate Directorate representatives. **Frequency of Meetings** Meetings of the Joint Trust Health and Safety Committee shall be held as often as required, but at least quarterly. This will not preclude the convening of a meeting at any other time for a special purpose.

Management's secretary will be responsible for arranging venues and agreeing dates.

Items not included on the agenda may be raised under any other business only by agreement with the Chair at the meeting.

Responses to actions assigned to individual members in the previous minutes should be received prior to the meeting if the member is unable to attend the meeting in person;

Non-attendances/apologies at three consecutive meetings will result in a new nomination being sought from Director or Trade Union/Professional Body.

Papers
Draft minutes of the meetings will be prepared by the management's secretary and agreed with the Chair

Agenda and papers will be disseminated to Committee members at a minimum of seven working days before the date of the meeting and, wherever possible, electronically.

The agenda will include:
- Members present;
- Apologies for absence;
- Minutes of the previous meeting;
- Matters arising from the previous minutes;
- RIDDOR reportable incidents reported to the Health & Safety Enforcing Authorities in the last quarter/s or year;
- Trade Union-side business;
- Chair's business;
- Potential impact of new legislation, codes of practice, etc;
- Training, education and communication regarding health and safety;
- Compliance with BRAAT and KPIs;
- Presentation of a Directorate Health & Safety Report, Occupational Health Service and Health and Safety Managers Reports.
- Any other relevant business;
- Date and time of next meeting.

The Agenda may also include:
- Matters raised by HSENI and other inspecting authority;
- Matters raised by internal audits and inspections;

Withdrawal of individuals in attendance
The Chair of the Committee may ask any or all of those who may attend but who are not members to withdraw to facilitate open and frank discussion of a particular matter.

REPORTING	The Joint Trust Health & Safety Committee is directly accountable to the Governance Steering Group for its performance in exercising the functions set out in these Terms of Reference. The Joint Trust Health & Safety Committee, through its Chair and members, shall work closely with the Assurance Framework's other Steering Groups and Committees, to provide advice and assurance to the Assurance Group through the: • Joint planning and co-ordination of Assurance Framework business; • Sharing of information. In doing so, the Joint Trust Health & Safety Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Trust's overall risk and assurance framework. The Joint Trust Health & Safety Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business. The Joint Trust Health & Safety Committee Chair shall: • Report formally, regularly and on a timely basis to the Governance Steering Group on its activities. This includes verbal updates on activity, the submission of minutes and written reports; • Bring to the Governance Steering Group's specific attention any significant matter under consideration of the Committee; • Ensure appropriate escalation arrangements are in place to alert the Executive Team or Chairs of other relevant Committees or Steering Groups of any urgent/critical matters that may compromise patient/service user care and affect the operation and/or reputation of the Trust. The Senior Manager for Corporate Governance on behalf of the Chair of the Assurance Group shall oversee a process of regular self-submission of quarterly written reports, including that of any sub-Committees established.
CONFLICT/ DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting of the Joint Trust Health & Safety Committee.
REVIEW	These Terms of Reference and operating arrangements will be reviewed on at least an annual basis by the Joint Trust Health & Safety Committee.

January 2016

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 50/08

Title:	**General Health and Safety Policy**			
Author(s)	Philip Boyle, Lead Health and Safety Manager Tel: [redacted]			
Ownership:	Dr Cathy Jack, Medical Director			
Approval by:	Trust Policy Committee Executive Team Meeting		**Approval date:**	6 December 2018 6 December 2018
Operational Date:	1 November 2018		**Next Review:**	31 October 2023
Version No.	5	**Supercedes**	V4 - 1 November 2015 - 31 October 2018	
Key words:	Health, Safety, Responsibilities			
Links to other policies	All other Trust Health and Safety Policies as listed in the Risk and Governance section of the HUB. Also see relevant Trust OHS & HR Policies.			

Date	Version	Author	Comments
03/09/2012	Draft 3.1	Karen Cunningham	3 yearly review of Belfast Trust General Health and Safety Policy
09/10/2012	Draft 3.2	Karen Cunningham	Incorporating comments from Health & Safety Team
07/11/2012	Draft 3.3	Karen Cunningham	Incorporating comments from Trust Wide consultation
11/08/2015	Draft 4	Karen Cunningham	3 yearly review of Version 3.
05/01/2016	Draft 5	Karen Cunningham	Health and Safety Team comments.
04/02/2016	Draft 6	Karen Cunningham	Add further changes arising from Trust Wide consultation including the Joint Health and Safety Committee
27/07/2018	5.1	Philip Boyle	The policy has been updated to include a number of appendices: Appendix 1 The Guidance on General Health & Safety Risk Assessment Process Appendix 2 Health & Safety Induction checklist Appendix 3 Health & Safety Competencies for Individual Trust Managers – Self Assessment Appendix 4 What to do if a member of staff identifies a health & safety concern Appendix 5 Flowchart for Processing HSENI Requests for RIDDOR Information

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This policy provides the Belfast Health and Social Care Trust with a clear sense of direction for the organisation identifying objectives, responsibilities including the need to achieve continual improvement in its health and safety performance and providing a structure for its health and safety management system.

1.2 Purpose

This policy and procedural arrangement is designed to provide managers and staff with clear guidelines on their general health and safety responsibilities. The Belfast Health and Social Care Trust in complying with the requirements of the Health and Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS guidance has produced this General Health and Safety Policy for the information and guidance of all staff.

1.3 Objectives

- To ensure, so far as is reasonably practicable, the health safety and welfare of all its staff, service users, contractors, visitors, placements, students, volunteers and members of the public, and promote a positive health and safety culture throughout the Trust.
- To advise, inform and instruct in a straightforward way the basic principles in health and safety management.
- To ensure that managers undertake and review the relevant risk assessments relating to the delivery of their services, to identify and implement relevant controls and associated Approved Codes of Practice.
- To ensure that the relevant human and financial resources are identified and prioritised as part of the risk assessment process.
- To implement the Trust's Statutory/Mandatory Training Matrix in relation to Health and Safety Training and to identify training specific to the work activity as part of the risk assessment process.
- To ensure that the Trust complies with the relevant health and safety legislation and guidance.
- To monitor the adequacy of safety and health communication and awareness in the workplace through the analysis of trends in incidents, investigation of incidents, during audits, inspections and observation of working practices, staff awareness of risk assessments associated with their work activities and their compliance with Trust and Directorate Policies and Procedures.
- To ensure that Directorates disseminate and communicate health and safety information as part of their assurance arrangements. Corporate health and safety policies, procedures and risk assessment documentation, is available via the Trust's HUB**.**
- To ensure staff, trade union side and professional body health and safety representatives are consulted on health and safety matters.
- To ensure that the management of Health and Safety is monitored through the organisations performance management and assurance frameworks.
- To include specific reference to health and safety issues in local induction programmes.

2.0 SCOPE OF THE POLICY

This is a corporate policy to advise, inform and instruct Directors, Managers, Staff and contracted services who work within the Belfast Trust, of their duties, to ensure the health, safety and welfare of all staff, service users, contractors, visitors, students, volunteers and members of the public.

3.0 ROLES/RESPONSIBILITIES

The ultimate responsibility for ensuring the health, safety and welfare of our staff and others who may be affected by the Trust's work activities rests with the Chief Executive.

The Medical Director (as Lead Director for Health and Safety) is responsible for co-ordinating compliance with the requirements in this Policy in conjunction with the Director of Human Resources.

The responsibility cascades down through the line management structure to Co-Directors, Senior Managers and Ward, Department and Facility Managers and to all staff who should familiarise themselves with this Policy and the impact of such on their work activities.

A. The responsibilities of the Board of Directors are as follows:

The Trust Board Directors together with the Chief Executive have the ultimate responsibility to ensure compliance, in the Trust's undertakings, with the statutory obligations described in health and safety legislation. The Board will:

1. Issue a policy statement under the Chief Executive officer's signature, detailing the Trust's policy and organisational arrangements for the effective management of health and safety.
2. Monitor and review the organisation's performance in health and safety management through the Assurance Committee, in particular the way in which the Trust's activities are managed and organised, taking cognisance of the requirements of the Corporate Manslaughter Act 2007.

B. The responsibilities of the Executive Team are as follows:

The Executive Team will be responsible for the implementation of the health and safety policy. It will:

1. Ensure that the organisational arrangements contained within the health and safety policy and its associated procedures are implemented.
2. Monitor and review the overall health and safety performance and receive an annual health and safety report.
3. Consider health and safety issues affecting the organisation's undertakings, as they arise.
4. Ensure health and safety management is integrated within the Trust's performance management and assurance framework.
5. Promote positive health and safety culture through all activities of the Trust.
6. Ensure that the Directorate's Trusts undertakings are carried out in compliance with health and safety legislation, the health and safety policy and other relevant guidelines.

C. The responsibilities of the Chief Executive are as follows:

The Chief Executive is the Accountable Officer. The Chief Executive is responsible to the Trust Board for the effective management of health and safety and for achieving the aims of the health and safety policy.
The Chief Executive will:

1. Report at regular intervals to the Board of Directors on health and safety performance.
2. Set targets for health and safety performance, assisted by the Joint Health and Safety Committee.

The Chief Executive has delegated these executive functions to the Medical Director.

D. The responsibilities of the Medical Director are as follows:

The Medical Director has responsibility for co-ordinating and monitoring health and safety activity throughout all the Belfast Health and Social Care Trust undertakings. The Medical Director will report to the Executive Team and Joint Health and Safety Committee in all matters relating to health and safety. The Medical Director will work directly with line management and safety representatives to encourage and facilitate the implementation of the Trusts health and safety policies.

The Medical Director is responsible for providing suitable organisational arrangements for the management of health and safety and ensuring that Directorates have access to competent advice and assistance from Specialist Advisors for the purposes of the Management of Health and Safety at Work Regulations (NI) 2000. (See Definitions for further details). The Medical Director will provide guidance to the Executive Team on health and safety legislation and issues, as they affect the organisation's undertakings.

E. The responsibilities of the Director of Finance are as follows:

The Director of Finance has responsibilities for the maintenance and management of work place plant and equipment. The Estates Co-Director has been delegated to attend the Joint Health and Safety Committee.
The Finance Director will:

1. Ensure compliance with statutory provisions and other authoritative guidance, as they affect workplace plant and equipment.
2. Be responsible to the Chief Executive for the management of fire safety within the Belfast Trust.

F. The responsibilities of the Director of Human Resources are as follows:

The Director of Human Resources will:

1. Ensure that all new staff (including permanent, temporary, placement and volunteers) has a health assessment to determine their suitability for employment.
2. Ensure that all new staff attends the Corporate Welcome that includes an explanation of the Trust's arrangements for managing health and safety.

G. The responsibilities of the Directors are as follows:

The Directors are responsible to the Chief Executive for implementation of the Trust Health and Safety Policies within their Directorate. They are responsible for making such health and safety arrangements as are appropriate, having regard to the nature of the Directorate activities, for the effective planning, organisation, control monitoring, review of preventative and protective measures. Directorates will each establish suitable arrangements for the management of health and safety risks associated with their Services. Any concerns of corporate interest should be reported through their Directorate representative on the Joint Health and Safety Committee and reported in their quarterly Health and Safety reports to this Committee.

H. The Senior Manager for Corporate Risk and Standards will:

1. Promote a positive health and safety culture and compliance with statutory obligations.
2. Agree corporate objectives for health and safety performance.
3. Develop and maintain systems to monitor health and safety performance within the organisation.
4. Support the Joint Health and Safety Committee and provide quarterly reports to the Trust's Assurance Committee.
5. Establish and Chair relevant Groups to promote a reduction in incidents.
6. Promote compliance with statutory/mandatory health and safety training and ensure adequate records of such are retained.
7. Set corporate objectives for health and safety management.
8. Agree key performance indicators.
9. Develop and maintain systems to monitor health and safety performance within the organisation.
10. To provide reports to the Committees within the Committee Structure on any matters of concern with regard to health and safety.

I. The Lead Health and Safety Manager will:

1. Promote a positive health and safety culture and compliance with statutory obligations.
2. To develop and present the Annual Health and Safety Report to the Medical Director and Joint Health and Safety Committee.
3. To manage the arrangements for the Joint Health and Safety Committee Meetings, which forms part of the Trusts Assurance Sub-Committee Structure.
4. To provide RIDDOR and Health and Safety Reports to Joint Health and Safety Committee.
5. To report to the Joint Health and Safety Committee on any matters of concern with regards to Health and Safety.
6. To promote the completion and implementation of the Belfast Risk Audit and Assessment tool (BRAAT) and to keep it under review.
7. To provide the relevant health and safety reports to the Assurance Committees.
8. To lead on the completion of the Department of Health assurance process.
9. To ensure arrangements are in place to assist managers in hazard identification, undertake risk assessments and establish and review control measures.

10. To ensure that Managers have access to competent advice and information on health and safety matters.
11. To liaise with the Occupational Health Service and other Specialist Advisors on relevant health and safety issues.
12. To develop an Annual Health and Safety Work Plan.
13. To ensure compliance with the requirements of the RIDDOR Regulations and that relevant investigations are completed.
14. To ensure the level of compliance for health and safety is measured and monitored through the completion of the Health and Safety Controls Assurance Process and the Belfast Risk, Audit and Assessment Tool (BRAAT) and other Key Performance Indicators.
15. To ensure arrangements are in place in relation to Health and Safety training (as per Statutory/Mandatory Training).
16. To liaise with external Statutory Bodies (HSENI, Local Councils), as required.
17. Ensure adequate arrangements to meet their health and safety training needs.

J. The Senior Manager Corporate Governance will promote procedures for the reporting, recording and analysis of adverse incidents, will make arrangements for the management of serious incidents and maintain accurate records of risks affecting the delivery of the Trust's objectives.

K. The Trust's Health and **Safety Team will** in addition to the professional and technical work inherent in their posts:

1. Provide specialist advice to all levels of management on those health and safety issues in which they have expertise and to maintain adequate records of such.
2. In conjunction with the Joint Health and Safety Committee develop and maintain policies and procedures on health and safety issues for which they have responsibility.
3. To assist in the implementation of the Annual Health and Safety Management Plan.
4. To assist in the development of the Annual Health and Safety Report.
5. To promote and advise on the completion of BRAAT and actions arising from such.
6. Contribute to training and education programmes relating to their area of expertise.
7. Collate the required evidence for the Department of Health Assurance process.
8. Maintain adequate records on RIDDOR Reportable Incidents occurring within the organisation.
9. To liaise with external Statutory Bodies (HSENI, Local Councils) as required.

L. The responsibilities of the Trust's Specialist Advisors

To provide advice, guidance and monitor and report on aspects of health and safety performance as they relate to their area of expertise and responsibility. Specialist Advisors may include:

- Radiation Protection Advisers
- Fire Officers
- Genetic Modification Safety Officer
- Infection Prevention & Control Advisers
- Occupational Health Professionals
- Decontamination Managers
- Ergonomics Managers/ Advisors

- Dangerous Goods Safety Advisors

M. The responsibilities of Directorate Managers / Heads of Department / Line Managers are as follows:

1. To ensure that they are familiar with the Trusts health and safety policies and the responsibilities laid out therein for the management of health and safety.
2. To ensure that a suitable and sufficient assessment is completed, reviewed and records maintained of the risk to the health and safety of employees and agency, locum, contractors, students, visitors, members of the public and other persons not in their employment arising out of, or in connection with, the activities within their Services. Risk assessments should be undertaken by competent departmental managers or appointed assessors and communicated to staff. The risk assessment process should be co-ordinated within Service Areas.
3. To ensure that the requirements of the Disability Discrimination Act (reasonable adjustment for example) are considered where relevant in risk assessments.
4. To ensure that measures are taken to avoid or control risks and that human and financial resources are identified and prioritised through the risk assessment process. Where this is beyond the competence, authority or resources of the manager, he/she must advise his/her senior manager.
5. To ensure that all staff know and accept their responsibilities under the Trust health and safety policies.
6. To operate within all legal and other requirements applicable to the work within their area of responsibility.
7. To ensure that reasonable measures are taken to prevent or control identified risk to health.
8. To ensure that systems of work are safe and without risk to health are agreed and implemented in conjunction with the relevant members of staff and staff practices regularly observed.
9. To ensure employees are properly trained and competent to perform their work safely and without risk to health. This includes attendance at statutory/mandatory training, training identified as a result of a risk assessment, local induction and communication and dissemination of health and safety information from newsletters, safety meetings, inspections/audits and the Trusts HUB.
10. To inform the Occupational Health Service of the relevant staff required to attend health surveillance programmes, for the protection of the member of staff for the duration of their employment with the Trust. The need for health surveillance should be identified by managers through the completion of local risk assessment.
11. To refer staff to the Occupational Health Service where a concern exists about their health, safety, or in relation to a work-related injury/disease.
12. To ensure that personal protective equipment, where required, is appropriate, readily available and properly maintained.
13. To ensure staff that are required to use personal protective equipment are appropriately trained in its use, maintenance and where appropriate fit tested for respiratory protective equipment use.
14. To ensure that all work place equipment is properly maintained, fit for purpose, serviced and appropriate records of such retained and staff trained in its use.
15. To demonstrate substantive compliance with the relevant Trust Health and Safety Policies, statutory and mandatory requirements by implementing the

relevant standards within the Belfast Risk Audit & Assessment Tool (BRAAT) in accordance with the guidance on completion.

16. To develop Service Area policies/procedures and safe systems of work where these are required, in relation to particular work activities.
17. To ensure that the Trust's procedures for the reporting of adverse incidents are adhered to, that all such events are investigated and that appropriate preventative action is taken.
18. To check and ensure that all plant, tools and equipment are available and safe to use and that safe and easy access to all places of work are maintained.
19. To ensure that all new and current staff has access to a copy of the health and safety policy.
20. To provide support or alternative formats in terms of communication support or linguistic needs, if required, to communicate the policy.

N. The responsibilities of all Staff are as follows:

All staff including managers are held accountable in law, not to commit acts in breach of Health and Safety Legislation. Staff have a duty under the Health and Safety at Work Order (NI) 1978 to take reasonable care of their own health and safety and that of others who may be affected by their acts or omissions. It is each employee's duty to co-operate with management to enable the employer to comply with statutory duties for health and safety.

All staff must:

1. Use any machinery, equipment, dangerous substances, and transport and safety device provided by the Trust in accordance with their training and safety instructions.
2. Conform to rules and procedures regarding health and safe working practices.
3. Report to management unsafe plant, tools, equipment, practices and methods of work and any other hazards.
4. Use correct method of work and not improvise by using methods, tools of equipment which entail unnecessary risk.
5. Co-operate in the work of any committees and in any inspections of the work place.
6. Report and assist in the investigation of incidents.
7. Ensure that any ill health or medical condition which may affect their ability to work safely to reported to their manager or the Occupational Health Service.
8. Participate in health surveillance programmes and exposure monitoring (refer to the Health Surveillance and COSHH Policies for further details), identified as part of the risk assessment process.
9. Wear and use the necessary personal protective equipment specified by the relevant risk assessments.
10. If required, to use Respiratory Protective Equipment of the required standard, to comply with the Trust's Fit Testing Policy.
11. Contribute to the completion of the Belfast Risk Audit & Assessment Tool (BRAAT).

O. The responsibilities of Other Persons on Trust Premises are as follows:

Any employees of organisations other than the Belfast Health and Social Care Trust who operate on Trust premises will be expected to abide by the Trust's Health and Safety Policy. They must therefore be informed in writing, by the Senior Manager who has permitted their access to the site, of the relevant Trust health and safety standards and the health and safety risks to which they may be exposed by the Trust's activities. Furthermore they must inform the Trust of any risks to the Trust, its service users, its staff and members of the public which may occur due to the operation of such contractors on site and comply with the relevant permit to work arrangements and method statements.

Any staff i.e. agency, students, not directly employed by the Trust, but working on Trust premises, are subject to the health and safety requirements established for Trust staff. Trust staff with responsibilities for overseeing such staff must ensure that they are familiarised with the Trust health and safety policies, procedures, committees and groups with health and safety responsibilities.

P. The responsibilities of Trade Unions, Professional Bodies and Employee Health & Safety Representatives are as follows:

The role of the Health & Safety representatives nominated by their Trade Union or Professional Body is laid down within the Safety Representative & Safety Committee Regulations (NI) 1979, Health & Safety (Consultation with Employees) Regulations (Northern Ireland) 1996 and also by the Joint Health & Safety Committee's Terms of Reference (Appendix 1).

Q. The responsibilities of the Trust Joint Health and Safety Committee are as follows:

The Joint Health and Safety Committee are constituted and works according to the requirements lay down by the Health and Safety at Work Order (NI) 1978 and the Safety Representative and Safety Committee Regulations (NI) 1979 which facilitates consultation on all health and safety matters. Its terms of reference and membership are outlined in Appendix 2.

1. To advise on the development and review of health and safety policies and procedures.
2. To ensure that management are aware of their health and safety responsibilities as contained in legislation and authoritative guidance.
3. To advise on priorities for the prevention or control of health and safety risks.
4. To promote and maintain a health & safety culture.
5. To promote and maintain consultation with Trade union and Employee Representatives and employees.

R. The responsibilities of the Trust Assurance Group are as follows:

The Assurance Group is responsible for co-ordinating the activities of the various expert groups reporting through the Assurance Group the following have an identified health and safety remit:

- Joint Trust Health & Safety Committee
- Infection Prevention and Control Committee
- Radiation Protection Committee
- Governance Steering Group
- Medicines Management Group
- Safety & Quality Steering Group
- Safety Assurance Team (SAT)
- SAI Group
- Medical Gases Committee

Other relevant Committees include Policy Committee, Standards and Guidelines Committee and Patient Falls Forum.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

The Belfast Health & Social Care Trust in complying with the requirements of the Health and Safety at Work (NI) Order 1978, the Management of Health and Safety at Work Regulations (NI) 2000, other relevant legislation, codes of practice and DHSSPS(NI) guidance has produced this General Health and Safety Policy for the information and guidance of all staff.

4.2 Policy Principles

- This policy describes how the health, safety and welfare issues should be identified, assessed and managed within the Belfast Trust.

- It is recognised that the people employed by the Trust are its most important asset and that this is reflected in a commitment to ensuring their health, safety and welfare.

- The Trust Board and Trust Directors have overall responsibility for workplace health and safety. The Executive Team and Directorate management are responsible for ensuring the undertakings outlined in this policy are adhered to throughout the Belfast Health and Social Care Trust.

- Health and safety is an integral part of management responsibilities, inseparable from all Trust Corporate Objectives. It is an essential component in the provision of high quality health care.

- The Management of Health and Safety at Work Regulations (NI) 2000 requires suitable and sufficient assessments of the risk to the health and safety of employees and others arising from the activities of the Trust. This responsibility falls to individual Directorates, Department Managers and Line Managers. Sample risk assessments are available on the Hub, for reference.

- Risk assessments should form the basis of health and safety management within each department/ward or facility. A regularly reviewed and dated record of each assessment must be maintained within each Directorate. The risk assessments will provide a basis for line managers to make health and safety arrangements for the planning, organisation, control, monitoring and review of preventative and protective measures.

- Risk Assessment should contribute to the population of the Directorate Risk Registers. Further details on Risk Registers can be obtained from the Trust's Risk Management Strategy.

- The risk assessment must include details of avoidance or control measures required, safe systems of work, training/communication needs and where appropriate, health surveillance.

- The details of risk assessments must be communicated to staff to assist in ensuring they are competent to carry out their duties safely. Staff and trade union side representatives should have access to completed risk assessments, RIDDOR reports and reports from the Health and Safety Executive for NI.

- All risk assessments must be reviewed at least every 2 years or upon significant change.

- The Trust will link with Health and Safety Inspectors from HSENI during the reporting and investigation of RIDDOR reportable incidents, during routine inspections and when it is necessary to request advice and assistance. The Trust will also link with Health and Safety Inspectors on health and safety matters raised at local seminars, conferences and best practice meetings.

- The organisational arrangements described in this document place health and safety at the centre of the Belfast Health and Social Care Trust arrangements for wider health and social care governance. Health and safety is incorporated within the Belfast Health and Social Care Trust wider governance strategy at both corporate and Directorate levels.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy is required to be implemented by all Directorates. All managers and staff are required to comply with this Policy, in particular those individuals and Departments with specific responsibilities, as detailed in Section 3.
If support or alternative formats are required in terms of communication in relation to the policy, this will be provided.

5.2 Resources

Responsibility for training and risk assessments associated with this policy are detailed in Section 3 – Roles and Responsibilities.

5.3 Exceptions

There are no exceptions.

6.0 MONITORING

It is the responsibility of line managers to monitor the completion and review of relevant risk assessments, staff training, incidents reporting and investigation and the completion of audit tools. Other specific monitoring responsibilities are detailed in Section 3. The Trust's Health and Safety Management System will be monitored through BRAAT score returns, validation visits, compliance with the Department of Health Assurance processes, and by Internal/External Audit.

7.0 EVIDENCE BASE / REFERENCES

Health and Safety at Work (NI) Order 1978, as amended, set our duties on the Trust to ensure the Health, Safety and Welfare of their staff whilst they are at work.

Safety Representatives and Safety Committee (NI) Regulations 1979.

Health and Safety (Consultation with Employees) Regulations (NI) 1996.

Management of Health and Safety at Work (NI) Regulations 2000, requires the Trust to undertake suitable and sufficient risk assessments of the risks to staff and others associated with the work activity.

Corporate Manslaughter 2007 relates to the organisation being found guilty of Corporate Manslaughter as a result of serious management failures resulting in gross breach of a duty of care

Relevant Belfast Trust policies relating to:

- Lone Working
- Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace
- Prevention and Management of Alcohol and Drugs in the Workplace
- Manual Handling
- Display Screen Equipment
- Control of Substances Hazardous to Health
- New and Expectant Mothers
- Driving for Work
- Management of Stress, Health and Well Being
- Noise
- Vibration
- Work at Height
- Safety Spectacles
- Sharps Injuries and Blood and body Fluid Exposures
- First Aid at Work
- Prevention and Management of Latex Sensitisation
- Radiation Protection Policy
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)
- Prevention and Management of Slips, Trips and Falls
- Respiratory Health Surveillance

- Fit Testing

and other relevant Belfast Trust policies.

All policies are accessible from the Trust's HUB.

8.0 CONSULTATION PROCESS

This policy has been revised in collaboration with the Trust's Health and Safety Managers, Joint Health and Safety Committee, Co-Directors and Senior Managers throughout the Trust.

Consultation with staff and their trade union representatives during development and introduction of a policy is a legal requirement and it will also help to enhance employee relations, ref: Health and Safety (Consultation with Staff) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

9.0 APPENDICES / ATTACHMENTS

**** All appendices below are available to download as separate documents from the Health & Safety section on the Hub**.**

Appendix 1- The Guidance on General Health and Safety Risk Assessment Process
Appendix 2 - Health and Safety Induction Checklist
Appendix 3 - Health and Safety Competencies for Individual Trust Managers – Self Assessment
Appendix 4- What to do if a member of staff identifies a health and safety concern
Appendix 5 - Flowchart for Processing HSENI Requests for RIDDOR Information

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. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

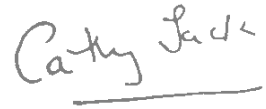
From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.

It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES



Name: Dr Cathy Jack
Title: Medical Director

Date: 12 December 2019

Name: Martin Dillon
Title: Chief Executive

Date: 12 December 2019

Ray Rafferty

Name Ray Rafferty
Title Chair- Trade Union JTHSC

Date: 6 February 2019

Name: Mr Philip Boyle
Title: Lead Health and Safety Manager

Date: 6 February 2019

Appendix 1- The Guidance on General Health & Safety Risk Assessment Process

Belfast Health & Social Care Trust

Guidance on the

General Health & Safety

Risk Assessment Process

1.0 INTRODUCTION

The Management of Health & Safety at Work Regulations (N.I.) 2000 (Regulation 3) require you to examine what in your workplace could cause harm to people so that you can weigh up and decide whether you have implemented the relevant controls to:

- Comply with legislation (in regulations, for example, as many of these are absolute – a must do).
- Reduce the risks as far as is reasonably practicable, taking into account the available HSE/HSENI guidance, principles of control and hierarchy of risk controls.

Potential hazards are associated with a wide range of activities within the Belfast Health & Social Care Trust. To protect service users, staff, visitors, members of the public, contractors, students and others, it is essential to identify and control these hazards by undertaking a risk assessment and documenting and implementing the required control measures.

DEFINITIONS

HAZARD: The potential or ability of something to cause harm, e.g. materials, equipment, methods of work and practices
(Harm means injury, ill health or damage to equipment, premises or the environment).

HAZARD	HARM
Failure of a patient hoist	Potential for physical injury
Inappropriately disposed of needle	Potential sharps injury and exposure to blood borne viruses
Working at Height	Potential for physical injury
Violent & aggressive service users	Physical or psychological injury
Stress	Potential for physical or psychological injury
Wet floor	Potential for physical injury
Electrical equipment	Potential for physical injury and electrical shock

RISK: The **likelihood that the potential for harm will occur** under the conditions of use and/or exposure **and the possible extent of the harm** i.e. severity (including the number of people who might be exposed).

RISK ASSESSMENT: is a systematic examination of the work activity and the work environment.
A risk assessment is carried out to identify the hazards and risks to health and safety to any person arising out of, or in connection with the work activity to be undertaken.

A process of identifying the hazards present and then evaluating the extent of the risk involved, taking into account whatever precautions are already being taken and implementing additional control measures to further reduce the risk occurring.

2.0 AIM

To prevent or control the exposure of staff, service users, members of the public, contractors, students and others to risk of harm as far as 'reasonably practicable'. Reasonably Practicable implies a balance of the degree of risk against the inconvenience and cost of overcoming it.

3.0 OBJECTIVES

The purpose of the risk assessment process is to prevent accidents by identifying hazards and reducing the risk of injury from those hazards to as low a level as is reasonably practicable. Risk Assessments should be carried out on all activities associated with the delivery of the Trust's Services.

4.0 KEY PRINCIPLES

Under Regulation 3 of The Management Regulations, the Risk Assessment must be 'suitable and sufficient'. It must:-

- Identify and evaluate all relevant hazards.
- Identify the significant risks arising out of or in connection with work.
- Take account of the views of staff and their safety representatives who will have practical knowledge to contribute.
- Check what really happens by observing the work activities and asking the people involved.
- Considers all relevant persons who could be affected including new and expectant mothers, young persons, persons with a disability.
- Take account of any existing control measures and their effectiveness
- Identify any inadequacies in the existing workplace precautions including those which are not properly implemented.

- Evaluate the risks and identify and prioritise the measures which need to be taken in order to comply with the legislation and guidance.
- Ensure the level of detail in a risk assessment should be proportionate to the risk.
- Identify who should take action and when.
- Take account of the way in which work is organised, and the effects this can have on health.
- Be based on informed judgement, reference to appropriate guidance and specialist advice.
- Relates to what actually happens in the workplace and covers all work activities.
- Remain valid and reviewed when relevant.

5.0 RESPONSIBILITIES AND DUTIES OF DIRECTORATE MANAGERS / HEADS OF DEPARTMENT / LINE MANAGERS

- To ensure that they are familiar with the Trusts health and safety policies and the responsibilities laid out therein for the management of health and safety.
- To ensure that a suitable and sufficient assessment is completed, reviewed and records maintained of the risk to the health and safety of employees and agency, locum, contractors, students, visitors, members of the public and other persons not in their employment arising out of, or in connection with, the activities within their Services. Risk assessments should be undertaken by competent departmental managers or appointed assessors and communicated to staff. The risk assessment process should be co-ordinated within Service Areas.
- To ensure that the requirements of the Disability Discrimination Act (reasonable adjustment for example) are considered where relevant in risk assessments.
- To ensure that measures are taken to avoid or control risks and that human and financial resources are identified and prioritised through the risk assessment process. Where this is beyond the competence, authority or resources of the manager, he/she must advise his/her senior manager.
- To ensure that all staff know and accept their responsibilities under the Trust health and safety policies.
- To operate within all legal and other requirements applicable to the work within their area of responsibility.
- To ensure that reasonable measures are taken to prevent or control identified risk to health.
- To ensure that systems of work are safe and without risk to health are agreed and implemented in conjunction with the relevant members of staff and staff practices regularly observed.
- To ensure employees are properly trained and competent to perform their work safely and without risk to health. This includes attendance at statutory/mandatory training, training identified as a result of a risk assessment,

local induction and communication and dissemination of health and safety information from newsletters, safety meetings, inspections/audits and the Trusts HUB.

- To inform the Occupational Health Service of the relevant staff required to attend health surveillance programmes, for the protection of the member of staff for the duration of their employment with the Trust. The need for health surveillance should be identified by managers through the completion of local risk assessment.
- To refer staff to the Occupational Health Service where a concern exists about their health, safety, or in relation to a work-related injury/disease.
- To ensure that personal protective equipment, where required, is appropriate, readily available and properly maintained.
- To ensure that staffs that are required to use personal protective equipment are appropriately trained in its use, maintenance and where appropriate fit tested for respiratory protective equipment use.
- To ensure that all work place equipment is properly maintained, fit for purpose, serviced and appropriate records of such retained and staff trained in its use.
- To demonstrate substantive compliance with the relevant Trust Health & Safety Policies, statutory and mandatory requirements by implementing the relevant standards within the Belfast Risk Audit & Assessment Tool (BRAAT) in accordance with the guidance on completion.
- To develop Service Area policies/procedures and safe systems of work where these are required, in relation to particular work activities.
- To ensure that the Trust's procedures for the reporting of adverse incidents are adhered to, that all such events are investigated and that appropriate preventative action is taken.
- To check and ensure that all plant, tools and equipment are available and safe to use and that safe and easy access to all places of work are maintained.
- To ensure that all new and current staff has access to a copy of the health and safety policy.
- To provide support or alternative formats in terms of communication support or linguistic needs, if required, to communicate the policy.

6.0 RESPONSIBILITIES AND DUTIES OF APPOINTED RISK ASSESSORS

Ensure that the tasks that are pertinent to their work area are identified, assessed and managed, so far as it is reasonably practicable to do so.

- Complete the risk assessments using the Belfast Health & Social Care Trust General Health & Safety Risk Assessment Form, review a risk assessment using the review form and ensure that all recommendations made following the assessment process are completed and reviewed with your line manager on a regular basis.
- To ensure that they attend General Risk Assessment training and refresher training as per statutory/mandatory training requirements.

7.0 RESPONSIBILITIES AND DUTIES OF THE EMPLOYEE

All staff must:

a. Use any machinery, equipment, dangerous substances, transport or safety device provided by his employer in accordance with their training and safety

instructions;
b. Conform to rules and procedures regarding healthy and safe working practices;
c. Report to management unsafe plant, tools, equipment, practices and methods of work and any other hazards;
d. Use the correct methods of work and not improvise by using methods, tools or equipment which entail unnecessary risk.
e. Co-operate in the work of any committees and in any inspections of the workplace;
f. Report and assist in the investigation of any adverse incidents that occur;
g. Wear and use the necessary personal protective equipment specified by the risk assessment.

8.0 DOCUMENTATION / TRAINING

Please download further copies of the blank general health and safety risk assessment form and the review sheet from the Health & Safety section of the Belfast Trust Hub site. Please see HRPTS if you wish to book further places on a General Health & Safety Risk Assessment Course (or other Risk Assessment Courses such as COSHH, Patient & Load Handling or Display Screen Equipment).

9.0 RISK ASSESSMENT PROCESS

Step 1: Provide a brief description of the activity, location or equipment.

Step 2: Divide your work into manageable categories and identify and document the hazards.

Assessors must consider all significant and foreseeable hazards that may be associated with the activity being carried out. It is essential that the assessor is familiar with the process or has taken advice from someone who is. Risk Assessors should seek help and assistance from other staff, Trade Union/ Professional body health and safety representatives or other 'competent persons' eg Health & Safety Managers, Ergonomic Advisors, Fire Officers and the Occupational Health Service.

Step 3: Person Affected by the Work Activity and How.

In this section list the people who would be affected if the potential harmful effects associated with the activity were realized and how.

This normally includes the person carrying out the activity, people in the vicinity including: Staff, Service Users, New & Expectant Mothers, Estates/Service Engineers, Portering & Domestic Staff, Children/Young Persons and Staff on Honorary Contracts, Volunteers/Work Placement/Students, General Public, Lone Workers, Temporary/Agency Staff, Staff with Disabilities, Visitors and Contractors. This list is not exhaustive.

Step 4: Existing Controls – record the controls already in place.

Some control measures are more effective than others. The following list shows the order of effectiveness of measures. It is often referred to as the 'hierarchy of control methods'.

1. Hazard elimination, for example, by changing a process.
2. Substitution, for example, substituting one substance or process for Another.
3. Controlling the risk at source eg. Use of engineering control such as local exhaust ventilation (LEV).
4. Procedural Control Measures eg. Safe system of work, permits to work and standard operating procedures to include emergency/ contingency arrangements.
5. Behaviour modification eg. encouraging staff to work in a safe manner eg. training & instruction, signage notices, safety briefings, leading by example, monitoring & supervision.
6. Good housekeeping, health surveillance, welfare arrangements.
7. Use of personal protective equipment (PPE), for example, goggles, gloves. This equipment should only be used when all other methods have been exhausted. *PPE should be used as a last resort and used in conjunction with other control measures.*

Step 5: Evaluate the risks arising from the hazard (using the risk rating matrix), taking into account the existing controls.

The risk rating is calculated using the Trust Risk Matrix Tables when assessing the risk existing control measures should be taken into account.

Risk= Likelihood/Severity

Likelihood- Make a judgement about the chance, likelihood of injury, or ill-health actually happening.

Severity- The most probable harm in the circumstance.

Step 6: Record the Sources of Information (e.g. Trust Policies etc) and Persons Consulted.

Step 7: Prepare a plan for controlling the risk including persons responsible for implementing actions, recommended timescales and dates completed. Review the risk rating.

Risk Assessors should refer to the hierarchy of controls detailed in Step 4 when preparing the action plan. It is good practice to set a review date shortly after the new measures are likely to be implemented. The "Person/s responsible for co-ordinating the recommended actions" should ensure that all controls are implemented.The risk rating should be reviewed following the completion of actions.

Step 8: Communicate the Risk Assessment.

Information on the hazards, risks, persons affected and control measures identified by the risk assessment should be communicated to staff and others as appropriate e.g. at induction training or team meetings/ briefings. A copy of the risk assessments must be available for all staff and others to access.

Step 9: Review of the risk assessment

Risk Assessment reviews should be documented on the **Record of Risk Assessment Reviews template.** The review sheet (once completed) should be attached to the Risk Assessment.

It is recommended that risk assessments are reviewed at least every 2 years or sooner, dependant on events such as the following:

- Other activities and hazards are identified
- Processes/work activities are altered or changed
- New methods of work are introduced
- An accident/incident or near miss occurs
- An Occupational Health concern
- New legislation/guidance/best practice

The risk assessment review will check that the existing controls are still in place and review their effectiveness.

Local Ref No:

Belfast Health and Social Care Trust

GENERAL HEALTH & SAFETY RISK ASSESSMENT INVENTORY

General Risk Assessor/s	
Location	
Ward/Facility/Department	

List all General Health and Safety Risk Assessments in the table below:

No	General Risk Assessment	Date of Original Assessment	Date of Review	Date of Review	Date of Review

When complete, keep this form on file alongside the General Health & Safety Risk Assessments.

Signed Risk Assessor		Date	
Signed Line Manager		Date	

Belfast Health and Social Care Trust

GENERAL RISK ASSESSMENT FORM AS REQUIRED BY THE MANAGEMENT OF HEALTH & SAFETY REGULATIONS (NI) 2000 as amended

Facility/Ward/Department…… Assessment Completed By……

Date…… (Names/Titles) ……

Brief Description of activity, location or equipment ……..

……

Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	Risk Rating

NOTE: There are also specific risk assessment forms for specific Health & Safety issues such as Substances Hazardous to Health (COSHH), Display Screen Equipment Self Assessment Form, Manual Handling Risk Assessment Form (which includes Patient & Load Handling) for particular clients or clinical issues.

Belfast Health and Social Care Trust

Action Plan

Sources of Information / Persons Consulted	Further Action if necessary to control the Risk	Person/s responsible for Co-Ordinating implementation of the Action.	Recommended Timescales	Date Completed	Revised Risk Rating

Please ensure that you:

1. Communicate this risk assessment with the staff and others affected by the work assessed. 2. Monitor the implementation of any further action identified.
3. Monitor the continued implementation of existing controls. 4. Revise the Risk Rating when additional actions have been implemented.
5. Retain this Risk Assessment in your Health & Safety Policy & Documentation folders. 6. When further action has been identified it is good practice to set a review
7. Review your risk assessment at least every 2 years or more frequently if required. In certain date shortly after measures are likely to be implemented. This will circumstances it will be necessary to undertake a new assessment eg. Following an enable you to assess their effectiveness in reducing risk. Accident/Incident, new legislation/guidance/best practice, changes in work activities/location, new hazards/activities identified.

KEY TO RISK RATING: Likelihood x Severity/Consequence = Risk Rating

Likelihood	Severity/Consequence	**Risk Rating**	
1 Rare	1 Insignificant	**Low Risk (Green)**	**(See Risk Management Strategy on Belfast Trust Intranet for Risk Rating Tables).**
2 Unlikely	2 Minor	**Medium Risk (Yellow)**	
3 Possible	3 Moderate	**High Risk (Amber)**	
4 Likely	4 Major	**Extreme Risk (Red)**	
5 Almost Certain	5 Catastrophic		

Line Manager Signature: _____ **Date:** _____

Initial Review Date: _____

Belfast Health and Social Care Trust

GENERAL HEALTH & SAFETY RISK ASSESSMENTS

Record of Risk Assessment Reviews

Ward/Department: _____ Completed by: _____

Brief Description of the Activity Assessed: _____ Local Reference No: _____

Date of Initial Assessment: _____

Date of Review	Completed By	Comments on any Changes or Observations on Compliance with the Required Controls	Outstanding Concerns	Is it Necessary to Undertake a New Risk Assessment?	Date Completed	Reviewed Risk Rating

Belfast Health and Social Care Trust

Date of Review	Completed By	Comments on any Changes or Observations on Compliance with the Required Controls	Outstanding Concerns	Is it Necessary to Undertake a New Risk Assessment?	Date Completed	Reviewed Risk Rating

Notes:
Please ensure that you:

1. **Use this review sheet for only one Risk Assessment (can therefore be used for several reviews).**
2. **Review your Risk Assessment at least 2 yearly * or more frequently if required, such as:**
   - **If other activities and hazards are identified**
   - **Processes/work activities are altered or changed**
   - **New methods of work are introduced**
   - **An accident/incident or near miss occurs**
   - **There is an Occupational Health concern**
   - **New legislation/guidance/best practice**
3. **When further controls have been identified it is good practice to set a review date shortly after the new measures are likely to be implemented. This will enable you to assess whether the new measures are effective in reducing risk to the required level and revise your risk rating.**
4. **Communicate any changes as a consequence of this review with staff & others affected by the work activity assessed.**
5. **Retain this review with the original Risk Assessment.**
6. **It is necessary to ensure the controls are implemented as outlined in the assessment; this is why the column for "Person/s responsible for co-ordinating implementation of action" is on the form.**

Staff have responsibility to adhere to procedures and safe systems, line management have overall responsibility for ensuring staff are adequately trained and control measures are being followed. * (Refer to Belfast Trust General Health & Safety Policy).

Belfast Health and Social Care Trust

Appendix 2

Table 1: Severity/Consequence Descriptors and Scores

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Medium-term harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term / permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2 – Likelihood Scores

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Belfast Health and Social Care Trust

Table 3 - BHSCT Risk Matrix

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Belfast Health and Social Care Trust

Table 4

Risk Colour	**Remedial Action**	**Decision to Accept Risk**	**Risk Register Level**
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	**Timescale for Action**	**Timescale for Review**
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Belfast Health and Social Care Trust

Table 6

➢ **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.**
➢ **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
➢ **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
➢ **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

GENERAL RISK ASSESSMENT FORM AS REQUIRED BY THE MANAGEMENT OF HEALTH & SAFETY REGULATIONS (NI) 2000 as amended

THIS IS A SAMPLE GENERAL RISK ASSESSMENT FOR REFERENCE ANDTRAINING & PURPOSES ONLY

Facility/Ward/Department: *Entrance Foyer leading to Main Outpatients/ X-Ray Departments*

Assessment Completed By: Jane Rollins, Outpatients Receptionist

(Names/Titles:) **David Byrne, Outpatients Manager**
Michael Ryan, PCSS Senior Manager
Clare Fields, Friends of Belfast Trust Shop Manager
Mr Mike Green, Stores Manager
Mrs Sheila Cooke, Imaging Services Manager

Date: 17/08/14

Brief Description of activity, location or equipment: Entrance foyer leading to the Outpatients/X-Ray Department

Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	Risk Rating
Hazard 1 Wet floor eg due to floor cleaning and spillages.	Staff, Students, Patients, Visitors and Members of the Public. Risk of slip and fall leading to injury/ trauma/ stress.	Caution wet floor signs placed out whilst PCSS staff conduct cleaning duties. The flooring includes an integrated entrance mat to reduce the amount of wet material carried onwards into the foyer/building. External canopy over main entrance. Area is well lit. Spillages are cleaned immediately within the area.	Likely (4)	**Moderate (3)**	MEDIUM **(12)** (Yellow)
Hazard 2 Stored items, eg. roll cages	Staff, Students, Patients, Visitors and Members of the Public. Risk of contact with stored items leading to injury/trauma/stress.	Area is well lit.	Likely (4)	**Moderate (3)**	MEDIUM **(12)** (Yellow)

NOTE: There are also specific risk assessment forms for specific Health & Safety issues such as Substances Hazardous to Health (COSHH), Display Screen Equipment Self Assessment Form, Manual Handling Risk Assessment Form (which includes Patient & Load Handling) for particular clients or clinical issues.

Action Plan

Sources of Information / Persons Consulted	Further Action if necessary to control the Risk	Person/s responsible for Co-Ordinating implementation of the Action.	Recommended Timescales	Date Completed	Revised Risk Rating
HAZARD 1 - Risk of a slip, trips or fall due to slip on a spillage or a wet floor					
Trust Prevention and Management of Slips, Trips and Falls Policy	**To assess the suitability of the flooring for the environment/activity**	**Mr John Hughes, Estates Manager (Projects)**	**August 14**	**02/09/14**	**UNLIKELY (2)/ MODERATE (3)=**
Belfast Risk Audit & Assessment Tool (BRAAT) Standard 6 (Slips, Trips & Falls)	**Liaise with Domestic Staff/ Supervisors regarding the cleaning regime and suitability of product for floor. Review time for floor cleaning to a quieter period.**	**Mrs Sheila Cooke, Imaging Services Manager, David Byrne, Outpatients Manager in conjunction with Michael Ryan, PCSS Senior Manager**	**August 14**	**24/08/14**	**MEDIUM (6) (YELLOW)**
Health & Safety Executive Guidance **eg www.hse.gov,uk/slips- slips & trips e-learning package, guidance on preventing slips & trips**	**Review PCSS risk assessment and introduce dry mopping or mechanise the process. Zone wet areas using cones and removal of cones when floor has dried.**	**Michael Ryan, PCSS Senior Manager**	**August 14**	**24/08/14**	
Monica Bell, Domestic Supervisor **regarding existing arrangements, products and equipment for flooring cleaning**	**Detail arrangements for reporting/** cleaning spillages **including signage and communicate to staff.**	**Clare Fields Shop Manager in conjunction with Michael Ryan, PCSS Senior Manager**	**August 14**	**17/08/14**	
John Hughes Estates Projects Officer regarding suitability of flooring for this environment.	**A Slips, Trips and Falls Environmental Checklist to be completed (Appendix 1 Trust Prevention and Management of Slips, Trips and Falls Policy)**	**Clare Fields, Shop Manager**	**August 14**	**18/09/14**	
Kevin Connor Stores Department regarding deliveries to area	Provision of lids for hot drinks **and trays to safely transport items. Provide tables for the consumption of drinks**	**Michael Ryan, PCSS Senior Manager in conjunction with Clare Fields Shop Manager**	**August 14**	**18/09/14**	

	Provision of waste bins within the area and arrangements for the disposal of liquids.	**Michael Ryan, PCSS Senior Manager**	**August 14**	**24/08/14**	
HAZARD 2 - Risk of a slip, trip or fall due to stored items eg Roll Cages					
	Review the arrangements of the collection of delivered goods by the various clinics and administration areas with the Department **Roll cages to be removed by Stores delivery staff immediately after deliveries**	**David Byrne, Outpatients Manager/Mr Mike Green, Stores Manager & Mrs Sheila Cooke, Imaging Services Manager** **David Byrne, Outpatients Manager/Mr Mike Green, Stores Manager& Mrs Sheila Cooke, Imaging Services Manager**	**August 14** **August 14**	**18/09/14** **24/08/14**	**UNLIKELY (2)/ MODERATE (3)=** **MEDIUM (6) (YELLOW)**

Please ensure that you:

1. Communicate this risk assessment with the staff and others affected by the work assessed. 2. Monitor the implementation of any further action identified.
3. Monitor the continued implementation of existing controls. 4. Revise the Risk Rating when additional actions have been implemented.
5. Retain this Risk Assessment in your Health & Safety Policy & Documentation folders. 6. When further action has been identified it is good practice to set a review
7. Review your risk assessment at least every 2 years or more frequently if required. In certain date shortly after measures are likely to be implemented. This will circumstances it will be necessary to undertake a new assessment eg. following an enable you to assess their effectiveness in reducing risk.
Accident/Incident, new legislation/guidance/best practice, changes in work activities/location,
new hazards/activities identified.

KEY TO RISK RATING: Likelihood x Severity/Consequence = Risk Rating

Likelihood		Severity/Consequence	Risk Rating		
1 Rare		1 Insignificant	Low Risk	(Green)	(See Risk Management Strategy On Belfast Trust Intranet for Risk Rating Tables)
2 Unlikely	2 Minor		Medium Risk	(Yellow)	
3 Possible		3 Moderate	High Risk	(Amber)	
4 Likely		4 Major	Extreme Risk (Red)		
5 Almost Certain		5 Catastrophic			

Line Manager Signature: David Byrne

Date: 18/09/2014

Initial Review Date: 18/09/2016

Appendix 2- Health & Safety Induction checklist

HEALTH AND SAFETY INDUCTION CHECKLIST
NEW STAFF, AGENCY / BANK WORKERS

1. Health and Safety Policy & Information	Yes	No	N/A	Further Information
• Staff's responsibilities as outlined within the General Health and Safety Policy -explain and direct to where a copy can be viewed. • Explain local health and safety procedures • A copy of the Trust's Health and Safety Induction Information Leaflet • Explain how to access Occupational Health Services and Staff Care Counselling • NOTE: Encourage member of staff to get involved in staff meetings				General Health & Safety Policy Ward Health & Safety Notice Boards / Staff Rooms within Wards OHS Leaflets **Note:** All Documentation listed in "Further Information" is available from the Trust Intranet.
2. Emergencies/Fire Arrangements and Smoking	**Yes**	**No**	**N/A**	**Further Information**
• Action to follow in the event of discovering a fire or hearing the alarm, escape routes, fire wardens and assembly/muster points. • Position of fire extinguishers/blankets and fire alarm call points. • Ward/Dept/Facility Evacuation Plan • Personal Emergency Evacuation Plan (PEEP), for staff with a disability • Trust's Policy on Smoking • Explain responsibilities under Belfast Trust Fire Safety Policy • Conduct walk/talk through/talk through of fire evacuation drill • NOTE: Encourage member of staff to report defective call points/extinguishers through misuse/neglect/vandalism – Trust Incident Reporting form				Trust Fire Policy Introduce to Fire Warden for Area Belfast Trust Smoke Free Policy
3. Risk Assessment and Training	**Yes**	**No**	**N/A**	**Further Information**
• Discuss the following issues with the new start, where these are appropriate to their work: • Highlight relevant risk assessments and safe systems of work specific to their job, i.e. lone working, slips, trips & falls, driving for work, ligatures etc, where these can be located and time to read through • General workplace health and safety (i.e. housekeeping, safe storage etc) • A copy of Zero Tolerance Personal Safety Update leaflet. Book for Management of Aggression training as appropriate. • Safe use of hazardous substances and the location of associated COSHH risk assessments and hazard data sheets and provide time to read through. • Safe moving and handling information and the use of mechanical handling devices and manual handling risk assessments and Care Pathways for Moving and Handling. Complete Manual Handling E-Learning programme. Apply for Patient/Client Handling training as appropriate. • If the work undertaken involves a significant amount of Display Screen Equipment (DSE) use, discuss the DSE Self Assessment form and entitlement to eyesight test. Complete DSE E-Learning programme.				Risk & Governance Safety Updates Personal Safety Update Leaflet HRPTS – General Health & Safety Risk Assessment Workshops Lone Worker Policy Zero Tolerance to Prevent and Manage Violence and Aggression Policy. Slips, Trips & Falls Policy Health & Safety Information/Induction Leaflet COSHH Policy / Relevant updates Relevant Risk Assessor(s) - introduce Manual Handling Policy Completed Manual Handling Risk Assessment Statutory and Mandatory Training Policy Display Screen Equipment Policy

• Standard Infection Control precautions including hand hygiene, waste, sharps, linen and isolation of patients. Book relevant mandatory Infection Prevention & Control training via TAS/HRPTS. • Safe use and maintenance of equipment, including pointing out the safety features. • Sign up to Discuss Safe Systems of Work where these can be found. • Process for reporting of faulty equipment. • If the person is a new or expectant mother, carry out specific risk assessment. • Awareness of the Trust Policy and local protocols on the Prevention & Management of Latex Sensitisation • The procedures in relation to the Alcohol and Drugs in the Workplace Policy and Driving for Work Policy				Statutory and Mandatory Training Policy Ergonomics /Advisors & DSE Facilitators (local) Infection Prevention and Control Policy Regional Infection Control Manual www.infectioncontrolmanual.co.ni Medical Devices Procedures & Guidelines Vibration Policy Noise Policy New and Expectant Mother Policy Latex Sensitisation Policy Alcohol & Drugs in the Workplace Policy Driving for Work Policy
4. Welfare facilities and First Aid	**Yes**	**No**	**N/A**	**Further Information**
• Names and locations for Emergency First Aiders – clarify if new start first aid trained • Location of the toilets, washing facilities, kitchen & rest areas, lockers, showers, drinking water etc. • Location for first aid boxes and how to contact first-aiders • Introduce to nominated First Aider(s) • No Smoking Policy requirements				Belfast Trust First Aid Policy Stress Policy / Here 4U and Trust's Health & Wellbeing Leaflets Management of Stress, Health & Wellbeing Policy Trusts Smoking Policy
5. Incident and Hazard Reporting	**Yes**	**No**	**N/A**	**Further Information**
When and how to report an incident and that it is everyone's responsibility to report incident and other concerns associated with their work activities immediately to their Line manager.				Adverse Incident Reporting & Management Policy Datix System – online
6. Personal Protective Equipment	**Yes**	**No**	**N/A**	**Further Information**
• Activities for which personal protective equipment or other safety equipment is required (and why it must be used). • Advise of any additional measures required from local risk assessments e.g. PPE to be used in the clinical setting i.e. Disposable gloves, aprons, masks, eye and other face protection. • Personal protective equipment (PPE) issue and explain its proper use, storage single use, disposal and maintenance • Procedure for reporting defective or damaged PPE and obtaining replacements.				MSDS – Material Safety Data Sheets COSHH Assessments Regional Infection Control Trust Policy available on the Intranet. Specific Risk Assessments - local
7. Health & Safety Training	**Yes**	**No**	**N/A**	**Further Information**
• Identify health and safety training needs (including frequency of attendance) and detail in the Personal Development Plan • Document below any additional H&S Information and supervision required e.g. asbestos, electricity, working at height, confined spaces, permit to work etc.				Statutory/Mandatory Training Matrix

Declaration - I certify that the above health and safety induction topics have been explained:

Induction conducted by: *(please include job title)* Date:

Signature – Member of Staff: Date:

Appendix 3- Health & Safety Competencies for Individual Trust Managers – Self Assessment

This self-assessment tool has been developed by the Trusts Health and Safety Team to enable you as a line manager to ensure that you have the keys skills in order to effectively manage health and safety in your area of responsibility. NOTE this document is based on two documents produced by NHS Employers; Health and Safety Competencies for NHS Managers[1] and the NHS Knowledge and Skills Framework (KSF)[2].
This document will assist you in achieving your required level of KSF competence in relation to the Core Dimension Health, Safety and Security; insert required level in the box below.

Core Dimension 3: Health , Safety and Security, level required to be achieved in your role (as per KSF outline) **please circle** 2 3 or 4

Health & Safety Competency for Individual Trust Managers	**Guidance/Sources of Further Information** *Please note that KSF indicators have been incorporated into the both the questions and guidance.*	**Insert current Level of Compliance for each question**
1. How you ensure that your Health & Safety Leadership and your Managers/Supervisors is visible and effective in the local areas and that are you developing a positive safety culture within your Service?	• This may involve observation of staff and contractors work practices, safety tours, inspections and walkabouts (Reference: Health & Safety Competencies for NHS Managers, NHS Employers, July 2015). • Leadership Advice for Managers http://www.hse.gov.uk/managing/ • Leading Health and Safety at Work INDG417 and Managing for Health and Safety HSG65 • Involving your workforce in health and safety - Good practice for all workplaces HSG26 • Health and Safety Executive Website on Organisational Culture http://www.hse.gov.uk/humanfactors/topics/culture.htm • Implementing Human Factors in Healthcare • Knowledge and implementation of Trust Health and Safety Policies and Procedures. Belfast Trust Policies can be found at this link http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Regulation%20and%20Improvement/Health%20and%20Safety.aspx • This will involve: - evaluating the extent to which legislation, policies and procedures are implemented in your work environment and ensuring a safety culture, safe practices and the ability for staff to feedback - Identifying processes and systems that promote own and others health and safety, Line managers should act as role models and intervene to protect others from risk.	**Please circle** **RED** **AMBER** **GREEN**

[1] Health and Safety Competencies for NHS Managers, July 2015 http://www.nhsemployers.org/news/2015/07/health-and-safety-guidance
[2] KSF, NHS Employers, October 2004, http://www.webarchive.org.uk/wayback/archive/20070626120000/http://www.dh.gov.uk/prod_consum_dh/DH_4090861b114.pdf

Question 1 response:		
2. Do you have the knowledge and skills to ensure that the hazards associated with your work activities are assessed, adequately controlled and monitored and an awareness of the process for escalating the relevant risks to your Service Area/Directorate Risk Register?	• Hazards include **physical** (e.g. slips and trips), **psychological** (e.g. stress), **environmental** (e.g. temperature) and **exposure to hazardous substances** and consideration as to who is exposed such as service users, carers, public, colleagues in the immediate work team, colleagues from other Directorates, contractors, visitors, bank staff, staff from other agencies etc. • The Trust has different risk templates for the various requirements for health & safety risk assessments e.g. COSHH, New & Expectant Mothers, General Health & Safety, Manual Handling, DSE etc. These are all available from the HUB together with associated guidance notes and completed samples http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Regulation%20and%20Improvement/Health%20and%20Safety.aspx • Refer to the Belfast Risk Audit and Assessment Tool (BRAAT) Phase 2 questions – Standards 2 – 7 & 9 – 17. • Line managers have a responsibility to regularly assess, monitor, review and sign risk assessments, so it is important that you have an understanding of the legal requirements and Trust Processes including the Risk Management Strategy. Management should use the outcome to take action, promote the issues and improve practice. • Emergency Preparedness and Contingency Planning contact [redacted]	**Please circle** **RED** **AMBER** **GREEN**
Question 2 response:		
3. How do you continually engage and communicate with your staff on safety issues?	• Refer to the Belfast Risk Audit and Assessment Tool (BRAAT) Phase 2 questions for example – 2.1, 2..11, 2.9, 3.1, 3.8, 4.1, 5.1, 6.1, 6.5, 7.1 ,8.1, 10.1, 11.1, 12.1, 13.1, 14.1 15.1, 16.1, 16.4 , 17.1 & 17.5. • Health & Safety should form part of your staff Meeting Agendas. • Trust Health & Safety Policies and documentation available from the HUB. • Safety Matters Newsletter • Health and Safety Induction/Checklist. • Health and Safety Information, Instruction and Training for staff as per risk assessments, specific job requirements, PCP's & PDP's	**Please circle** **RED** **AMBER** **GREEN**
Question 3 response:		

4. Do you have the skills, knowledge and access to systems to monitor trends and reduce incidents including RIDDOR occurring within your Service Area and identify where resources should be targeted?	**Policies, Procedures and Guidance - s**ee above * and • RIDDOR • Read only Guidance notes for Datixweb incidents • Datixweb for Incidents Guidance Pack • Saved Queries Instructions • Searches - 5 examples of common searches • Datixweb Poster **Contact details for incident reporting:** [redacted] and **contact details for RIDDOR Reporting** is [redacted]	**Please circle** **RED** **AMBER** **GREEN**
Question 4 response:		
5. How do you ensure that incidents are reported, investigated and actioned according to their severity and in particular where they result in lost time, major injuries and ill health? How do you ensure lessons learnt from incident investigation are shared with the relevant staff?	Trust Policies & Procedural Arrangements on the following are available from the HUB: • Adverse Incident Report and Management Policy • Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Policy • Procedure for Reporting and Managing Incidents • Procedure for Grading an Incident • Procedure for Investigating an Incident • Procedure for Sharing Learning • Trust SAI Procedure & HSCB Procedures for Reporting and Managing Serious Adverse Incidents (SAIs) • Guidance on Writing a Witness Statement These policies refer to the need to investigate any potential or actual breaches of legal, professional or organisational requirements and take the necessary action to deal with them appropriately and to support others to improve their practice, issue warnings when there are issues, secure resourcing and engage in exercises to update knowledge and extend skills.	**Please circle** **RED** **AMBER** **GREEN**
Question 5 response:		

6. Are you aware of and access other sources of specialist advice available to you when managing a particular health &	The Trust has a number of competent persons available to provide advice and guidance on specific aspects of health & safety e.g. • Partnered Health & Safety Managers • Ergonomics/Manual Handling Advisors (patient and load handling) • Infection, Prevention and Control Advisors	**Please circle** **RED** **AMBER**

safety concern or when undertaking risk assessment?	• Medical Physics • Radiation/Laser Protection Advisors • Management of Aggression Trainers – MAPA, SCIP & TCI • Waste Manager • Estates Department • Capital Planning & Redevelopment • Fire Officers • Medical Device Co-ordinators (medical gases & equipment and decontamination issues) • Occupational Health Service. • Laboratory Health and Safety Co-Ordinator • Trade Union Side The Trust also has access to external Services for occupational exposure monitoring, noise and vibration – please ask your partnered H&S Manager or Occupational Health Service for further information.	**GREEN**
Question 6 response:		
7. How do you ensure that your staff have the appropriate Health and Safety Information, Instruction and Training?	• Health and Safety Induction Information and Checklist • Staff Health and Safety Information, Instruction and Training within the Job KSF framework, Health and Safety competencies within the Job Description, PCP & PDP. • Statutory and Mandatory Training Policy • Training in local procedures • Training in equipment by a competent person	**Please circle** **RED** **AMBER** **GREEN**
Question 7 response:		
8. How do you involve safety representatives/ Trade Union Side in local health & safety issues/risk assessments?	• General Health & Safety Policy • HSENI Guidance Leaflet on Safety Representatives • Joint Health and Safety Committee Membership – link to list of current members http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Documents/Membership%20of%20the%20Joint%20Trust%20Health%20and%20Safety%20Committee%20October%202014.pdf	**Please circle** **RED, AMBER** or **GREEN**
Question 8 response:		
9. How are you managing health & wellbeing within your Service Area?	• Do you consider health issues in your risk assessments e.g. potential occupational exposures, diseases, conditions? • Have you completed BRAAT Phase 2 standard 15 and assessed for Stress within your Service Area? This should consider staff workloads, how you communicate with your Team, provide regular feedback on performance, clearly define staff's roles and responsibilities and main challenges facing your Team	**Please circle** **RED** **AMBER**

Consider the list of points in the guidance column	Do you? • Promote the Smoke Free Policy? • Encourage staff to site less/move more e.g. standing meetings/lunchtime walks • Advise staff of alternative form of travel between sites e.g. car sharing, buses cycling, Belfast Bikes • Promote Health & Wellbeing Events on Noticeboards, e-mail and Team Meetings and encourage staff to participate e.g. Health Fairs, £ for Ib challenge, HERE for U Activities • Celebrate staff's lifestyle changes • Encourage staff to take lunch breaks and their annual leave • Conduct and record comprehensive return to work interviews following periods of absences • Set a good examples in the way you manage your own personal health & wellbeing • Include staff wellbeing on your staff meeting agenda's • Distribute staff leaflets on Mental Health & Wellbeing, HERE for U and Improving Working Lives • Do you seek advice from HR, refer staff to the OHS or the Fast Track Physiotherapy Service • Encourage staff to attend available programmes e.g. Mindfulness, Health Lifestyle Training • Avail of the Trust HUB and Trust Internet site information on Health & Wellbeing e.g. Fit 4 Work and Fit 4 Life Apps, B Well http://www.bwellbelfast.hscni.net/	**GREEN**
Question 9 response:		
10. How do you incorporate reference to managing health and safety issues into your selection and recruitment processes?	• Recruitment & Selection Policy • Recruitment and Selection Training • Trust Values • Trust's Engagement Framework • KSF Outlines	**Please circle RED, AMBER** or **GREEN**
Question 10 response:		

Overall Action Plan for all responses: What do you need to do and what support do you require?
If any of your identified actions below link specifically to your personal development, then ensure this is captured on your PDP (Personal Development Plan) as part of the Trust Staff Development Review (SDR) Process.

Action required	Support/Resources Required	Timescale	Date Completed

Please refer to Statutory/Mandatory Matrix on the HUB, HRPTS or speak to the Risk & Governance Department for further information on available Training Programmes, for example:
H&S Awareness (1 ½ hrs) COSHH Awareness (1 ½ hrs every 3 years)
General H&S RA (Initial 4 hour Course and then 2hr refresher every 5 years) COSHH RA (initial 4 hr course and then 2hr refresher every 3 years)
Incident Reporting including Root Cause Analysis & Serious Adverse Incidents Fire/Emergency Preparedness Training
Learning & Development Portfolio Health Improvement Courses

FOR REFERENCE - APPENDIX 1 – Summary Descriptions of KSF Core Dimensions[3]

Health Safety and Security– definition This dimension focuses on maintaining and promoting the health, safety and security of everyone in the organisation or anyone who comes into contact with it either directly or through the actions of the organisation. It includes tasks that are undertaken as a routine part of one's work such as moving and handling		**Why it is important** Everyone needs to promote the health, safety and security of patients and clients, the public, colleagues and themselves	
Level 1 Assist in maintaining own and others' health, safety and security. For example: ■ follows trust policies, procedures and risk assessments to keep self and others safe at work ■ helps keep a healthy, safe and secure workplace for everyone ■ work in a way that reduces risks to health, safety and security ■ knows what to do in an emergency at work, knows how to get help and acts immediately to get help ■ reports any issues at work that may put self or others at a health, safety or security risk	**Level 2 Monitor and maintain health, safety and security of self and others** ■ looks for potential risks to self and others in work activities and processes ■ manages identified risk in the best way possible ■ works in a way that complies with legislation and trust policies and procedures on health, safety and risk management ■ takes action to manage an emergency, calling for help immediately when appropriate ■ reports actual or potential problems that may put health, safety or security at risk and suggests solutions ■ supports and challenges others in maintaining health, safety and security at work	**Level 3 Promote, monitor and maintain best practice in health, safety and security** ■ identifies and manages risk at work and helps others to do the same ■ makes sure others work in a way that complies with legislation and trust policies and procedures on health, safety and risk management ■ carries out, or makes sure others carry out risk assessments in own area. Checks work area to make sure it is free from risks and conforms to legislation and trust policies and procedures on health, safety and risk management ■ takes the right action when risk is identified ■ finds ways of improving health, safety and security in own area	**Level 4 Maintain and develop an environment and culture that improves health, safety and security** ■ evaluates the extent to which legislation and trust policies and procedures on health, safety and risk management have been implemented across the trust, in own sphere of activity ■ evaluates the impact of policies, procedures and legislation across the trust in own sphere of activity ■ identifies the processes and systems that will promote health, safety and security in the trust ■ regularly assesses risks and uses the results to make improvements and promote best practice ■ takes appropriate action when there are issues with health, safety and security ■ investigates any actual or potential health, safety or security incidents and takes the required action

[3] http://www.nhsemployers.org/SimplifiedKSF

Appendix 4- What to do if a member of staff identifies a health & safety concern

<table>
<tr><td colspan="7">What to do if a member of staff identifies a health & safety concern

Individual members of staff in the Belfast Health and Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have</td></tr>
<tr><td>Initial options</td><td>Refer to the relevant Trust Health & Safety Policy on the HUB
or
Search for the health & safety topic on

www.hseni.go.uk
or www.hse.gov.uk

for further advice/guidance</td><td>Report Health & Safety Concern to your Line Manager /Person in Charge</td><td>Complete an Incident Form on Datix Web (if relevant)</td><td>Ask your Ward/Department General or COSHH Risk Assessor to complete/ review the associated risk assessment.

The issue may then subsequently form part of the Service Area Risk Register</td><td colspan="2">Check that your line manager has sought advice from the relevant Departments/Individuals which may include:
• Your partnered Health & Safety Manager
• Trust’s Estates Department
• Occupational Health Service (staff can self-refer)
• Ergonomics Advisors
• Infection Prevention and Control Department,
• MAPA Team, Therapeutic Crisis Intervention (TCI), or Strategy for Crisis Intervention & Prevention (SCIP)
• Trade Union/Professional Body Representative
• or, Other Competent Persons</td></tr>
<tr><td colspan="7">Please ensure that you keep your Manager advised as to who else you have reported your concerns too</td></tr>
<tr><td>Other options available if you feel that your concerns has not been addressed and you need to escalate your concerns</td><td>Report to your Service Area Senior Manager</td><td colspan="4">Reporting under the Trust’s Whistleblowing Policy.
The Term “whistleblowing” includes acts or omissions which create a risk to the health and safety within the Trust.

For example a “disregard for legislation, particularly in relation to Health and Safety at Work”

Trust Whistleblowing Guidance</td><td>Report to your partnered Health & Safety Manager</td></tr>
<tr><td>External Options Available</td><td colspan="6">Report as a Complaint to the Health & Safety Executive for NI

It is recommended that you initially try all available internal options to resolve your Health & Safety Concerns</td></tr>
</table>

Appendix 5 - HSENI Consultation Flowchart

EXTERNAL SOURCE (HSENI) TO THE BHSCT
RIDDOR and ANONYMOUS COMPLAINT INVESTIGATONS

Health & Safety Executive for NI (HSENI) sends correspondence to the Chief Executive's Office (CEO)
(These are often copied to Risk & Governance – but this process relates to actions to be taken by the primary addressee)

CEO forwards correspondence (via email) to **Lead / & Health & Safety Managers (H&SM)- Health and Safety Partnered Arrangements (on the Hub)**

↓

Risk & Governance Health and Safety Department

Action: Lead/Partnered Health & Safety Manager (directly liaise with Governance Manager / Senior Service Area Manager):

- Identify Directorate/Service Area affected / actions required
- Communicate actions required to identified Director
- Copy to relevant Co Director/Governance Mgrs/ASM +, Medical Director, Deputy Medical Director, Risk & Governance Co Director, Corporate Risk and Standards Senior Manager, & Lead Health and Safety Mgr for information
- Confirm with the Directorate the commitment to meet the timeline for reply outlined by the HSENI

→ **Lead/Partnered Health & Safety Manager** acknowledges receipt to HSENI of the correspondence and confirms date for reply.

↓

Action by Lead Director/Responsible Lead & H&SM

- Identify 'Responsible Lead' within the Directorate.
- Where necessary: set up a group to prepare a response and consider any actions e.g. learning, change in practice with consideration to the date for reply.
- 'Responsible Lead' escalate as a matter of importance to Lead Director if timeline not being met and notify H&SM. H&SM liaise with the HSENI and informs Directorate accordingly.
- Partnered Health and Safety Manager to request a minimum of 2 updates from Responsible Lead to provide assurance the response is kept on track

↓

Action by Responsible Lead

Forwards formal response to partnered **Health &Safety Manager** approved by the Directorate at least **4 days before the agreed response time limit.**

↓

Action by Lead/Health and Safety Manager

Lead H&SM forward response to Corporate Risk and Standards Senior Manager and Co-Director for review. Response forwarded to the **CEO 3 days of the agreed response time limit** by the **Lead/Partnered Health & Safety Manager.**

↓

Action: CEO sends formal response (signed by CEO) via email to the **HSENI in accordance with timescale.**
Copy: Directorate Director/ Co-Director, Governance Manager, Service Manager, Medical Director, Deputy Medical Director, Risk & Governance Co Director, Corporate Risk and Standards Senior Manager, Lead/ Partnered Health & Safety Manager.

NB Lead/ Partnered Health & Safety Manager attach relevant correspondence to the Datix record for the incident.

Belfast Health and Social Care Trust

TYPE OF DOCUMENT *(delete as appropriate)*	Trust Policy for approval by **Trust Policy Committee** **or** Patient based standard, guideline or policy for approval by **Standards and Guidelines Committee**

REFERENCE NUMBER	To be assigned
TITLE	RIDDOR Guidance for Managers/Supervisors
Summary *Insert a brief summary of policy.* *This is limited to the provided fixed space.*	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR) require employers and others to report accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to investigate serious accidents. This guidance is designed to provide managers and supervisors with information on their legislative responsibilities and explains how RIDDOR applies to the healthcare sector.
Supercedes	This Guidance supersedes the previous Corporate (Legacy) Guidance relating to Riddor reporting
Operational date	1st July 2009
Review date	30th June 2012
Version Number	Version 1
Director Responsible	Dr A S Stevens, Medical Director
Lead Author	Andy Lamont
Lead Author, Position	Health & Safety Manager
Department / Service Group	Medical Directors Office
Contact details	Andy Lamont, Health & Safety Manager, Tel: 028 9063 1068, [redacted]
Additional Author(s)	Laota McQuitty Health and Safety Manager Philip Boyle Health and Safety Manager

RIDDOR GUIDANCE FOR MANAGERS / SUPERVISORS

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations(NI) 1997

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR) require employers and others to report accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to investigate serious accidents. This information sheet explains how RIDDOR applies to the healthcare sector.

Under RIDDOR you must report some work-related accidents, diseases and dangerous occurrences. This requirement covers all work activities, but not all incidents.

Managers and supervisors should provide as much detail as possible in the **RIDDOR section on the incident report form** to enable the Trust to comply with the RIDDOR regulations. It is also important to continue to update the Risk & Governance Department following the initial report for example, if a member of staff is off work or goes off at a later date for more than three days as a result of an injury following an incident.

Who Should Report?

The Belfast Health and Social Care Trust as an employer and in control of work premises have duties under the RIDDOR Regulations.
Corporate Risk Services/Occupational Health will notify and report to the enforcing authorities i.e. Health and Safety Executive NI, Environmental Health and Employment Medical Advisory Service.
Trust staff should not report RIDDOR incidents directly.

Accidents

'Accidents' include acts of physical violence to people at work, but not violence to other people, such as patients or visitors.

You do not need to report accidents arising *directly* from the conduct of an operation, examination or other medical treatment, carried out or supervised by a doctor or dentist.

For an accident to be reportable it must arise 'out of or in connection with' work. Accidents which arise solely from the condition of the injured person are not reportable, neither are suicides.

Examples: Reportable Accidents

Reportable

- A confused patient falls from a window on an upper floor and is badly injured.
- A hospital patient is scalded by hot bath water and has to be moved to a burns unit for treatment.

Not Reportable

- A frail elderly woman falls and breaks her leg, there are no obstructions or defects in the premises which contributed to the fall.
- A patient commits suicide.

Death or major injuries

In the event of a death, major injury or dangerous occurrence the Risk & Governance Department based at 6th Floor, McKinney House, Musgrave Park Hospital must be notified immediately by telephone No. 028 9063 1072.
You need to report the following accidents connected with work:

- Trust staff (wherever they are working), or a self-employed person working on Trust premises is killed or suffers a major injury (including as a result of physical violence).
- Someone not at work eg non staff is killed or suffers an injury as a result of an accident and is taken to hospital from the site of the accident.
- Someone not at work is injured in an accident at a hospital, and suffers a major injury. The different reporting requirements for accidents at hospitals are designed to ensure that accidents which would have required removal to hospital if they had happened elsewhere are reported

Reportable major injuries include:

- Fractures, except to fingers, thumbs or toes.
- Amputation.
- Dislocation of the shoulder, hip, knee or spine.
- Loss of sight (temporary or permanent).
- Chemical or hot metal burn to the eye, or any penetrating injury to the eye.
- Injury resulting from an electric shock or electrical burn, leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours.
- Acute illness requiring medical treatment, or loss of consciousness resulting from the absorption of any substance by inhalation, ingestion or through the skin or exposure to a biological agent.
- Any other injury which:
  - leads to: hypothermia, heat-induced illness or unconsciousness;
  - requires resuscitation or admittance to hospital for more than 24 hours; or if the injured person is already in hospital, then the injury would have resulted in admission for more than 24 hours.

A full list of reportable major injuries is in the guide to the Regulations (see back page for details).

Over-three-day injuries

You must report accidents connected with work (including acts of physical violence) which result in a member of staff, or a self-employed person working in Trust premises being away from work or unable to do their normal duties for more than three days (including non-work days).

For example, if a person who normally works Monday to Friday is injured on Friday and returns to work the following Wednesday, the Saturday and Sunday would have to be included when counting the days of incapacity. If the total period of incapacity is four days then the injury must be reported.

Examples: Over-3-day injuries:

- A porter suffers a back injury when lifting a heavy load and is unable to work for four days.
- A receptionist is punched by an angry patient in Accident & Emergency, suffers severe bruising and is off work for a week as a result of the injury and shock.
- A doctor's finger is broken when it is trapped by a closing door, she is unable to do her normal work from Friday until Tuesday.
- When requesting a person in Accident & Emergency to stop shouting a security officer receives a blow to the face, suffers a cut to the mouth which requires minor treatment and is off work for 4 days.

DISEASE OCCUPATIONALLY RELATED & CONDITIONS

If a member of staff is diagnosed by a doctor with an occupational disease or condition this will be reported directly to the relevant enforcing authority by the doctor.

Reportable diseases include:

- Some skin diseases, such as occupational dermatitis.
- Occupational asthma or respiratory sensitisation.
- Infections such as hepatitis, tuberculosis, legionellosis and tetanus.
- Any other infection reliably attributable to work with biological agents; exposure to blood or body fluids or any potentially infective material.
- Other conditions such as occupational cancer and certain musculoskeletal disorders.

You can find out details about reportable diseases in the guide to the Regulations (see back page for details).

Examples: Reportable diseases:

Reportable

- A nurse contracts TB after nursing a patient with TB.
- A laboratory worker suffers from typhoid after working with specimens containing typhoid.
- A nurse suffers asthma and becomes sensitised to glutaraldehyde after working in a gastroenterology unit.
- A secretary suffers from work-related upper limb disorder.
- A surgeon suffers dermatitis associated with wearing latex gloves during surgery.
- A paramedic becomes Hepatitis B positive after contamination with blood from an infected patient.

Not Reportable

- A nurse becomes colonised with MRSA after nursing patients infected with MRSA.
- A domestic catches chicken pox. Patients in areas where she has worked have chicken pox but so does her child.

Dangerous Occurrences

Dangerous occurrences are specified events which may not result in a reportable injury, but have the potential to do significant harm.
Reportable dangerous occurrences include the following:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment.
- The accidental release of a biological agent likely to cause severe human illness (a hazard group 3 or 4 pathogen).
- The accidental release of any substance which may damage health.
- The explosion, collapse or bursting of any closed vessel or associated pipework.
- An electrical short circuit or overload causing fire or explosion.
- An explosion or fire causing suspension of normal work for over 24 hours.

A full list is included in the guide to the Regulations (see back page for details).

Examples: Dangerous Occurrences:

Reportable

- A patient hoist falls, due to overload.
- Asbestos is released from ducting during maintenance work.
- A nurse suffers a needlestick injury from a needle and syringe known to contain Hepatitis B positive blood.
- A laboratory worker spills a container of formaldehyde.
- A container of a TB culture is broken and releases its contents.

Not reportable

- A domestic suffers a needlestick injury, the source of the sharp is unknown.
- A urine specimen container is broken and the contents are spilled.
- A doctor is injured by a sharp containing a patient's blood. The patient is not known to have any infection.

Further Reading

The full text of regulations, together with guidance notes, are available in a separate detailed guide A *leaflet on* the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI)1997 is available free from HSENI.*

HSE priced and free publications are available by mail order from HSE Books, PO Box 1999, Sudbury, Suffolk, CO10 6FS. Tel: 01787 881165 Fax: 01787 313995.

HSE priced publications are also available from good booksellers.

For other enquiries ring HSENI Tel: 028 90243249, or write to HSENI 83 Ladas Drive Belfast BT6 9FR.

HSE home page on the World Wide Web: http://www.open.gov.uk/hse/hsehome.htm

Contact Details

Risk & Governance Dept
6th Floor, McKinney House
Musgrave Park Hospital
Stockman's Lane
Belfast BT9 7JB
Tel: 028 9063 1072

Belfast Health and Social Care Trust

Reference No: TP042/08

Title:	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements.		
Author(s)	Karen Cunningham Lead Health and Safety Manager, Tel: [redacted]		
Ownership:	Dr A B Stevens, Medical Director		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	30 June 2014 09 July 2014
Operational Date:	June 2014	**Next Review:**	June 2016
Version No.	V2	**Supercedes**	V1-July 2009-2012
Key words:	RIDDOR		
Links to other policies	Adverse Incident Reporting Policy General Health & Safety Policy		

Date	Version	Author	Comments
01/02/14	Draft 1.0	Karen Cunningham	

1.0 INTRODUCTION / PURPOSE OF POLICY

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 requires the Belfast Health and Social Care Trust to report injuries and occupational diseases, conditions and dangerous occurrences arising out of the work activity.

1.1 Background

Trust generated RIDDOR reports enable the Health and Safety Enforcing Authorities to identify where and how risks arise and to investigate serious incidents.

1.2 Purpose

This Procedural Arrangement is designed to provide managers and staff with clear information on their legislative responsibilities under the RIDDOR Regulations.

1.3 Objectives

The key objectives of the policy are:

1. To raise awareness of the Trust's statutory requirement to report incidents that fall within the reporting criteria within the RIDDOR Regulations.

2. To advise Ward, Department and Facility Managers to identify RIDDOR reportable incidents within their own areas of responsibility

2.0 SCOPE OF THE POLICY

This is a Corporate Procedure and Guidance and is applicable to all staff including Directors and Managers who investigate and record incidents involving patients and staff. This procedure assists in the identification and management of RIDDOR incidents within the Belfast Trust.

3.0 ROLES/RESPONSIBILITIES

It is the responsibility of the Service Area to report adverse incidents in a timely manner to the **Risk and Governance Department** who will facilitate the onward reporting to the Health and Safety Executive Northern Ireland (HSENI) or Local Council Environmental Health Departments (EHOs) within the required reporting period.

Managers should provide as much detail as possible in **Section 9** of the electronic adverse incident form (Datix web) or **Section 12** of the paper copy of the adverse incident form to enable the Trust to comply with the RIDDOR Regulations.

Section 9 (Datix web) includes the following question:
Is this incident reportable under RIDDOR?

Section 12 (paper copy) includes the following questions:

Work related illness?	Yes ☐	No ☐		
Did the person go off duty?	Yes ☐	No ☐		
Off duty for 4 calendar days or more?	Yes ☐	No ☐	Unable to confirm	☐
Is further absence likely?	Yes ☐	No ☐		

The **Risk and Governance Department**, 6th Floor, McKinney House, Musgrave Park Hospital, will notify and report RIDDOR Reportable incidents to the enforcing authorities i.e. HSENI and local council Environmental Health Departments.

The **Estates Department** will report **Estates related only RIDDOR reportable dangerous occurrences** directly to the relevant enforcing authorities and notify the Risk and Governance Department.

Trust staff should not report RIDDOR Reportable incidents directly to the enforcing authorities.

See RIDDOR reporting flowchart for guidance (attached).

What Should You Report?

For an incident to be RIDDOR reportable it must arise 'out of or in connection with' work.

Death, Major Injuries and Injuries requiring Hospital Treatment

In the event of a death, major injury or dangerous occurrence the Health and Safety Managers must be notified immediately on Telephone No: 028 9504 8665/ 9504 8684/ 9504 8927/ 9504 8761/ 95047571. You must report the following incidents connected with work:

- Trust staff (wherever they are working), or a self-employed person working on Trust premises is killed or suffers a major injury (including as a result of physical violence).
- An injury to a person who is NOT at work (e.g. patient, visitor, service user etc) is reportable under RIDDOR if it results from an accident arising out of or in connection with the work being undertaken and the person being taken to hospital (or if it happens in hospital involves a Major Injury).
  This covers incidents associated in some way with work activities, equipment or environment, including how work is carried out, organised or supervised.

Patient/Service User Falls

Please add in details, where relevant in relation to the following points, in the description of incident or managers/investigators section – **Sections 3 & 9** of the electronic version (Datix web) of the incident form or **Section 7 & 12** paper copy of the incident form:

- Reference to the action resulting from the patient/service user's history of falls, falls risk assessment or Bed Rails Assessment; as part their care plan
- Fall protection measures identified as a result of the above risk assessments and in place at the time of the incident including the need for assistance, supervision or access to call bell
- Reference to assessments completed in relation to floor surfaces

The Health & Safety Team may subsequently contact you to ensure that clinical staff check the patient notes for queries relating to the incident and that the Health & Safety Managers facilitate the completion of a "Patient & Service Users" form.

Reportable major injuries include for example:

- any fracture other than to fingers, thumbs or toes;
- any amputation;
- crush injuries leading to internal organ damage
- head injuries that result in a loss of consciousness;
- burns or scalds covering more than 10% of the body's surface area;
- permanent blinding in one or both eyes;
- any degree of scalping;
- any asphyxiation from whatever cause;
- any injury arising from working in a confined space resulting in
- hypothermia, heat-induced illness, requiring resuscitation or admittance to
- hospital for more than 24 hours; and
- any diagnosed illness requiring medical treatment, which is reliably attributable to a work-related exposure to a biological agent or its toxins or infected material.

A full list of reportable major injuries is in the guide to the Regulations available from www.hseni.gov.uk

Over-Three-Day Injuries (this may be extended to over 7 day injuries in the future)

You must report incidents connected with work (including acts of physical violence) which result in a member of staff, or a self-employed person working in Trust premises being away from work or unable to do their normal duties for more than three days (including non-work days).

If a person who normally works Monday to Friday is injured on Friday and returns to work the following Wednesday, the Saturday and Sunday would have to be included when counting the days of incapacity. If the total period of incapacity is four days then the injury must be reported.

Disease Occupationally Related and Conditions

If a member of staff is diagnosed by a doctor with an occupational disease or condition this will be reported directly to HSENI by the doctor; through the Trust's Health & Safety Department or by the Occupational Health Service.

Reportable diseases/conditions include, for example:

- Carpal Tunnel Syndrome
- Occupational Dermatitis.
- Occupational Asthma

- Tendonitis or tenosynovitis of the hand or forearm
- Severe cramp in the hand or forearm
- Hand Arm Vibration Syndrome
- Occupational Cancer
- Any disease attributable to an occupational exposure to a biological agent.

For a complete list of reportable conditions/diseases please refer to www.hseni.gov.uk

Dangerous Occurrences

Dangerous occurrences are specified events which may not result in a reportable injury, but have the potential to do significant harm.

Reportable dangerous occurrences include the following:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment.
- The accidental release of a biological agent likely to cause severe human illness (a Hazard Group 3 or 4 pathogen).
- The accidental release of any substance which may damage health.
- The explosion, collapse or bursting of any closed vessel or associated pipework.
- An electrical short circuit or overload causing fire or explosion.
- An explosion or fire causing suspension of normal work for over 24 hours.

A full list is included in the guide to the Regulations available from www.hseni.gov.uk

4.0 KEY POLICY PRINCIPLES

- The Trust recognises its duty to formally report incidents to the relevant enforcing authority that fall within the requirements of RIDDOR.
- Staff recording incidents will be provided with training, guidance and further support to ensure this procedure is implemented throughout the organisation.
- Staff will be provided with information and training to enable them to assess the need to report under RIDDOR.
- Trust staff should not report RIDDOR Reportable incidents directly to the enforcing authorities.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy is required to be implemented by all Directorates.
All staff recording incidents and Departments with specific responsibilities are required to comply with this Procedure as detailed.

5.2 Resources

Responsibility for training requirements and other aspects associated with this policy are detailed in Section 3.0, Roles & Responsibilities.

5.3 Exceptions

There are no exceptions.

6.0 MONITORING

It is the responsibility of the Health & Safety Department to monitor the implementation of this procedure.

The Health & Safety Department will provide quarterly reports to the Joint Health & Safety Committee and RIDDOR reportable incidents form part of the Trust's Annual Report.

The Trust annually benchmarks with other Health & Social Care Trusts regarding RIDDOR reportable statistical information.

7.0 EVIDENCE BASE / REFERENCES

This procedure is based on the requirements of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (NI) 1997

The Health & Safety at Work (NI) Order 1978, as amended, set out duties on the Trust to ensure the health, safety and welfare of their staff whilst they are at work.

Health Services Information Sheet No 7 (revision 3), 1 October 2013 - Reporting Injuries Diseases and Dangerous Occurrences in Health & Social Care – Guidance for Employers.

8.0 CONSULTATION PROCESS

The Policy has been devised in collaboration and consultation with the Trust's Occupational Health Service, Health & Safety and Estates Departments.

Consultation with employees and their trade union representatives during the development and introduction of a Policy is a legal requirement and it will also help to enhance employees relations. ref: Health & Safety (Consultation with Employees) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

The Trust's Joint Health & Safety Committee are aware of the reporting requirements under RIDDOR and recent changes in associated guidance.

9.0 APPENDICES / ATTACHMENTS

RIDDOR Reporting Flowchart Appendix 1

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).

Date: 9 July 2014

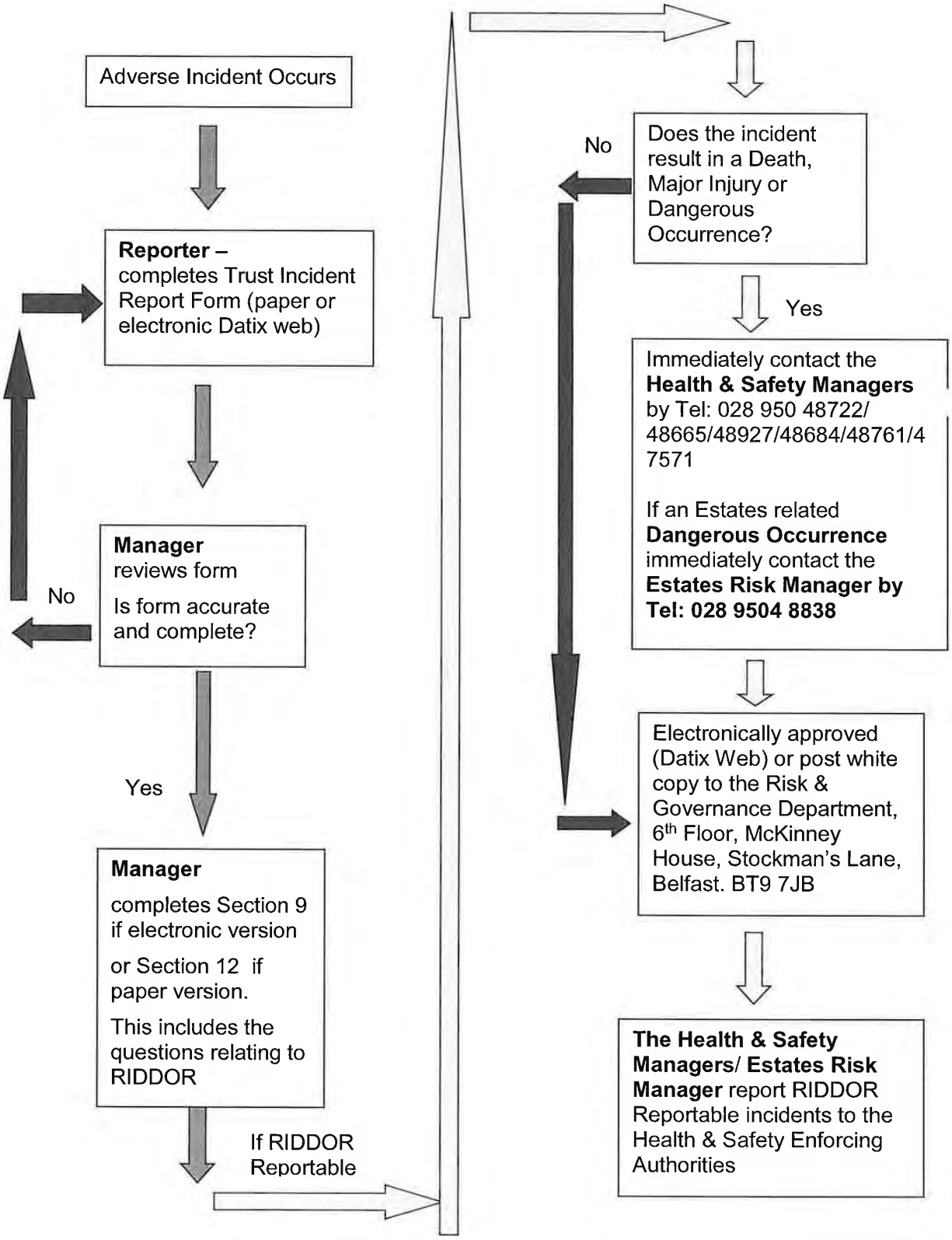
Dr Tony Stevens
Medical Director

Date: 9 July 2014

Martin Dillon
Interim Chief Executive

Appendix1

RIDDOR Reporting Flowchart



Belfast Health and Social Care Trust

Reference No: TP042/08

Title:	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements.		
Author(s)	Karen Cunningham Lead, Health and Safety Manager, Tel: [redacted] Philip Boyle, Health & Safety Manager, Tel: [redacted]		
Ownership:	Dr Cathy Jack, Medical Director		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	1st April 2015 15th April 2015
Operational Date:	May 2015	**Next Review:**	May 2018
Version No.	V3	**Supercedes**	V2 – June 2014-2016
Key words:	RIDDOR, incidents, dangerous occurrences, occupational diseases, conditions, absence management, over 3 day.		
Links to other policies	Adverse Incident Reporting and Management Policy General Health & Safety Policy		

Date	Version	Author	Comments
01/02/14	V1	Karen Cunningham Philip Boyle	Draft
30/6/2014	V2	As above	Review
06/03/15	V3	Karen Cunningham Philip Boyle	Procedural arrangement revised to incorporate new reporting arrangements for the Occupational Health Service with regard to Dangerous Occurrences and Occupational Diseases/ Conditions Additional section on reporting requirements for Service User choking and wandering incidents following guidance from HSENI.

1.0 INTRODUCTION / PURPOSE OF POLICY

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) requires the Belfast Health and Social Care (HSC) Trust to report certain types of injury, death, occupational diseases/ conditions and dangerous occurrences that **"arise out of or in connection with work"**to enforcing authorities. The enforcing authorities in such cases will be the Health & Safety Executive NI (HSENI) or Local Council Environmental Health Departments.

1.1 Background

Trust generated RIDDOR reports enable the Health and Safety Enforcing Authorities to identify where and how risks arise, establish trends and investigate serious incidents.

1.2 Purpose

This procedural arrangement is designed to provide managers and staff with guidance on their legislative responsibilities under the RIDDOR Regulations. It contains details of the types of incidents that are reportable and the processes by which they should be reported.

1.3 Objectives

The key objectives of the policy are:

1. To raise awareness of the Trust's statutory requirement to report incidents that fall within the reporting criteria within the RIDDOR Regulations.

2. To provide information and guidance to Managers to enable staff to identify RIDDOR reportable incidents.

3. To inform staff of the processes for reporting such incidents to the enforcing authorities.

2.0 SCOPE OF THE POLICY

This procedural arrangement is a corporate procedure and guidance and is applicable to all staff including Directors and Managers who investigate and record incidents involving patients and staff. This procedure assists in the identification and management of RIDDOR incidents within the Belfast Trust.

3.0 ROLES/RESPONSIBILITIES

A) The responsibilities of Line Managers (Approving Managers) are as follows:

1. To ensure adverse incidents are reported in a timely manner to the **Risk and Governance Department** who will facilitate the onward reporting to the relevant Health & Safety enforcing authorities for example Health and Safety Executive Northern Ireland (HSENI) or Local Council Environmental Health Departments (EHOs) within the required reporting period.

2. Managers should provide as much detail as possible on the electronic adverse incident form (Datix web) or **Section 12** of the paper copy of the adverse incident form to enable the Trust to comply with the RIDDOR Regulations.

Datix web-includes the following question:

Is this incident reportable under RIDDOR? Yes ☐ No ☐

Section 12 (paper copy) includes the following questions:

Work related illness?	Yes ☐	No ☐		
Did the person go off duty?	Yes ☐	No ☐		
Off duty for 4 calendar days or more?	Yes ☐	No ☐	Unable to confirm	☐
Is further absence likely?	Yes ☐	No ☐		

3. To ensure staff are aware of the procedural arrangements for reporting RIDDOR reportable incidents and inform staff they **should not** report RIDDOR Reportable incidents directly to the enforcing authorities.
4. To ensure that staff absent from work due to an injury or occupationally related ill health from work are referred to the OHS in line with the Attendance Management protocol.
5. To provide support or alternative formats in terms of disability or language needs, if required, to communicate the policy.

B) The responsibilities of the Health & Safety Department (6th Floor, McKinney House, Musgrave Park Hospital) are as follows:

1. To report RIDDOR Reportable injury incidents to the enforcing authorities (exceptions noted under Estates and Occupational Health Service responsibilities).

C) The responsibilities of the Estates Department as follows:

1. To report **Estates related RIDDOR reportable dangerous occurrences** directly to the relevant enforcing authorities and notify the Risk and Governance Department.

D) The responsibilities of the Occupational Health Service (OHS) are as follows:

1. To report RIDDOR reportable occupationally related diseases/ conditions to the Health & Safety enforcing authority.
2. To report RIDDOR reportable dangerous occurrence incidents involving the accidental release of a biological agent likely to cause severe human illness (Hazard Group 3 or 4 pathogens) to the enforcing authority.

E) The responsibilities of all staff are as follows:

1. To report incidents appropriately in accordance with the Trust's Adverse Incident Reporting Policy and associated procedures.

What Should You Report?

For an incident to be RIDDOR reportable it must arise 'out of or in connection with' work.

Death, Major Injuries and Injuries requiring Hospital Treatment

In the event of a death, major injury, dangerous occurrence the Health and Safety Managers must be notified immediately on ***Telephone No: 028 9504 8665/ 9504 8684/ 9504 8927/ 9504 8761/ 95047571/ 9504 3373***.

Staff must report the following incidents connected with work:

- Trust staff (wherever they are working), or a self-employed person working on Trust premises is fatally injured or suffers a major injury (including as a result of physical violence).
- An injury to a person who is NOT at work (e.g. Patient/ Service User, Visitor, Member of the Public etc) is reportable under RIDDOR if it results from an accident arising out of or in connection with the work being undertaken and the person being taken to hospital (or if it happens in a hospital and involves a Major Injury). This covers incidents associated in some way with work activities, equipment or environment, including how work is carried out, organised or supervised.

"Reportable Major Injuries" include for example:

- any fracture other than to fingers, thumbs or toes;
- any amputation;
- crush injuries leading to internal organ damage
- head injuries that result in a loss of consciousness;
- burns or scalds covering more than 10% of the body's surface area;
- permanent blinding in one or both eyes;
- any degree of scalping;
- any asphyxiation from whatever cause;
- any injury arising from working in a confined space resulting in hypothermia, heat-induced illness, requiring resuscitation or admittance to hospital for more than 24 hours; and
- any diagnosed illness requiring medical treatment, which is reliably attributable to a work-related exposure to a biological agent or its toxins or infected material.

A full list of reportable major injuries is in the guide to the Regulations available from www.hseni.gov.uk

Patient/Service User falls and choking incidents

In the event of a death or major injury arising due to a patient/service user fall, choking or other incident, in connection with the Trust's work activities and it could have been prevented through risk assessment, identifying and implementing control measures or failure to do any of these, this should be reported under RIDDOR.

Patient Falls

- This includes reference to patient falls, bed rails and moving and handling risk assessments completed as part the plan of care and when these were reviewed..
- Fall protection measures (identified as a result of the above risk assessments) ~~and~~ in place at the time of the incident including arrangements for supervision, assistance, access to call and use of mobility aids etc.
- Reference to environmental factors which may have contributed to the fall for example defective flooring, wet floors, housekeeping issues and any assessments completed in relation to slips, trips and falls.

Choking Incidents

- Reference to Service User choking assessments completed as per plan of care and when these were reviewed.
- Measures in place at the time of the incident as per patient assessment for example supervision at meal times, personal placemat, safe eating strategies and staff training in swallowing, eating, drinking assessments.

The Health & Safety Team may subsequently contact you to ensure that clinical staff check the patient notes for queries relating to these incidents.

Please add in details, where relevant in relation to the points above in the description of incident or managers/investigators section of the electronic version (Datix web) of the incident form or **Section 7 & 12** paper copy of the incident form:

Over-Three-Day Injuries

Staff must report incidents connected with work (including acts of physical violence) which result in a member of staff, or a self-employed person working in Trust premises being away from work or unable to do their normal duties for more than three days (including non-work days) but not including the day the incident occurred.

For example, if a person who normally works Monday to Friday is injured on Friday and returns to work the following Wednesday, the Saturday and Sunday would have to be included when counting the days of incapacity. If the total period of incapacity is four days or more then the injury must be reported.

Occupationally Related Diseases and Conditions

If a member of staff is diagnosed by an Occupational Health professional with an occupational disease or condition this will be reported directly to the Health & Safety Executive (HSENI) as required by RIDDOR by the Occupational Health Service.

Reportable diseases/conditions include, for example:

- Occupational Dermatitis.
- Occupational Asthma
- Tendonitis or tenosynovitis of the hand or forearm
- Severe cramp in the hand or forearm
- Occupational Cancers

- Diseases attributable to an occupational exposure to a biological agent for example sharps injuries and contraction of a blood borne virus and transmission of Tuberculosis from patient to staff.

For a complete list of reportable conditions/diseases please refer to www.hseni.gov.uk

Dangerous Occurrences

Dangerous occurrences are specified events which may not result in a reportable injury but have the potential for significant harm.

Reportable dangerous occurrences include the following:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment.
- The accidental release of a biological agent likely to cause severe human illness (a Hazard Group 3 or 4 pathogen) for example sharps injury from a HIV patient.
- The accidental release of any substance which may damage health.
- The explosion, collapse or bursting of any closed vessel or associated pipework.
- An electrical short circuit or overload causing fire or explosion.
- An explosion or fire causing suspension of normal work for over 24 hours.

A full list is included in the guide to the Regulations available from www.hseni.gov.uk

See RIDDOR reporting flowchart for further guidance in Appendix 1.

4.0 KEY POLICY PRINCIPLES

- The Trust recognises its duty to formally report incidents that fall within the requirements of the RIDDOR regulations to the relevant enforcing authority.
- To ensure staff recording incidents will be provided with information, training, guidance and further support to enable them to identify RIDDOR reportable incidents and ensure this procedure is implemented throughout the Trust.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This procedure is required to be implemented by all Directorates. All staff recording incidents and departments with specific responsibilities are required to comply with this Procedure as detailed.

If support or alternative formats are required in terms of communication in relation to the policy, this will be provided.

5.2 Resources

Responsibility for training requirements and other aspects associated with this policy are detailed in Section 3.0, Roles & Responsibilities.

5.3 Exceptions

There are no exceptions.

6.0 MONITORING

It is the responsibility of the Health & Safety Department to monitor the implementation of this procedure.

The Health & Safety Department will provide quarterly reports to the Joint Health & Safety Committee and RIDDOR reportable incidents form part of the Trust's Annual Report.

The Trust annually benchmarks with other Health & Social Care Trusts regarding RIDDOR reportable statistical information.

7.0 EVIDENCE BASE / REFERENCES

This procedural arrangement is based on the requirements of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (NI) 1997

The Health & Safety at Work (NI) Order 1978, as amended, set out duties on the Trust to ensure the health, safety and welfare of their staff whilst they are at work.

Health Services Information Sheet No 7 (revision 3), 1 October 2013 - Reporting Injuries Diseases and Dangerous Occurrences in Health & Social Care – Guidance for Employers.

8.0 CONSULTATION PROCESS

The procedural arrangement has been devised in collaboration and consultation with the Trust's Occupational Health Service, Health & Safety, Risk & Governance and Estates Departments.

Consultation with employees and their trade union representatives during the development and introduction of a Policy is a legal requirement and it will also help to enhance employees relations. ref: Health & Safety (Consultation with Employees) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

The Trust's Joint Health & Safety Committee members have also been consulted on this procedural arrangement.

9.0 APPENDICES / ATTACHMENTS

Appendix 1- RIDDOR Reporting Flowchart

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:

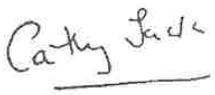
Major impact ☐

Minor impact ☐

No impact. √

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

Director



Dr Cathy Jack
Medical Director

Date: 15 April 2015

Dr Michael McBride
Medical Director

Date: 15 April 2015

Authors

Mrs Karen Cunningham,
Lead Health & Safety Manager

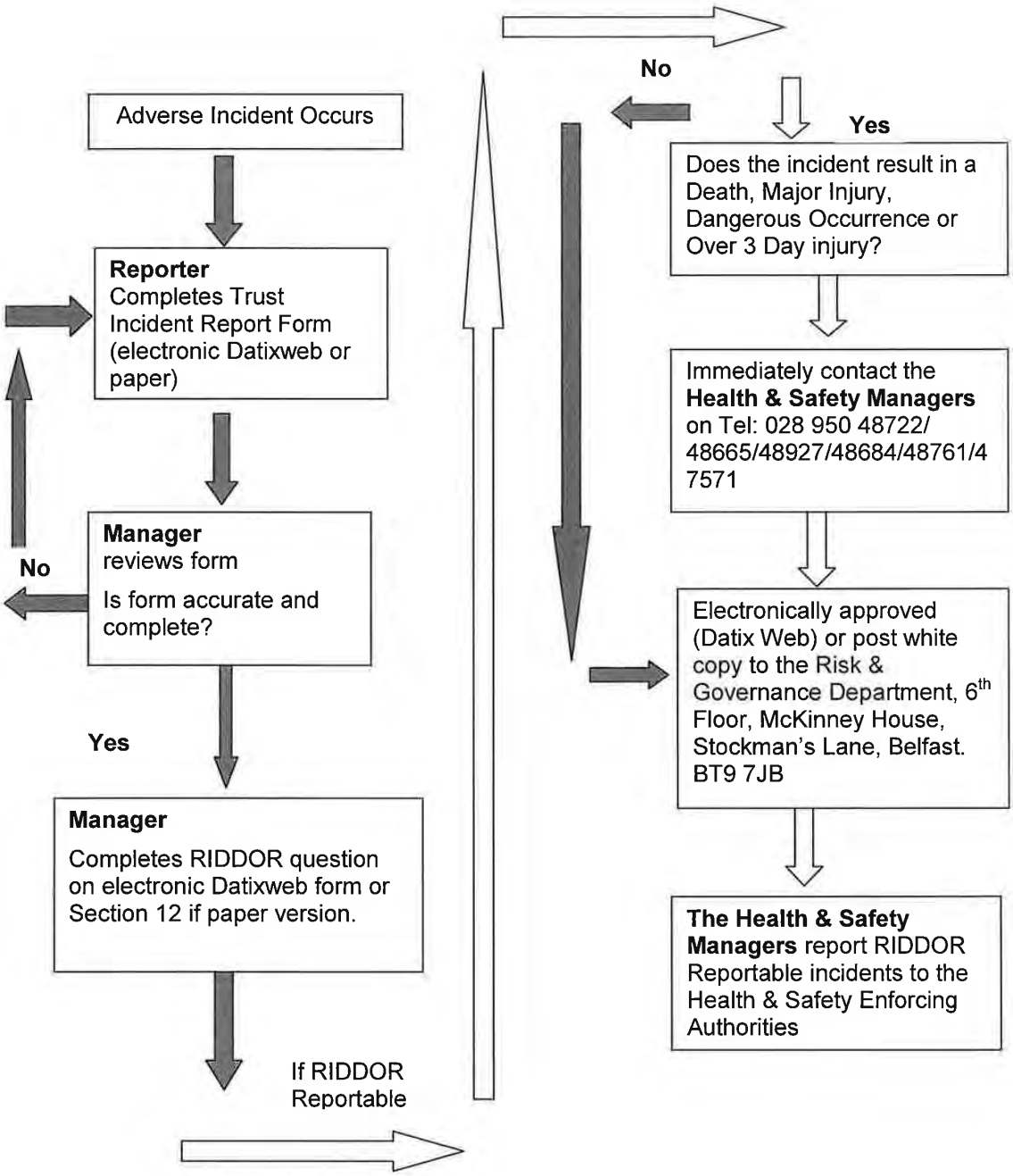
Date: 1 April 2015

Mr Philip Boyle
Health & Safety Manager

Date: 1 April 2015

Appendix1

RIDDOR Reporting Flowchart



Occupational Health Service report all RIDDOR reportable Occupational Diseases/Conditions and Dangerous Occurrences relating to biological agents to the enforcing authority.

If an Estates related **Dangerous Occurrence** immediately contact the **Estates Risk Manager** on Tel: 028 9504 8838 who reports such incidents under RIDDOR.

Belfast Health and Social Care Trust

Reference No: TP042/08

Title:	**The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Policy**				
Author(s)	Philip Boyle, Health and Safety Manager, Tel: [redacted]				
Ownership:	Dr Cathy Jack, Medical Director				
Approval by:	Trust Policy Committee Executive Team		**Approval date:**	2 May 2018 9 May 2018	
Operational Date:	May 2018		**Next Review:**	May 2023	
Version No.	4	**Supercedes**	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements v3, May 2015 – April 2018		
Key words:	RIDDOR, incidents, dangerous occurrences, occupational diseases, conditions, absence management, over 3 day injury, major.				
Links to other policies	• Adverse Incident Reporting and Management Policy • General Health & Safety Policy • Policy & Procedural Arrangement for the Prevention and Management of Slips, Trips and Falls • Zero Tolerance Approach To The Prevention And Management Of Aggression & Violence Towards Staff In The Workplace • Falls Reduction and Prevention Policy • The Prevention & Management of Patient, Client and Service Users with Identified Choking Risks • COSHH • Management of Latex Sensitisation • Safe Use of Bed Rails • Manual Handling • Prevention of the spread of Blood Borne Virus (BBV) Infection and the Management of patients with BBV infection in the Department of Nephrology & Transplant				

Date	Version	Author	Comments
01/02/2014	Draft 1	Karen Cunningham Philip Boyle	
06/03/2015		Karen Cunningham Philip Boyle	Procedural arrangement revised to incorporate new reporting arrangements for the Occupational Health Service with regard to Dangerous Occurrences and Occupational Diseases/ Conditions. Additional section on reporting requirements for Service User choking and wandering incidents following guidance from HSENI.
03/01/2018	4.1	Philip Boyle	3 year review and consultation. This policy was revised to enhance the Managers, Health & Safety Managers and staff responsibilities section; the “Major Injuries” section updated to reflect version in RIDDOR NI Regulations,

			reference to Patient Falls/ Bed Rails and Prevention and Management of Patient/Client and Service Users with Identified Choking Risks. Include an appendix on "HSENI Correspondence and Belfast Trust CEO Flowchart"

1.0 INTRODUCTION / PURPOSE OF POLICY

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) requires the Belfast Health and Social Care (HSC) Trust to report certain types of injury, death, occupational diseases/ conditions and dangerous occurrences that **"arise out of or in connection with work"** to enforcing authorities. The enforcing authorities in such cases will be the Health & Safety Executive NI (HSENI) or Local Council Environmental Health Departments.

1.1 Background

The Trust generated RIDDOR reports enable the Health and Safety Enforcing Authorities to identify where and how risks arise, establish trends and investigate serious incidents.

1.2 Purpose

This policy is designed to provide managers and staff with guidance on their legislative responsibilities under the RIDDOR Regulations. It contains details of the types of incidents that are reportable and the processes by which they should be reported to the Health & Safety Department.

1.3 Objectives

The key objectives of the policy are:

1. To raise awareness of the Trust's statutory requirement to report incidents that fall within the reporting criteria for the RIDDOR Regulations.

2. To provide information and guidance to Managers to enable staff to identify RIDDOR reportable incidents.

3. To inform staff of the processes for reporting such incidents to the enforcing authorities through the Health & Safety Department which forms part of the Risk & Governance Department, Occupational Health Service (OHS) and Estates.

2.0 SCOPE OF THE POLICY

This Corporate Policy is applicable to all staff including Directors and Managers who investigate and record incidents involving patients, visitors, staff, volunteers and members of the public. This policy assists in the identification and management of RIDDOR incidents within the Belfast Trust.

3.0 ROLES/RESPONSIBILITIES

A) The responsibilities of Line Managers (Approving Managers) are as follows:

1. To ensure adverse incidents are reported and approved within 7 working days to the **Risk and Governance Department** who will facilitate the onward reporting by the Health & Safety Team to the relevant Health & Safety enforcing authorities for example Health and Safety Executive Northern Ireland (HSENI) or Local Council Environmental Health Departments (EHOs) within the required reporting period.

2. To notify the **Trust Health & Safety Managers immediately** in the event of an incident which has been identified as meeting RIDDOR reporting criteria ie Death, Major injury, Over 3 day injury or Dangerous Occurrence.

3. To ensure that as much detail as possible is provided on the Datix web incident form to enable the Trust to comply with the RIDDOR Regulations.

Datix web includes the following question:

Is this incident reportable under RIDDOR? Yes ☐ No ☐

4. To ensure staff are aware of the arrangements for reporting RIDDOR reportable incidents and inform staff they **should not** report RIDDOR Reportable incidents directly to the enforcing authorities.
5. To ensure that staff absent from work due to an injury or occupationally related ill health from work are referred to the OHS in line with the Attendance Management protocol.
6. To ensure that staff complete core statutory/mandatory Adverse Incident Reporting Training which includes reference to RIDDOR reportable incidents, as provided by the Risk & Governance Department.
7. Provide support or alternative formats in terms of communication support or linguistic needs, if required, to communicate the policy.

B) The responsibilities of the Health & Safety Department (7th Floor, McKinney House, Musgrave Park Hospital) are as follows:

1. To report RIDDOR reportable incidents through the HSENI on-line reporting system.
2. To implement the Health & Safety Teams internal RIDDOR procedures, including reporting timescales to HSENI, in relation to the reporting of incidents involving staff, patients, visitors and members of the public.
3. To contact the HSENI in accordance with notification and the reporting timescales outlined in the RIDDOR regulations ie Death, Major Injury and Dangerous Occurrence incidents which have been confirmed as meeting RIDDOR reporting requirements. HSENI to be **contacted immediately** by phone and RIDDOR on-line report to be completed.
4. To obtain all relevant details prior to reporting RIDDOR Reportable injury incidents to the enforcing authorities using the secure online system (exceptions noted under Estates and OHS responsibilities).
5. To contact the incident reporter in relation to the requirement to provide further details on their investigation into the incident categorised as major injury, fatality, dangerous occurrence or admitted to hospital for treatment.
6. To visit the scene of the incident where required and retain photographs, measurements and any other relevant details. To review nursing assessment and plan of care documentation for example patient fall risk assessments in conjunction with ward/facility and facility Manager.

7. To participate in annual regional benchmarking exercise in relation to RIDDOR reportable incidents and report on such in the Annual Health & Safety Report.
8. To liaise with HSENI and the Service Area in relation to the subsequent incident investigation following the procedure outlined in **Appendix 2.**
9. To update and check RIDDOR coding on the Datix record.
10. To produce RIDDOR reports for the Joint Health & Safety Committee, Partnered Governance Meetings and the Annual Health & Safety Report.

C) The responsibilities of the Estates Department as follows:

1. To report **Estates related RIDDOR reportable dangerous occurrences** directly to the relevant enforcing authorities and notify the Risk and Governance Department.

D) The responsibilities of the Occupational Health Service (OHS) are as follows:

1. To report RIDDOR reportable occupationally related diseases/ conditions to the Health & Safety enforcing authority including sharps injuries.
2. To report staff RIDDOR reportable dangerous occurrence incidents involving the accidental release of a biological agent likely to cause severe human illness (Hazard Group 3 or 4 pathogens) to the enforcing authority.

E) The responsibilities of all staff are as follows:

1. To report all incidents on Datix Web in accordance with the Trust's Adverse Incident Reporting, Training, Policy and associated procedures.
2. To complete statutory/mandatory training on Adverse Incident Reporting as listed on HRPTS. This training is also available as e-learning.
3. To co-operate with the internal investigations, including claims and those conducted by Enforcing Authorities.

4.0 KEY POLICY PRINCIPLES

Definitions

For an incident to be RIDDOR reportable it must arise 'out of or in connection with' work.

In the event of a RIDDOR reportable **death, major injury, dangerous occurrence or over 3 day injury** the Health and Safety Managers **must be notified immediately** on **Telephone Number: 9504 8722**.

Death, Major Injuries, Dangerous Occurrences and Injuries requiring Hospital Treatment

Staff must report the following incidents connected with work:

- Trust staff (wherever they are working), or a self-employed person working on Trust premises is fatally injured or suffers a major injury (including as a result of physical violence).
- An injury to a person who is NOT at work (e.g. Patient/ Service User, Visitor, Member of the Public etc) is reportable under RIDDOR if it results from an accident arising out of or in connection with the work being undertaken and the person is taken to hospital

(or if it happens in a hospital and involves a Major Injury). This covers incidents associated in some way with work activities, equipment or environment, including how work is carried out, organised or supervised.

Reportable major injuries are:

- fracture other than to fingers, thumbs or toes;
- amputation;
- dislocation of the shoulder, hip, knee or spine;
- loss of sight (temporary or permanent);
- chemical or hot metal burn to the eye or any penetrating injury to the eye;
- injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- unconsciousness caused by asphyxia or exposure to harmful substance or biological agent;
- acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin;
- acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material;
- any other injury leading to hypothermia, heat induced illness or to unconsciousness; or requiring resuscitation; or requiring admittance to hospital for more than 24 hours.

A full list of reportable major injuries is in the guide to the Regulations available from www.hseni.gov.uk

Patient/Service User falls and Choking Incidents
In the event of a death or major injury arising due to a patient/service user fall, choking or other incident, in connection with the Trust's work activities and it could have been prevented through risk assessment, identifying and implementing control measures or failure to do any of these, this should be reported under RIDDOR.

Patient Falls
Please refer to the Trust's Patient Falls & Bed Rails Policies

- This includes reference to patient falls, bed rails and moving and handling risk assessments completed as part the plan of care and when these were reviewed..
- Fall protection measures (identified as a result of the above risk assessments) in place at the time of the incident including arrangements for supervision, assistance, access to call and use of mobility aids etc.
- Reference to environmental factors which may have contributed to the fall for example defective flooring, wet floors, housekeeping issues and consider any assessments completed in relation to slips, trips and falls.

Choking Incidents
Please refer to the Trust's policy on The Prevention & Management of Patient, Client and Service Users with Identified Choking Risks.

- Reference to Service User choking assessments completed as per plan of care and when these were reviewed.
- Measures in place at the time of the incident as per patient assessment for example supervision at meal times, personal placemat, safe eating strategies and staff training in swallowing, eating, drinking assessments.

The Health & Safety Team may subsequently contact you to ensure that clinical staff to check the patient notes for queries relating to these incidents.

Please add in details, where relevant in relation to the points above in the description of incident or managers/investigators section of Datix web of the incident form.

Over-Three-Day Injuries

Staff must report incidents connected with work (including acts of physical violence) which result in a member of staff, or a self-employed person working in Trust premises being away from work or unable to do their normal duties for more than three days (including non-work days) but not including the day the incident occurred.

For example, if a person who normally works Monday to Friday is injured on Friday and returns to work the following Wednesday, the Saturday and Sunday would have to be included when counting the days of incapacity. If the total period of incapacity is four days or more then the injury must be reported.

Occupationally Related Diseases and Conditions

If a member of staff is diagnosed by an Occupational Health Doctor with an occupational disease or condition this will be reported directly to the Health & Safety Executive (HSENI) as required by RIDDOR by the Occupational Health Service.

Reportable diseases/conditions include, for example:

- Diseases attributable to an occupational exposure to a biological agent for example sharps injuries and contraction of a blood borne virus and transmission of Tuberculosis from patient to staff
- Occupational Dermatitis.
- Occupational Asthma
- Tendonitis or tenosynovitis of the hand or forearm
- Severe cramp in the hand or forearm
- Occupational Cancers

For a complete list of reportable conditions/diseases please refer to www.hseni.gov.uk

Dangerous Occurrences

Dangerous occurrences are specified events which may not result in a reportable injury but have the potential for significant harm.

Reportable dangerous occurrences include the following:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment.
- The accidental release of a biological agent likely to cause severe human illness (a Hazard Group 3 or 4 pathogen) for example sharps injury from a HIV patient.
- The accidental release of any substance which may damage health.
- The explosion, collapse or bursting of any closed vessel or associated pipework.
- An electrical short circuit or overload causing fire or explosion.
- An explosion or fire causing suspension of normal work for over 24 hours.

A full list is included in the guide to the Regulations available from www.hseni.gov.uk

See RIDDOR reporting flowchart for further guidance in Appendix 1.

Policy Principles

- The Trust recognises its duty to formally report incidents that fall within the requirements of the RIDDOR regulations to the relevant enforcing authority.
- To ensure staff recording incidents are provided with information, training and guidance to enable them to identify RIDDOR reportable incidents and ensure this procedure is implemented throughout all Service Areas.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This procedure is required to be implemented by all Directorates. All staff recording incidents and departments with specific responsibilities are required to comply with this Policy as detailed.

If support or alternative formats are required in terms of communication in relation to the policy, this will be provided.

5.2 Resources

Responsibility for training requirements and other aspects associated with this policy are detailed in Section 3.0, Roles & Responsibilities.

5.3 Exceptions

There are no exceptions.

6.0 MONITORING

It is the responsibility of the Health & Safety Team to monitor the implementation of this Policy. The Health & Safety Team will provide quarterly reports to the Joint Health & Safety Committee and RIDDOR reportable incidents form part of the Trust's Annual Report. The Trust annually benchmarks with other Health & Social Care Trusts regarding RIDDOR reportable incidents.

7.0 EVIDENCE BASE / REFERENCES

This Policy is based on the requirements of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (NI) 1997 and associated guidance.

The Health & Safety at Work (NI) Order 1978, as amended, set out duties on the Trust to ensure the health, safety and welfare of their staff whilst they are at work.

Health Services Information Sheet No 7 (revision 3), 1 October 2013 - Reporting Injuries Diseases and Dangerous Occurrences in Health & Social Care – Guidance for Employers.

Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern

Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland. March 2013

8.0 CONSULTATION PROCESS

The policy has been devised in collaboration and consultation with the Trust's Occupational Health Service, Health & Safety Team, Risk & Governance Department Estates Department and members of the Joint Health & Safety Committee.

Consultation with employees and their trade union representatives during the development and introduction of a Policy is a legal requirement and it will also help to enhance employees relations. ref: Health & Safety (Consultation with Employees) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979. The Trust's Joint Health & Safety Committee members have also been consulted on this Policy.

9.0 APPENDICES / ATTACHMENTS

Appendix 1- RIDDOR Reporting Flowchart .
Appendix 2 - HSENI Correspondence and Belfast Trust CEO Flowchart.

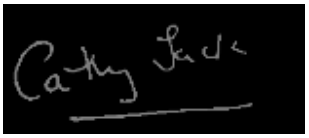
10.0 EQUALITY STATEMENT

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).

Date: 02/05/2018

Philip Boyle, Health & Safety Manager



Date: 09/05/2018

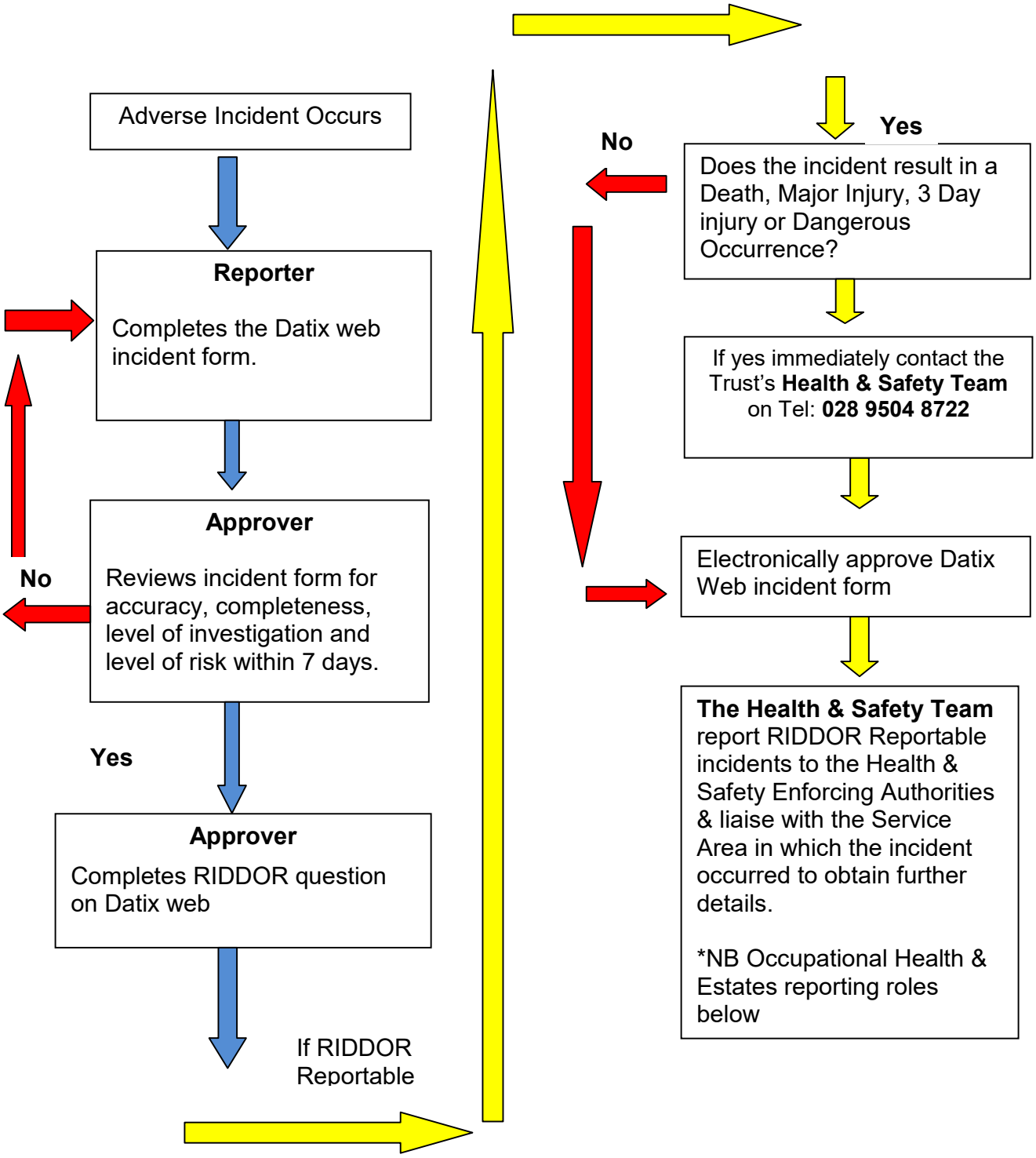
Dr Cathy Jack
Deputy Chief Executive/Medical Director

Date: 09/05/2018

Martin Dillon
Chief Executive/Medical Director

Appendix1

RIDDOR Reporting Flowchart



Occupational Health Service report all RIDDOR reportable Occupational Diseases/Conditions and Dangerous Occurrences relating to biological agents directly to the HSENI.

*If an Estates related **Dangerous Occurrence** immediately contact the **Estates Risk Manager** on Tel: 028 9504 8838 who reports such incidents under RIDDOR.

Appendix 2

HSENI Correspondence and Belfast Trust CEO Flowchart

EXTERNAL SOURCE (HSENI) TO THE BHSCT
RIDDOR and ANONYMOUS COMPLAINT INVESTIGATONS

Health & Safety Executive for NI (HSENI) sends correspondence to the Chief Executive's Office (CEO)
(These are often copied to Risk & Governance – but this process relates to actions to be taken by the primary addressee)

CEO forwards correspondence (via email) to **Lead / & Health & Safety Managers (H&SM)-** Health and Safety Partnered Arrangements **(on the Hub)**

↓

Risk & Governance Health and Safety Department

Action: Lead/Partnered Health & Safety Manager (directly liaise with Governance Manager / Senior Service Area Manager):

- Identify Directorate/Service Area affected / actions required
- Communicate actions required to identified Director
- Copy to relevant Co Director/Governance Mgrs/ASM +, Medical Director, Senior Manager Licensing & Regulation & Lead Health and Safety Mgr for information
- Confirm with the Directorate the commitment to meet the timeline for reply outlined by the HSENI

→ **Lead/Partnered Health & Safety Manager** acknowledges receipt to HSENI of the correspondence and confirms date for reply.

↓

Action by Lead Director/Responsible Lead & H&SM

- Identify 'Responsible Lead' within the Directorate.
- Where necessary: set up a group to prepare a response and consider any actions e.g. learning, change in practice with consideration to the date for reply.
- 'Responsible Lead' escalate as a matter of importance to Lead Director if timeline not being met and notify H&SM. H&SM liaise with the HSENI and informs Directorate accordingly.
- Partnered Health and Safety Manager to request a minimum of 2 updates from Responsible Lead to provide assurance the response is kept on track

↓

Action by Responsible Lead

Forwards formal response to partnered **Health &Safety Manager** approved by the Directorate at least **4 days before the agreed response time limit.**

↓

Action by Lead/Health and Safety Manager

H&SM forward response to Lead H&S Manager for review

Response forwarded to the **CEO 3 days of the agreed response time limit** by the **Lead/Partnered Health & Safety Manager.**

↓

Action: CEO sends formal response (signed by CEO) via email to the **HSENI in accordance with timescale.**
Copy: Medical Director, Directorate Director/ Co-Director, Governance Manager, Service Manager, Senior Manager Licensing & Regulation, Lead/ Partnered Health & Safety Manager.

NB Lead/ Partnered Health & Safety Manager attach relevant correspondence to the Datix record for the incident.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 42/08

Title:	**The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) policy**		
Author(s)	Philip Boyle, Health and Safety Manager Tel: [redacted] Regional Working Group		
Ownership:	Dr Chris Hagan, Medical Director		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	04 June 2020 10 June 2020
Operational Date:	June 2020	**Next Review:**	June 2025
Version No.	5 **Supersedes** V4 - May 2018		
Key Words	RIDDOR, incidents, dangerous occurrences, occupational diseases, conditions, absence management, over 3 day injury, major.		
Links to other policies	• BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 • General Health and Safety Policy (2018) TP 50/08 • BHSCT Policy & Procedural Arrangement for the Prevention and Management of Slips, Trips and Falls (2018) TP 69/11 • BHSCT Zero Tolerance Approach To The Prevention And Management Of Aggression & Violence Towards Staff In The Workplace (2019) TP 02/08 • BHSCT Management And Prevention Of Adult Inpatient Falls In A Hospital Setting (2020) SG 45/09 • BHSCT The Prevention & Management of Patient, Client and Service Users with Identified Choking Risks (2019) TP 106/17 • BHSCT The Control of Substances Hazardous to Health (COSHH) Trust Policy & Procedural Arrangements (2018) TP 35/08 • BHSCT Policy & Procedural Arrangements relating to the Prevention and Management of Latex Sensitisation (2018) TP 67/10 • BHSCT Safe Use of Bed Rails (2011) SG 09/08 • BHSCT Manual Handling Policy and Procedural Arrangements (2018) TP 34/08 • BHSCT Prevention of the spread of Blood Borne Virus (BBV) Infection and the Management of patients with BBV infection in the Department of Nephrology & Transplant (2016) SG 43/11		

Date	Version	Author	Comments
03/01/2018	4.1	Philip Boyle	3 year review and consultation. Policy revised to enhance the Managers, Health & Safety Managers and staff responsibilities section; "Major Injuries" section updated to reflect version in RIDDOR NI Regulations, reference to Patient Falls/ Bed Rails and Prevention and Management of Patient/Client and Service Users with Identified Choking Risks. Include

			an appendix on “HSENI Correspondence and Belfast Trust CEO Flowchart”
08/11/2018	4.2	Irene Low	RIDDOR policy was subject to a review by a Regional HSC Trusts. Comments from July 2018 consultation process
31/03/2020	4.3	Philip Boyle Laota McQuitty	Adapted Regional RIDDOR policy to the Belfast Trust and added appendices
28/05/2020	4.4	Laota McQuitty	Comments from Trust Wide Consultation detailed

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

The Belfast Trust (herein referred to as “The Trust”) recognises its statutory obligations under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997. RIDDOR relates to a defined process enshrined in law, which must be completed within a stipulated timeframe (ie within 10 days of the occurrence of specified “incidents”).

RIDDOR legislation requires employers to report certain types of injury, some occupational diseases and dangerous occurrences that *‘arise out of or in connection with work’* to either the Health Safety Executive Northern Ireland (HSENI) or the respective local authority. The regulations cover (in summary):

- Accidents which result in death of any person;
- Accidents which result in an employee (or self-employed person) suffering a major injury (See Appendix 1);
- Accidents which result in an employee (or self-employed person, eg self-employed contractor) being absent from work or unable to undertake their normal duties for more than three days following the date of the incident (including nights);
- Accidents which result in a person not at work (eg patient, service user, visitor) suffering an injury (eg as a result of an incident/accident within Trust premises) and being taken to hospital (or if the accident happens at a hospital, suffering a major injury which would otherwise have required hospital treatment);
- Specified dangerous occurrences (See Appendix 2), which may not result in a reportable injury but have the potential to do significant harm (eg collapse, overturning or failure of load-bearing parts of lifts and lifting equipment);
- An employee (or self-employed person) suffering from a specified work related disease (See Appendix 3).

1.2 Failure to report a reportable injury, dangerous occurrence, or disease in accordance with the requirements of RIDDOR, is a criminal offence, and may result in prosecution. Reporting an incident is not an admission of liability.

The prompt and accurate reporting of all such incidents is therefore essential in ensuring that the Trust fulfils its legal obligations and in turn avoids potential prosecution for failure to comply with the aforementioned legislation. The Trust aims to comply with RIDDOR legislation and to submit timely returns to the appropriate enforcing authorities

1.3 Intrinsic to this is an onus on all staff members to ensure that fully completed incident report forms are completed and approved on the Trust incident reporting system within 7 days following an incident. In the event of a major injury or fatality, the Trust Health & Safety Department **must be notified immediately** by telephone.

1.4 Purpose

This policy has been developed to meet the statutory requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) which sets out the need to have a system of formal reporting of specified incidents to the appropriate enforcing authority (ie the relevant District Council and/or the Health & Safety Executive for Northern Ireland). This policy also aims to give assurance to the Trust Board of continued statutory compliance with regards to the above listed legislation. This document is intended to provide managers and staff with guidance on RIDDOR reportable incidents. It contains details of the types of incidents that are RIDDOR reportable and the methods by which they should be reported (See Appendices 1, 2, 3, 4).

1.5 Objectives

The objective of this policy is to ensure that all managers and staff are aware of their responsibilities under the RIDDOR Regulations.

2.0 SCOPE OF THE POLICY

2.1 This policy provides guidance on the arrangements for the reporting and management of incidents under RIDDOR within the Trust's owned, leased or managed premises/property and when its staff (staff for the purposes of this policy will include Bank staff), self-employed persons and Contractors are working within the remit of their employment (including whilst volunteering) for the Trust, patients/clients and members of the public. .

2.2 The Trust recognises that some staff may be required, as part of their employment, to work at locations outside of Trust premises (eg Peripatetic working in the community). Such working also falls within the remit of this policy and is reportable under RIDDOR legislation.

2.3 Incidents involving agency workers should be reported by their respective agency to the HSENI. The Health & Safety team will discuss Agency worker RIDDOR reportable incidents with the Service Area Manager who will be requested to notify the Agency. If there is no confirmation that the Agency will report to the HSENI, the Health & Safety team will complete the RIDDOR form to the HSENI.

3.0 ROLES & RESPONSIBILITIES

3.1 **Risk & Governance Department:** Will review all incident report forms on a regular basis and the Health & Safety and Estates will undertake to report incidents which are subject to RIDDOR to the Health & Safety Executive, Northern Ireland (HSENI) in compliance with the regulations using the relevant extant pro formas. It is the responsibility of Health & Safety and Estates to complete and submit this form through the HSENI on-line system and it is included within this policy for reference purposes only. It should be noted that since 1 April 2013, employers have the option to report all work related incidents to HSENI, regardless of which jurisdiction (and local enforcing authority area) the incident occurred in.

3.2 **Managers (Approving Managers):** It is the responsibility of all managers to ensure that incident report forms are completed and approved on the Trust's incident reporting system, submitted to Risk & Governance Department and that any death, major injury and dangerous occurrence incidents are communicated to the Health & Safety department by the fastest possible means (e.g. telephone). It is essential that all parts of the incident report forms are completed in their entirety.

3.3 **Staff**: It is the responsibility of all staff to ensure that incident reports are completed promptly and that all parts of the incident report are completed in their entirety.

3.4 It should be noted that reporting to the HSENI as a requirement under RIDDOR is a function of the Health & Safety and Estates and should not be undertaken at local level.

3.5 Health and Safety Managers:
To liaise with HSENI and the Service Area in relation to the subsequent incident investigation following the procedure outlined in Appendix 6.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

4.1.1 RIDDOR: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

4.2 Guidance Notes – General Points

4.2.1 All incidents must be reported as soon as practicable to Risk & Governance Department. This must typically be no later than the next working day following the incident.

4.2.2 These forms will be evaluated by the Risk & Governance Department in order to decide whether they meet the reporting requirements under RIDDOR.

4.2.3 If applicable the Health & Safety and Estates will complete form NI2508 and submit it to the appropriate enforcing authority. This is completed via the HSENI On-line reporting system.

4.2.4 All incidents and associated reporting are recorded in the Trust's Datix database. Records of all RIDDOR reportable incidents are maintained by the Risk & Governance Department or a period of ten years (in accordance with The Trust's Retention & Disposal Schedule).

4.2.5 All RIDDOR reportable incidents will be subject to an investigation.

4.3 Incident types which must be reported

4.3.1 Death or Major Injury (Appendix 1)

If there is an accident connected with the workplace and a staff member, patient/client or self-employed person working on Trust premises is killed or suffers a major injury (including as a result of physical violence); or there is an accident connected with the workplace and a member of the public is killed or taken to hospital; then the HSENI must be notified without delay (e.g. telephone). Within 10 days of the incident, a completed NI2508 form must be sent to the HSENI as required under RIDDOR legislation. Both of these actions

will be carried out by Health & Safety and Estates upon the incident being reported to them by the respective manager concerned.

In the event of an incident involving a contractor the employer will report the incident to the enforcing authority and notify the Trust of the incident.

4.3.2 Over 3 Day Injury

If there is an accident connected with work (including as a result of physical violence) and a staff member or self-employed person working on Trust premises, or within the remit of their employment, suffers an injury which prevents them from carrying out their duties for more than 3 days, a completed report form, NI2508, must be sent to the enforcing authority within 10 days by Health & Safety Department staff. This type of injury is not classified as major but results in the injured person being away from work or unable to conduct their normal duties for more than three days (including non-work days but not including the day on which the incident occurred). **If an injury is detected subsequent to an incident report being submitted, (which gives rise to the aforementioned absence from work) it is the responsibility of the manager of the facility where the incident occurred to provide details of the injury (via email, providing incident report number) to the [Health & Safety Department].**

In the event of an incident involving a contractor the employer will report the incident to the enforcing authority and notify the Trust of the incident.

4.3.3 Dangerous Occurrence (Appendix 2)

If an incident occurs which does not result in a reportable injury, but clearly could have done, then it may constitute a dangerous occurrence (see examples in Appendix 2) and must therefore be reported without delay (e.g. telephone) and supplemented by a notification to the HSENI within 10 days (using form NI2508). This action is carried out by the Health & Safety and Estates. This is completed via the HSENI Online system.

If the Health and Safety Department is notified by a doctor (eg GP or Occupational Health) that a staff member suffers from a contaminated blood born virus (BBV) biological Hazard group 3 or 4 needlestick injury** (*eg hepatitis B or C or HIV*) the Health and Safety managers must then complete a NI2508 form and forward to the HSENI.

4.3.4 Disease** (Appendix 3)

If the Health and Safety Department is notified by a doctor (eg GP or Occupational Health) that a staff member suffers from a reportable, work related disease (e.g. dermatitis, a sharps injury and a BBV acquired by this route sero-converts), the Health and Safety managers must then complete a disease report form NI2508A and forward to the HSENI. (This form is available online and can be accessed as necessary).

** Sharing of information with the Health and Safety Executive NI for legal RIDDOR requirement on Disease and Dangerous Occurrence biological Hazard Group 3 or 4 is detailed in Occupational Health Privacy Notice.

See Patient/Service User Falls and Choking Incidents for guidance in Appendix 4.

See RIDDOR reporting flowchart for further guidance in Appendix 5.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

5.1.1 This policy is applicable to all staff within the Trust. This policy will be made available to all staff via the Trust's intranet site.

5.2 Resources

5.2.1 Training on the application of this policy for relevant managers and staff will be facilitated and delivered by the Trust's Risk & Governance Department as part of wider training on incident reporting.

5.3 Exceptions

5.3.1 There are no service areas exempt from the operation of this policy.

6.0 MONITORING

It is the responsibility of the Health & Safety Department to monitor the implementation of and assess the level of compliance with this policy.

7.0 EVIDENCE BASE/REFERENCES

- Health & Safety at Work (NI) Order 1978
- RIDDOR (NI) 1997
- NI2508 Report Form
- NI2508A Report Form
- Health & Safety Executive "A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995" (L.73)
- Health Services Information Sheet No 7 (revision 3), 1 October 2013 - Reporting Injuries Diseases and Dangerous Occurrences in Health & Social Care – Guidance for Employers
- Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland. March 2013

8.0 CONSULTATION PROCESS

Via the Regional Working Group on Adverse Incidents consultee list.

The policy has been developed in consultation with the Trust's Occupational Health Service, Health & Safety Team, Risk & Governance Department Estates Department and members of the Joint Health & Safety Committee.

Consultation with employees and their trade union representatives is a legal requirement, ref: Health & Safety (Consultation with Employees) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

9.0 APPENDICES/ATTACHMENTS

Appendix 1 – Definitions of Major Injuries
Appendix 2 – Reportable Dangerous Occurrences
Appendix 3 – Reportable Diseases
Appendix 4 – Examples of Patient/Service User Falls and Choking Incidents
Appendix 5 – RIDDOR Reporting Flowchart
Appendix 6 – HSENI Correspondence and Belfast Trust CEO Flowchart

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. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

09 June 2020

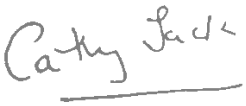
_____ **Date:** _____

Name: Philip Boyle
Title: Lead Health & Safety Manager

10 June 2020

_____ **Date:** _____

Name: Chris Hagan
Title: Medical Director



10 June 2020

_____ **Date:** _____

Name: Dr Cathy Jack
Title: Chief Executive

Appendix 1

DEFINITIONS OF MAJOR INJURIES

Reportable major injuries are:

- Fracture other than to fingers, thumbs or toes;
- Amputation;
- Dislocation of the shoulder, hip, knee or spine;
- Loss of sight (temporary or permanent);
- Chemical or hot metal burn to the eye or any penetration injury to the eye;
- Injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- Unconsciousness caused by asphyxia or exposure to harmful substances or biological agent;
- Acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material;
- Any other injury leading to hypothermia, heat induced illness or to unconsciousness, or requiring admittance to hospital for more than 24 hours;
- Acute illness requiring medical treatment or loss of consciousness which results from the absorption of any substance by inhalation, ingestion or through the skin.

Further information in respect of Appendices 1, 2 and 3 is available at https://www.hseni.gov.uk/publications/riddor-guidance - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997

Appendix 2

REPORTABLE DANGEROUS OCCURRENCES

[Note – each Trust to modify this list as they wish ie, consider excluding non-healthcare related dangerous occurrences]

- Collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
- Explosion, collapse or bursting of any closed vessel or associated pipework;
- Failure of any freight container in any of its load-bearing parts;
- Plant or equipment coming into contact with overhead power lines;
- Electrical short circuit or overload causing fire or explosion;
- Any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;
- Accidental release of a biological agent likely to cause severe human illness;
- Failure of industrial radiography or irradiation equipment to de-energise or return to its safe position after the intended exposure period;
- Malfunction of breathing apparatus while in use or during testing immediately before use;
- Failure or endangering of diving equipment, the trapping of a diver, an explosion near a diver, or an uncontrolled ascent;
- Collapse or partial collapse of a scaffold over 5 meters high, or erected near water where there could be a risk of drowning after a fall;
- Unintended collision of a train with any vehicle;
- Dangerous occurrences at a pipeline;
- Failure of any load-bearing fairground equipment, or derailment or unintended collision of cars or trains;
- A road tanker carrying a dangerous substance overturns, suffers serious damage, catches fire or the substance is released;
- A dangerous substance being conveyed by road is involved in a fire or released.

The following dangerous occurrences are reportable except in relation to offshore workplaces:

- Unintended collapse of: any building or structure under construction, alteration or demolition where over 5 tonnes of materials fall; a wall or floor in a place of work; any false work;

- Explosion or fire causing suspension of normal work for over 24 hours;

- Sudden, uncontrolled release in a building of : 100kg or more of flammable liquid; 10kg of flammable liquid above its boiling point; 10kg or more of flammable gas; or of 500kg of these substances if the release is in the open air;

- Accidental release of any substance, which may damage health.

Appendix 3

REPORTABLE DISEASES

1. Occupational Diseases

Conditions due to physical agents and physical demands of work

- Inflammation, ulceration or malignant disease of the skin due to ionising radiation;
- Malignant disease of the bones due to ionising radiation;
- Blood dyscrasia due to ionising radiation;
- Decompression illness;
- Barotrauma resulting in lung or other organ damage;
- Dysbaric osteonecrosis;
- Cramp of the hand or forearm due to repetitive movements. *Activity – work physically involving prolonged periods of handwriting, typing or other repetitive movements of the fingers, hand or arm;*
- Subcutaneous cellulitis of the hand (beat hand). *Activity – physically demanding work causing severe or prolonged friction or pressure on the knee;*
- Bursitis or subcutaneous cellulites arising at or about the knee due to severe or prolonged external friction or pressure at or about the elbow (beat elbow*). Activity – physically demanding work causing severe or prolonged friction or pressure on the elbow;*
- Traumatic inflammation of the tendons of the hand or forearm or of the associated tendon sheaths. *Activity – physically demanding work, frequent or repeated movements, constrained postures or extremes of extension or flexion of the hand or wrist;*
- Carpal tunnel syndrome. *Activity – work involving the use of hand-held vibrating tools;*
- Hand-arm vibration syndrome. *Activity – work involving:-*
    - The use of chain saws, brush cutters or hand-held or hand-fed circular saws in forestry;
    - The use of hand-held rotary tools in grinding material or in sanding or polishing metal;
    - The holding of material being ground or metal sanded or polished by rotary tools;
    - The use of hand-held percussive metal working tools or the holding of metal being worked upon by percussive tools in connection with riveting, caulking, chipping, hammering, fettling or swaging;
    - The use of hand-held powered percussive drills or hand-held powered percussive hammers in mining, quarrying or demolition, or on roads or footpaths (including road construction);

- The holding of material being worked upon by pounding machines in shoe manufacture.

2. Conditions due to biological agents

- Anthrax
- Brucellosis
- Avian Chlamydiosis
- Ovian Chlamydiosis
- Hepatitis
- COVID-19
- Legionellosis
- Leptospirosis
- Lyme disease
- Q fever
- Rabies
- Streptococcus suis
- Tetanus
- Tuberculosis
- Poisonings
    - Acrylamide monomer
    - Arsenic or one of its compounds
    - Benzene or a homologue of benzene
    - Beryllium or one of its compounds
    - Cadmium of one of its compounds
    - Carbon Disulphide
    - Diethylene dioxide
    - Lead or one of its compounds
    - Manganese or one of its compounds
    - Mercury or one of its compounds
    - Methyl bromide
    - Nitrochlorobenzene, or a nitro –or amino- or chloro-derivitive of benzene or a homologue of benzene
    - Oxides of nitrogen
    - Phosphorous or one of its compounds

- Cancer of a bronchus or lung
- Primary carcinoma of the lung
- Cancer of the urinary tract
- Bladder cancer
- Angiosarcoma of the liver
- Peripheral neuropathy
- Chrome ulceration
- Follicilitis
- Acne
- Skin cancer
- Pneumoconiosis
- Byssinosis
- Mesothelioma

- Lung Cancer
- Asbestosis
- Cancer of the nasal cavity or associated air sinuses
- Occupational dermatitis
- Extrinsic Alveolitis
- Occupational Asthma

Appendix 4

Patient/Service User Falls and Choking Incidents

Please refer to the Trust's Patient Falls & Bed Rails Policies

In the event of a death or major injury arising due to a patient/service user fall or choking incident, in connection with the Trust's work activities and it could have been prevented through risk assessment, identifying and implementing control measures or failure to do any of these, this should be reported under RIDDOR.

- A patient fall incident would be reportable if:-

    - The fall protection measures identified in the falls assessments were not in place at the time of the incident including arrangements for supervision, assistance, access to call and use of mobility aids etc;
    - There was an environmental factor which may have contributed to the fall for example defective flooring, wet floors, housekeeping issues etc.

Examples of Patient Falls:

- A confused patient falls from a hospital window on an upper floor and is badly injured;
- A service user falls in the lounge area, there is previous history of fall incidents, but reasonably practicable measures to reduce the risks have not been put in place;
- A service user falls out of bed, is injured and taken to hospital. The assessment identified the need for bedrails but they, or other preventative measures, had not been provided;
- A service user trips over a loose or damaged carpet in the hallway.

(Source: HSE Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers Health Services Information Sheet No 1 (Revision 3).

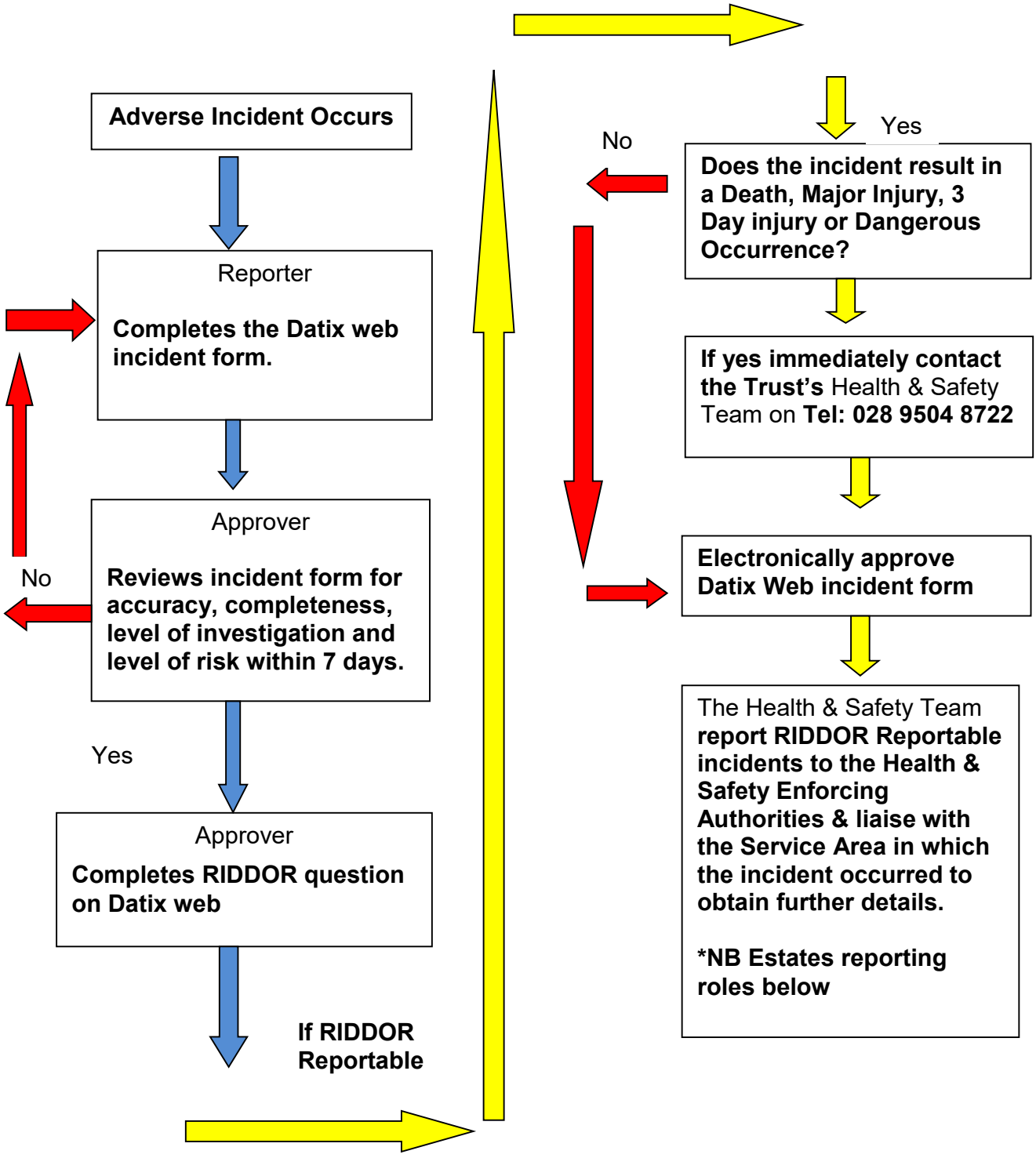
Patient Choking

Please refer to the Trust's policy on The Prevention & Management of Patient, Client and Service Users with Identified Choking Risks.

- A patient choking incident would be RIDDOR reportable if measures in place at the time of the incident as per patient assessment were not in place for example supervision at meal times, personal placemat, safe eating strategies and staff training in swallowing, eating, drinking assessments.

Appendix 5

RIDDOR Reporting Flowchart



***If an Estates related** Dangerous Occurrence **immediately contact the** Estates Risk Manager **on Tel: 028 9504 8838 who reports such incidents under RIDDOR.**

Appendix 6

HSENI Correspondence and Belfast Trust CEO Flowchart

EXTERNAL SOURCE (HSENI) TO THE BHSCT
RIDDOR and ANONYMOUS COMPLAINT INVESTIGATONS

Health & Safety Executive for NI (HSENI) sends correspondence to the Chief Executive's Office (CEO)
(These are often copied to Risk & Governance – but this process relates to actions to be taken by the primary addressee)

CEO forwards correspondence (via email) to Lead / & Health & Safety Managers (H&SM)- Health and Safety Partnered Arrangements (on the Hub)

Risk & Governance Health and Safety Department

Action: Lead/Partnered Health & Safety Manager (directly liaise with Governance Manager / Senior Service Area Manager):

- **Identify Directorate/Service Area affected / actions required**
- **Communicate actions required to identified Director**
- **Copy to relevant Co Director/Governance Mgrs/ASM +, Medical Director, Deputy Medical Director, Risk & Governance Co Director, Corporate Risk and Standards Senior Manager, & Lead Health and Safety Mgr for information**
- **Confirm with the Directorate the commitment to meet the timeline for reply outlined by the HSENI**

Lead/Partnered Health & Safety Manager acknowledges receipt to HSENI of the correspondence and confirms date for reply.

Action by Lead Director/Responsible Lead & H&SM

- **Identify 'Responsible Lead' within the Directorate.**
- **Where necessary: set up a group to prepare a response and consider any actions e.g. learning, change in practice with consideration to the date for reply.**
- **'Responsible Lead' escalate as a matter of importance to Lead Director if timeline not being met and notify H&SM. H&SM liaise with the HSENI and informs Directorate accordingly.**
- **Partnered Health and Safety Manager to request a minimum of 2 updates from Responsible Lead to provide assurance the response is kept on track**

Action by Responsible Lead

Forwards formal response to partnered Health &Safety Manager approved by the Directorate at least 4 days before the agreed response time limit.

Action by Lead/Health and Safety Manager

Lead H&SM forward response to Corporate Risk and Standards Senior Manager and Co-Director for review.

Response forwarded to the CEO 3 days of the agreed response time limit by the Lead/Partnered Health & Safety Manager.

Action: CEO sends formal response (signed by CEO) via email to the HSENI in accordance with timescale. Copy: Directorate Director/ Co-Director, Governance Manager, Service Manager, Medical Director, Deputy Medical Director, Risk & Governance Co Director, Corporate Risk and Standards Senior Manager, Lead/ Partnered Health & Safety Manager.

NB Lead/ Partnered Health & Safety Manager attach relevant correspondence to the Datix record for the incident

IHRD Implementation Plan

Workstream Brief

Workstream 5:

Serious Adverse Incidents

WORKSTREAM BRIEF

Programme Workstream: IHRD Implementation Programme
5 - Serious Adverse Incidents

Document Information

Author:	Patricia Donnelly / Fergal Bradley
Owner:	Richard Pengelly, SRO
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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

SERIOUS ADVERSE INCIDENTS

Contents

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   1.2 IHRD Report summary
   1.3 Objectives
   1.4 Authority

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   2.2 Implementation Programme Director
   2.3 Implementation Programme Manager
   2.4 Implementation Programme Management Group
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   2.6 Role of Workstream Chair
   2.7 Serious Adverse Incidents -Workstream 5

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   3.1 Terms of reference
   3.2 Membership
   3.3 Administrative arrangements
   3.4 Reporting

4. Governance

5 Appendices:
   5.1 Action Plan Matrix for report reference and programme workstreams
   5.2 Workstreams and delegated tasks
   5.3 Workstream membership

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

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

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 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.

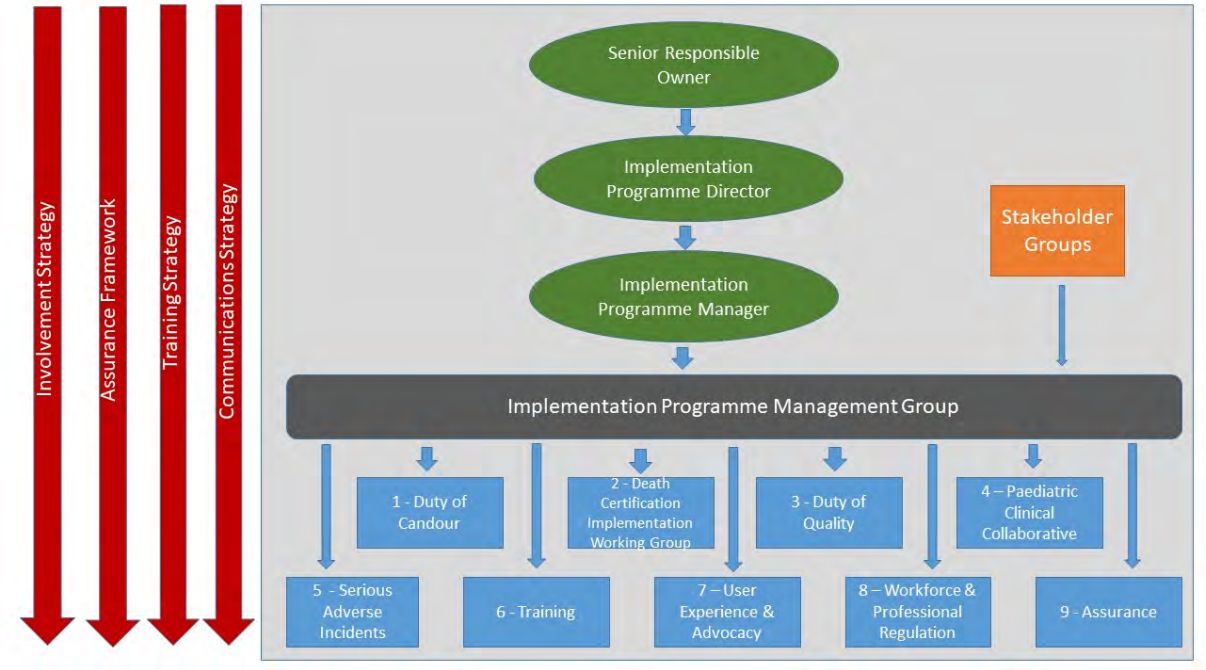
1.4 Authority for the Programme

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. He will provide regular reports to the SRO. 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 the 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 Implementation Working Group	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.

[5] Appendix 5.2: IHRD Action Plan Matrix

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

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
- Develop a **Work Plan** for the implementation of delegated Inquiry Report Recommendations
- Develop 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 5 Serious Adverse Incidents (SAI) is to implement 18 actions from 10 IHRD recommendations as set out below:

Table 1: IHRD Recommendation delegated to Workstream 5 - SAI

IHRD Number	Workstream Action	Recommendation
31	1	**SAI Reporting:** Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').
33	2	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.
37 (i)	3	**SAI Investigation:** Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.
37 (ii)	4	(ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.
37 (iii)	5	(iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.
37 (v)	6	(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.
37 (vi)	7	(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.
37 (vii)	8	(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.
37 (viii)	9	(viii) Family GPs should, with family consent, receive copies of feedback provided.
37 (ix)	10	(ix) Families should be formally advised of the lessons learned and the changes effected

IHRD Number	Workstream Action	Recommendation
37 (x)	11	(x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation
38	12	Investigations should be subject to multi-disciplinary peer review.
39	13	Investigation teams should reconvene after an agreed period to assess both investigation and response.
42	14	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.
66	15	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.
82	16	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.
83	17	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.
91	18	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.

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[6]

[6] 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 18 specific actions (as set out in section 2.8) arising from 10 recommendations from the IHRD report and to report to the Implementation Programme 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 5: Serious Adverse Incidents

Chair: Conrad Kirkwood

Members: Appendix 5.3

3.3 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. These include 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 in order 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's 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 in order 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.

3.4 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.

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		Vol 2, Chapter 5: Section 5.122 (ii) Page 140	**4-Paediatric/Clinical Collaborative**

	Ref	RECOMMENDATION	Report Reference	Workstream
		The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can 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		Vol 1, Chapter 3: Section 3.61 Page 143	**4-Paediatric/Clinical Collaborative**

	Ref	RECOMMENDATION	Report Reference	Workstream
		Children's ward rounds should be led by a consultant and occur every morning and evening		*Linked to:* *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**

	Ref	RECOMMENDATION	Report Reference	Workstream
	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** *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 - INVES	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

	Ref	RECOMMENDATION	Report Reference	Workstream
				5-SAI
	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:*

	Ref	RECOMMENDATION	Report Reference	Workstream
				3-Duty of Quality *7-User experience*
		(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:*

	Ref	RECOMMENDATION	Report Reference	Workstream
				3-Duty of Quality *6-Training*
	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*

	Ref	RECOMMENDATION	Report Reference	Workstream
				6-Training
	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**

	Ref	RECOMMENDATION	Report Reference	Workstream
				Linked to: *6-Training*
	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: (i) 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*
		(ii) 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 (i) 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*
		(ii) 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
		(iii) 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: (i) 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*
		(ii) 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	Organisation
Conrad Kirkwood	Department of Health

Members

Name	Organisation
Anne Kane	Health & Social Care Board
Sinead O'Kane	Northern Health & Social Care Trust
Claire Cairns	Belfast Health & Social Care Trust
Brendan Mullen	Mental Health DRO/Investigation
Denise Boulter	Public Health Agency
Jacqui Burns	Health & Social Care Board
Marian Thompson	Service User
Mr Tom Hughes	Service User
Mrs Linda Hughes	Service User
Dr Catherine O'Mullan	Western Health & Social Care Trust
Stephanie Lowry	Health & Social Care Board
Richard Dixon	Patient Client Council

The Regulation and Quality Improvement Authority

RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland

June 2022

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Health and Social Care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors who are either experienced practitioners or experts by experience. RQIA reports are submitted to the Department of Health (DoH) and are available on the RQIA website at www.rqia.org.uk.

Acknowledgements

RQIA wishes to thank all those who facilitated this review by participating in discussions, meetings, surveys and by providing relevant information.

Membership of the Expert Review Team

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Dr David Evans	Former Medical Director and Interim Chief Executive Northumbria Healthcare National Health Service Foundation Trust, England.
Dr Lourda Geoghegan	Former Director of Improvement and Medical Director, Regulation and Quality Improvement Authority (role in review ceased March 2020)
Emer Hopkins	Director of Hospital Services, Independent Healthcare, Audit and Reviews, RQIA (role in review commenced March 2020)
Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority.
Mrs Vivien Jess	Lay Representative and Independent Expert Advisor to the review
Mr Brian O'Hagan	Lay Representative and Independent Expert Advisor to the review
Dr Richard Wright	Former Medical Director of Southern Health and Social Care Trust and Professional Medical Advisor, Regulation and Quality Improvement Authority.

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Glossary of Terms

Belfast Trust	Belfast Health and Social Care Trust
CAMHS	Children and Adolescent Mental Health Services
CQC	Care Quality Commission
DoH	Department of Health
DRO	Designated Review Officer
HSC	Health and Social Care
HSCB	Health and Social Care Board
IHRD	Inquiry into Hyponatraemia-related Deaths
Multidisciplinary	Involving professionals from different disciplines who have different professional skills, expertise and experience.
NIAS	Northern Ireland Ambulance Service
Northern Trust	Northern Health and Social Care Trust
PCC	Patient Client Council
PHA	Public Health Agency
PPI	Personal and Public Involvement
RCA	Root Cause Analysis
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
SPPG	Strategic Performance and Planning Group (formerly Health and Social Care Board)
Western Trust	Western Health and Social Care Trust

Foreword

This Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland resulted from the independent Public Inquiry led by Justice O'Hara which investigated the deaths of five children in hospitals in Northern Ireland. After hearing evidence from a wide range of individuals and organisations, it concluded that deaths had been avoidable and that the culture of the health service at the time, arrangements in place to ensure the quality of services and behaviour of individuals had contributed to those unnecessary deaths.

A key finding of the Public Inquiry was that the internal investigations into the deaths and their surrounding circumstances were inadequate. They had failed to identify the underlying causes. It also found that, as guidance on fluid management on children became available, it was not disseminated and actioned effectively across the Health and Social Care (HSC) system.

The reality is that similar situations, where events leading to harm have been inadequately investigated and examples of recognised good practice have not been followed, have been, and are likely to be repeated in current practice.

Such inadequacies bring distress and suffering to the individuals affected and their loved ones; and the staff whose efforts to provide good and safe care are undermined.

Serious Adverse Incident (SAI) reviews are a fundamental part of how the whole system should learn from harm, and make improvements to Health and Social Care services in Northern Ireland.

This Review, commissioned by the Department of Health (DoH), in its response to the recommendations of the Inquiry, and undertaken by the RQIA, has assessed the effectiveness of the current SAI process.

It has been one of our most significant Reviews, which has benefited from engagement with a wide range of individuals, organisations and groups across the Health and Social Care system.

We would especially like to thank all families who contributed to the Review, as their experience of the reality from a patient and family perspective has been a key feature in shaping the Review's findings.

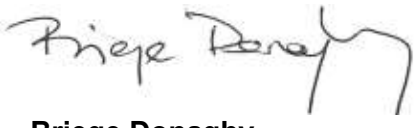
The Expert Review Team found that neither the SAI review process nor its implementation is sufficiently robust to consistently enable an understanding of what factors, both systems and people, have led to a patient or service user coming to harm.

HSC leaders and managers must work to make sure that if something goes wrong, all staff are confident to speak up, through a competent and independent review process, knowing that doing so will help them keep their patients and service users safe and improve the quality of care they are able to deliver.

Patients and service users, and their loved ones and advocates, must be able to take part freely and fully in the process, so they find out what happened and can help make sure it won't happen again.

On behalf of RQIA, we hope that the recommendations in this Review, which have been produced with the assistance of a wide range of patients, service users, families, clinicians and managers from across HSC, will be accepted, implemented fully, and drive improvement in safety and quality throughout the system.

Christine Collins MBE
Chair



Briege Donaghy
Chief Executive

Executive Summary

Background and Context

Serious Adverse Incident (SAI) reviews are a fundamental component of how we learn from harm and subsequently make improvements to the systems for the delivery of safe patient care. Regional guidance for the reporting and follow-up of SAIs in Northern Ireland has been in place since 2004. However, over the last decade, the SAI process and its implementation has come under scrutiny both regionally and nationally. Concerns have been raised around the current procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs) in Northern Ireland (November 2016)[1] (here-after the SAI procedure). It has also been highlighted that there is a clear need for improvement in terms of how patients, their families and staff are engaged in reviews and how subsequent learning is derived and implemented. These issues are not unique to Northern Ireland or indeed the United Kingdom. Ensuring the effective implementation of SAI reviews and subsequent learning is a considerable undertaking. Not only does the procedure itself need to be robust, but its effective application necessitates an open and supportive learning culture with SAI reviewers who are trained in the necessary skill set to undertake effective SAI reviews.

In April 2018, the Regulation and Quality Improvement Authority (RQIA) was commissioned by the Department of Health (DoH) to examine the application and effectiveness of the SAI procedure. Terms of Reference for this review were approved by the Department of Health in October 2019 and fieldwork on this review concluded in January 2021. The time taken to complete and publish this review has been significantly impacted by the system response to Covid-19 Pandemic.

Terms of Reference

The terms of reference for this review, as agreed with the DoH, were as follows:

1) To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAIs) across the six Health and Social Care (HSC) Trusts, the HSCB and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

2) To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.

3) To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.

4) To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.

5) To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.

6) To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.

7) To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.

8) To assess the level of professional support provided to (i) staff who were delivering care at the time of the SAIs, as well as (ii) staff conducting the review of the SAIs.

9) To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response to SAIs, their assessment and review, and the learning arising through these processes.

Methodology

The Expert Review Team developed a methodology specific to this review incorporating extensive engagement with a range of key individuals and organisations and patients their relatives and representative groups. Focus Groups and individual interviews were undertaken. The engagement was supported by the development of a number of semi-structured questionnaires. An important aspect of this review was the undertaking of a rigorous assessment of 66 serious adverse incident reports from all HSC Trusts in Northern Ireland.

Findings

The Expert Review Team determined that the current SAI procedure and its implementation in Northern Ireland **does not** support:

- Fulfilment of the statutory duty of Personal Public Involvement as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.
- Reasonable application of the principles of effective SAI review practice.
- Confidence in the independence of chairs of SAI reviews at Level 2, or Level 3. Particularly in the case of Level 3 reviews, where the appointed chair is a former employee of an HSC Trust.
- Accountability of Health and Social Care organisations for:

    - decisions made regarding the level of review conducted
    - involvement and engagement with a patient and/or relatives
    - the quality of the review conducted and the acceptance of its findings and approval processes
    - evidencing that HSC Trust services have improved and are safer because of the reviews conducted
    - ensuring that issues requiring regional action to improve safety are appropriately identified and then escalated to the right people in the right organisations

- The formulation of evidence-based recommendations.
- The design of action plans that will enhance the safety and quality of healthcare provision across the region both in the short and longer term.
- The production of SAI review reports that are well-formulated, evidence-based and readable.

The Expert Review Team identified a number of reasons for this:

- The implementation of the SAI procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently conducting these reviews to a high standard.
- There was an absence of clear regional guidance on how to execute Personal Public Involvement duties and in relation to patient rights as part of an SAI review.
- There was no regional patient safety training strategy and curriculum.
- There were not clearly defined competencies required of lead investigating officers and SAI review panel chairs.
- There were not sufficient numbers of trained independent advocates for families and patients.
- There was a lack of effective training in how to execute an effective and meaningful SAI review.
- Furthermore, even where training had been delivered, the appointed chair or review leads, they did not always have sufficient authority to independently devise a review plan that fully delivers the required quality of review.
- There were also a large number of reviews identified as requiring an in-depth review but which did not require this, which was creating an unsustainable work pressure within the system.

The conclusion of the Expert Review Team is that current practice for reviewing and learning from SAIs in Northern Ireland is not achieving the intended purpose of the SAI procedure. Improving this situation will require both the SAI procedure and the system in which it operates to be re-designed.

Summary of Recommendations

The following recommendations are made to support the delivery of a new regional policy/procedure for reporting, investigating and learning from adverse events.

Number	Recommendation	Priority
1	The Department of Health should work collaboratively with patient and carer representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.	**2**

2	Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.	**3**
3	The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.	**3**
4	The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by 'just culture' principles and a clear evidence-based framework that delivers measurable and sustainable improvements.	**3**
5	The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.	**3**

Key Benefits

The Expert Review Team concluded that, should these recommendations be fully implemented and embraced by the Health and Social Care system in Northern Ireland, they would deliver the following key benefits:

- A clear regional framework which provides for learning from unexpected harm.
- Greater flexibility in the SAI review process, which is aligned to international best practice and allows a better opportunity for learning and safety improvement.
- A single, new report template and regional style guide that supports consistency across the region but is flexible enough to allow reviewers to add and remove sections as required.
- A lower number of in-depth Root Cause Analysis (RCA) reviews, where early case assessment shows that this level of review is not required or proportionate.
- Increased capacity within HSC to deliver structured, in-depth reviews, where early assessment indicates this is necessary.
- An appropriate amount of time to conduct a review well and involve patients and families in a way that is meaningful.
- A review process that does not cause further harm to patients, their families or staff.
- A culture of safety, openness and compassion.

1.0 Background and Context

1.1 Introduction

Health and Social Care services are used extensively across Northern Ireland daily, and most patients and their families are satisfied with their care. However, it is inevitable that some will not have a satisfactory experience while others may even experience harm. When harm occurs, there is a moral, ethical and professional duty on those involved in the delivery of care to review what happened.

When such an incident is identified, the process of reviewing an event in an effort to learn is known as an Adverse Incident (AI) review, and some will warrant a Serious Adverse Incident (SAI) review. The SAI review aims to:

- Determine if any element of the care delivery or treatment plan contributed to the harm and any underlying systemic reasons for this.
- Ensure that the necessary improvements are made to the standard of care delivered and to the underlying systems and processes that support patient safety.
- Facilitate the recovery of the patient and their family from the harming experience, so that reconciliation can occur, including continuing trust in the Health and Social Care services.

Fundamental to achieving these aims is a clear, regionally agreed approach to identifying, reporting, reviewing and learning from incidents of harm, including serious near-miss events or apparent near-miss events. Furthermore, this approach must be clearly articulated within policies and procedures.

Throughout this report, the term 'patient and family' is used to represent those that would fall under the category of patient, service user, carer, family, or family member. The Expert Review Team recognises that users of mental health and learning disability services are normally referred to as service users rather than patients.

1.2 Context

Regional guidance for the reporting and follow-up of SAIs has been in place in Northern Ireland since 2004. Over the last decade, the SAI process has come under scrutiny both regionally and nationally. Following the Public Inquiry into Mid-Staffordshire NHS Foundation Trust in 2014[2] the Chief Medical Officer in Northern Ireland wrote to HSC Trusts to remind them of their statutory duty in relation to the review and reporting of SAIs. This correspondence outlined a need for candour alongside meaningful engagement with patients and their families when incidents of harm have occurred.

The Donaldson Report in 2014[3] highlighted concerns around the reporting of adverse incidents, ineffective processes for review, lack of expertise amongst reviewers (particularly in relation to human factors) and a failure for learning to translate into improvements in systems and patient safety. Donaldson also outlined

a need for a 'just culture' for healthcare staff participating in SAI reviews, in addition to a need for candour and openness with patients and families.

In 2018, Justice O'Hara published his long-awaited inquiry report; Hyponatraemia-related Deaths (IHRD) in Northern Ireland[4]. It called for a statutory duty of candour and made a number of recommendations in relation to reporting, investigating and sharing of learning from SAIs, including a need to increase the involvement of families in these processes. This served to further highlight a need for a review of the regional procedure for SAI reviews in Northern Ireland.

In April 2018, the RQIA was commissioned by the Department of Health (DoH) to examine the effectiveness of the current procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs) (November 2016) and its implementation within Health and Social Care services and make recommendations for improvement. A final Terms of Reference for this work was agreed with the DoH in October 2019 and fieldwork on this review concluded in January 2021.

The review was conducted in phases, with interim reports submitted to DoH upon completion of each phase. This document is the culmination of this work and is an overall assessment of the effectiveness of the SAI procedure and its implementation across Health and Social Care in Northern Ireland

1.3 Overview of Regional SAI Procedure

The system for reporting adverse incidents was first introduced in Northern Ireland in 2004 by the former Department of Health, Social Services and Public Safety (DHSSPS), now known as the DoH. Reporting arrangements were transferred to the Health and Social Care Board (HSCB), now the Strategic Planning Performance Group (SPPG) within the DoH, in partnership with the Public Health Agency (PHA), in 2010. Updates to this procedure were implemented in 2010, 2013 and 2016.

The current version of the regional SAI procedure which was last updated in 2016, advises that SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

Incidents which meet the following criteria may be classified as an SAI.

- Serious injury to, or the unexpected/unexplained death of:
    - a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
    - a staff member in the course of their work
    - a member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and/or member of the public.
- Unexpected or significant threat to provide service and/or maintain business continuity.

- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.
- Serious self-harm or serious assault (including homicide and sexual assaults)

    - on other service users,
    - on staff or
    - on members of the public.

- By a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including Children and Adolescent Mental Health Services (CAMHS), psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Serious incidents of public interest or concern relating to:

    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

Three levels of review are described in the regional procedure. The expectation in respect of each level is summarised below:

Level 1 Review: Significant Event Audit (SEA)

For Level 1 reviews, membership of the SEA review team should include all relevant professionals, yet be appropriate and proportionate to the type of incident and professional groups involved.

The review panel undertakes an SEA of the incident to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local or regional learning.

Level 2 Review: Root Cause Analysis (RCA)

For Level 2 reviews, the level of review undertaken will determine the degree of leadership, overview and strategic review required. A core review panel should be comprised of a minimum of three people of appropriate seniority and objectivity. Review panels should be multidisciplinary and have no conflict of interest with the incident concerned. The review should have a chairperson who is independent of the service area involved, while possessing relevant experience of the service area in general and of chairing reviews.

The chairperson should also not have been directly involved in the care or treatment of the individual or be responsible for the service area under review.

The review panel undertakes a RCA to a high level of detail, using appropriate analytical tools to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning.

Level 3 Review: Independent Review

For Level 3 reviews, the same principles as Level 2 reviews apply; however, team membership must be agreed upon between the reporting organisation and the HSCB/ PHA (PHA) Designated Review Officer (DRO) prior to the review commencing.

The 2016 procedure states that: "The review panel undertakes an in-depth review of the incident, to a high level of detail, using appropriate analytical tools to assess: what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning."

In 2016, the Regional SAI procedure was updated to guide SAI review panels in relation to providing patients and families with an opportunity to contribute to the SAI review.

The guidance outlined that:

- The level of involvement depended on the nature of the SAI and the patient and family's willingness to be involved.
- Teams involved in the review of SAIs should ensure sensitivity to the needs of the patient and family/carer involved.
- Teams should agree on appropriate communication arrangements with the patient and family/carer involved.

To support the involvement process, an SAI leaflet[5] was designed by the HSCB and PHA for organisations to give to patients and families prior to their initial discussion regarding the SAI which had occurred.

1.4 Patient and Family Involvement and Engagement

Health and Social Care services across Northern Ireland have a legal duty to involve service users and their carers. Personal and Public Involvement (PPI) is a legislative requirement for Health and Social Care organisations as set out in the Health and Social Services (Reform) Northern Ireland Act 2009[6].

The Act states that service users and carers must be involved in and consulted on:

- The planning of the provision of care.
- The development and consideration of proposals for changes in the way that care is provided.

- Decisions to be made by the body that has the responsibility for the provision of that care.
- The efficacy of that care.

PPI is the active and meaningful involvement of service users and carers in the planning, commissioning, delivery and evaluation of Health and Social Care (HSC) services, in ways that are relevant to them. It is the process of empowering and enabling those who use services and their carers to make their voices heard, ensuring that their knowledge, expertise and views are listened to.

Given this statutory duty, service user and family involvement were considered a pivotal aspect of this review. Throughout the review, the effectiveness and extent of patient and family engagement have been examined from the perspective of patients and families, frontline staff and managers.

2.0 Terms of Reference

The terms of reference for this review, as agreed with the Department of Health, were as follows:

1) To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAIs) across the six HSC Trusts, the HSCB and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

2) To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.

3) To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.

4) To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.

5) To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.

6) To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.

7) To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.

8) To assess the level of professional support provided to (i) staff who were delivering care at the time of the SAIs, as well as (ii) staff conducting the review of the SAIs.

9) To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response to SAIs, their assessment and review, and the learning arising through these processes.

3.0 Review Methodology

The review used a range of methodologies to ensure each term of reference was addressed. Each methodology aimed to optimise the quality of information sought by the expert panel to ensure a robust evidence-base for their recommendations.

The methods included:

1) The assessment of SAI review reports, by the Expert Review Team. The criteria for assessment as agreed with the Department of Health.

2) The design of a structured assessment questionnaire which was applied by the Expert Review Team to all SAI review reports submitted by the participating HSC Trusts.

3) Questionnaires issued to a range of Trust staff, from senior management to frontline practitioners, and SAI panel chairs, seeking their views of their involvement in the SAI review process.

4) Engagement of patients and families who had experienced healthcare-induced harm and the offer of face-to-face conversations to learn about their experiences and hear their views as to how these experiences could have been improved.

5) Focus groups involving staff involved in an SAI, as well as staff involved in the SAI review process.

6) Meetings with individuals and groups of staff in HSC organisations involved in SAI reviews.

7) Engagement with other relevant organisations.

It was intended that the effectiveness of implementation of SAI recommendations would be examined in specific detail by the Expert Review Team to explore further the arrangements within services to deliver on sustained and measurable improvements to patient safety. However due to the COVID-19 pandemic, this aspect of the methodology was unable to be performed in full, but was explored though other aspects of the methodology.
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3.1 The Identification and Selection of SAIs

For the aspect of this review SAIs selected had been conducted between 30 November 2016 and 31 March 2018 and fell within the following categories:

- Deaths of women and babies related to pregnancy and childbirth: maternal deaths, stillbirths and neonatal deaths. Serious illness of women and babies where this has been related to pregnancy and childbirth.
- Sepsis
- Choking on Food
- Never Events[1]
- Cases where private hospitals or private nursing homes feature in the care pathway.
- People with a learning disability who have died from a treatable physical condition.
- People with a learning disability in residential care.
- Primary Care
- Any other categories RQIA considered appropriate for inclusion the review.

The information relating to these SAIs was obtained from the HSCB. After validation, 54 SAIs were identified for inclusion. A total of 12 additional SAIs were subsequently selected, comprised of Level 2 and Level 3 reviews, resulting in a total of 66 SAIs being selected for expert review (Appendix A).

3.2 The Structured Assessment of SAI Reports

A structured assessment tool was developed and applied to each SAI report reviewed. The assessment captured the perspectives of members of the Expert Review Team who were:

- Experienced investigators.
- Clinicians.
- Lay and family representatives.

Two distinct types of structured assessment tools were developed, one for use by the lay members of the Expert Review Team and one for the technical assessment of the SAI reports by other Expert Review Team members. This approach ensured consistent and objective assessment of each SAI report.

Due to the differences in templates used and levels of review required, for Level 1 and Level 2 SAI reviews set out in the regional procedure, the core assessment tool, which applies to Level 2 SAIs, was modified to meet the requirements of a Level 1 SAI report.

[1] Never Events are serious, wholly preventable safety incidents that should not occur if the available preventative measures are implemented. They include things like wrong site surgery or foreign objects left in a person's body after an operation. The full scope of Never Events is detailed in the Care Quality Commission report, Learning from Never Events (July 2018).

To ensure a robust approach, members of the Expert Review Team with either a clinical qualification or extensive prior experience in the conduct of SAI review were grouped in pairs. This resulted in each pair reviewing a total of 33 SAI reports.

The lay members of the Expert Review Team reviewed all 66 SAI reports individually before comparing their assessments and discussing any differences of opinion. This resulted in three subgroups with two members of the Expert Review Team in each, assessing the SAI review reports.

Table 1 below shows the breakdown of trusts and reports allocated to each technical team.

Table 1: Breakdown of trusts and reports allocated to each technical team

Team	Organisation	Number of SAI reports for review
Team 1	Northern Trust	10
	South Eastern Trust	13
	Western Trust	10
Team 2	Belfast Trust	11
	Southern Trust	14
	NIAS	4
	Integrated Care Team, HSCB	4
TOTAL		**66**

Source: RQIA Structure Assessment Exercise

3.2.1 Quality Assurance of the Structured Assessments

The structured assessment tool developed by the Expert Review Team considered the extent to which the SAI report described:

- The incident under review and why it was being reviewed.
- The level of independence of the review panel members and the competencies and skills they had to conduct the review.
- The degree of patient and family engagement with the review process.
- The nature of the recommendations made and their relevance to improving patient safety.
- The robustness of the action plans constructed to deliver the recommendations and whether they would deliver a measurable and sustained improvement in quality and safety.

3.2.2 Technical Assessment

To ensure reliable and accurate assessments of the SAI reports, two quality assurance exercises were undertaken.

Firstly, for each of the three technical teams referenced above, an intra-team reliability exercise was undertaken. This required the assessors to submit a sample of four assessments to each other for a repeat assessment to ascertain the similarity or differences in assessment outcome. This process demonstrated a high level of consistency between the assessments. Where there were significant differences in the assessments, these were presented and discussed at a round table conversation between the technical assessors to reach consensus. A lay member of the Expert Review Team was included in this process.

The second quality assurance exercise was undertaken upon completion of the assessment of all SAI reports.

This involved a sample of four completed assessments being selected from each technical assessment team and reassessed by the other team. Following this, the technical assessment teams met to compare findings. There were few discrepancies between the teams which confirmed a high level of consistency. Any discrepancies were discussed, and a consensus position was reached.

3.2.3 Lay Assessment

The lay members of the Expert Review Team assessed all 66 SAI reports adopting the perspective of a family member who might receive these reports. To achieve a comparable process of quality assurance, each lay member assessed all 66 reports and subsequently met with their lay counterpart to discuss each report, including any differences in perspective.

As with the technical assessments, there were few discrepancies between the assessments conducted by the two lay members of the Expert Review Team, and any differences were resolved by discussion thereby reaching a consensus view.

3.2.4 Analysis of the SAI Report Assessments

Themes were extracted from SAI report assessments and collated to inform key findings. These findings informed engagement with the HSC organisations during subsequent phases of this review. During the review, emerging findings and key messages were shared with the Department of Health via interim reports.

3.3 How each Trust responds to Significant Unexpected Harm Events

Questionnaires were developed for and issued to each HSC Trust, the HSCB and the PHA. These were designed to gather information from each organisation about their respective approaches to SAI review and the related structures and processes in place, including the extent of patient and family involvement.

A thematic analysis of the responses received was subsequently undertaken.

3.4 Patient and Family Engagement

Initially, it was intended that the Expert Review Team would make direct contact with those patients and/or families affected by the 66 SAIs which were included in the structured review undertaken in the first phase of this review. Recognising the potential for further psychological impact, the Expert Review Team agreed the following patients and/or family members would not be contacted:

- Where there had been an expressed wish by the patient and family not to be contacted further or where there were issues of confidentiality.
- Families of cases who were subject to a coroner's investigation.
- Patients/families of cases which were subject to legal proceedings.
- Patients/families of those involved in significantly distressing SAIs (including suicide of a family member).

This resulted in 38 out of the 66 patients/families being contacted to seek their involvement in the review process. Of the invitations sent to each patient and family, only six responses were received. Following this, two decided not to be involved. This resulted in four out of 38 individuals contacted agreeing to become involved. Individuals subsequently met with RQIA staff members. This number was considered too few for the purposes of this review. As such a decision was made to supplement the engagement and further seek experiences via several additional routes, including approaching the Department of Health and the Patient Client Council (PCC) to supplement the experiences of those four initially contacted. Both organisations had previously engaged with patients/families who have had an experience of the SAI process following an incident of unexpected harm.

The PCC agreed to meet with the Expert Review Panel to share the views of patients/families with whom they had engaged. Communication with the Department of Health also resulted in three additional families agreeing to participate and share their experiences.

3.4.1 Additional information considered on engagement with patients and families

Experiences of patients and families involved in SAI reviews were also ascertained through engagement with other groups and work streams:

- In November 2019, the Inquiry into Hyponatraemia-related Deaths Implementation Programme (Work stream 5, Serious Adverse Incidents), held a workshop in conjunction with the PCC to engage with families on their experience of the region's SAI review process. The findings from the workshop were shared with RQIA and considered by the Expert Review Team.

- In October 2019, the PCC shared its Serious Adverse Incident Complaints A Thematic Review of Client Support Service Cases 2014-2018 report. It outlined the experiences of families who had been through the region's SAI review process and the findings were considered by the Expert Review Team.

- In December 2020, the Expert Review Team met with staff from Cause NI[2] who shared the experiences of families they had supported through the SAI review process and provided insight into how to achieve quality family engagement in the process.

These findings were articulated in the Expert Review Team's interim report on Patient and Family Engagement. .

3.5 Staff Engagement

As part of this review, the Expert Review Team engaged with those staff involved in the care of the 66 patients who were the subject of the SAI review reports involved in the structured assessment undertaken in the earlier phase of the review. Several methods of staff engagement were utilised:

- Focus group meetings using a café style approach.
- A private post box method.
- An online survey.
- One-to-one telephone interviews.

3.5.1. Focus Groups

Focus groups were held between 5 November and 21 November 2019. To accommodate the range of staff involved in the SAI process, each focus group had a different emphasis:

- Staff involved in the care of the patient who was harmed.
- Staff involved in the SAI review process.
- Staff involved in a named SAI review.

The focus groups focused on three primary areas:

- The experience of staff who had been involved in the SAI process.
- Their experience of engaging and involving patients/families in the SAI process.
- The views of staff in relation to how the SAI process could be improved.

Table 2 below shows the number of staff who attended each of the focus groups.

[2] Cause NI is an organisation which supports people with a mental health problem and their family members.

Table 2: Staff Engagement Focus Groups by Participation and Organisation

Source: Information recorded by RQIA during the focus groups

	Focus Group 1	Focus Group 2	Focus Group 3	
Organisation	Staff involved in an incident	Staff involved in reviewing an incident	Team involved in reviewing an incident	Total number of staff by organisation
Belfast Trust	5	12	4	21
Northern Trust	19	16	2	37
South Eastern Trust	14	15	4	33
Southern Trust	12	10	3	25
Western Trust	5	19	4	28
NIAS	2	8	n/a	10
Integrated Care	n/a	8	n/a	8
Total number of staff by focus group	**57**	**88**	**17**	**162**

3.5.2 Confidential Post-Box Feedback

At each staff focus group, a confidential post-box was provided to enable staff to share their experiences of the SAI process should they not be comfortable with speaking out in front of a group.

3.5.3 Online Survey

The third method to support staff engagement was via an online survey. All staff working within HSC Trusts were offered an opportunity to respond, provided they had experienced the SAI review process.

Overall, 201 staff completed the survey. However, 114 of those had not been involved in an SAI process, either as a member of a care team involved in an incident or as a member of the SAI review panel. Their responses were therefore not included in these analyses.

Of 87 respondents who had an experience of the SAI review process, 40 staff members had been involved in care and treatment related to an incident and 47 staff members had been part of the panel reviewing an incident.

3.5.4 Telephone Interview

All staff who attended the focus group meetings were also offered the opportunity to speak confidentially with a member of the Expert Review Team by telephone interview. Four staff members were subsequently interviewed.

3.6 Meetings with HSC Organisations

The Expert Review Team met with Senior Managers in each of the HSC Trusts. The meetings focused on the management and oversight of the SAI review process within the organisations and included a discussion on potential improvements to the SAI review process.

The Expert Review Team also met with the HSCB and PHA to discuss their regional responsibilities, their roles in oversight of the SAI review process and the role of the Designated Review Officer. This meeting also included a discussion on potential improvements to the SAI review process.

3.7 Engagement with other Organisations

The Expert Review Team met with representatives of the RQIA's Mental Health inspection team and the Coroners Service in NI, both of which were identified as having had frequent engagement with the SAI process. The purpose of this discussion was to gain an insight into their experience of the SAI process and what improvements they considered could be made.

A broad range of organisations are involved and impacted by the regional SAI review process. Engagement with these organisations focussed on those that had most frequently experienced the process. Other organisations, such as other regulatory bodies, trade unions, and the Police Service for Northern Ireland were provided with information about the review and asked if they would like to make a written submission regarding their views and opinions in relation to the current SAI process and their suggestions for change to the SAI process.

Of the organisations contacted, the following nine responded. These were; the British Medical Association, the Royal College of Nursing, the Eastern Local Medical Committee, the Pharmacy Forum, the Coroner's Service, the Northern Ireland Public Sector Alliance, the Northern Ireland Medical and Dental Training Agency, the Information Commissioners Office and the Health and Safety Executive Northern Ireland.

The full list of organisations contacted is outlined in Appendix B.

4.0 Findings

4.1 Overall findings of the Expert Review Panel

After full consideration of all the evidence gathered from each of the contributors to this review, the Expert Review Team was confident in their determination that the current regional policy for SAI review in Northern Ireland must change. It was clear that the current procedure and its implementation does not support:

- Fulfilment of the statutory duty of PPI as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.
- Reasonable application of the principles of effective review practice.
- Confidence in the independence of Chairs of SAI reviews at Level 2, or Level 3 - particularly so for Level 3 reviews where the appointed chair is a former employee of an HSC Trust.
- Health and Social Care organisations embracing their accountability for:

    - decisions made regarding the level of review conducted
    - how they involve and engage with a patient and family
    - the quality of review conducted, acceptance of its findings and approval processes
    - demonstrating how HSC Trust services have improved and are safer because of the reviews conducted
    - ensuring that issues requiring regional attention to improve safety are escalated to the right people/organisations.

- The formulation of evidence-based recommendations.
- The design of action plans that will enhance the safety and quality of healthcare provision across the region both in the short and longer-term.
- Review reports that are well-formulated, evidence-based and readable.

The Expert Review Team identified a number of reasons for this:

- The implementation of the regional procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently delivering the practice of conducting high quality SAI reviews.
- There was an absence of clear regional guidance on PPI duties in relation to patient rights within the serious adverse incident process.
- There was no defined regional patient safety training strategy and curriculum.
- There were not defined competencies required of lead investigating officers and serious adverse incident panel chairs.
- There were insufficient numbers of trained independent advocates to support family involvement in the process.
- There was a regional lack of effective training in how to conduct a meaningful review. Furthermore, even where training had been delivered, the appointed chair or investigative leads did not have sufficient authority to independently devise a review plan that fully delivers the required quality of a review.

The evidence underpinning these findings was derived across a broad range of engagements and is detailed further in the following sections under three key themes.

1) Patient and family engagement.
2) Staff engagement.
3) The effectiveness of the procedure and approach for delivery of SAI reviews.

4.2 Patient and Family Engagement

A hallmark of success in any approach to the review and learning from incidents of unexpected and avoidable harm is the manner in which a health provider organisation engages with the patient and their family through the review process. The families who provided information to the Expert Review Team, the PCC and the lay members of the Expert Review Panel (who themselves have lived experience of healthcare induced harm) provided consistent reflections on how this aspect of SAI Reviews is delivered in Northern Ireland.

The Expert Review Team identified several of themes after listening to the views and experiences of patients and families:

- There was inconsistency in the practice of HSC Trusts in when and how they informed families about:
    - the incident
    - the decision to conduct an incident review process
    - the rights of patients and families to be engaged at all stages of the review, including shaping the terms of reference or lines of enquiry
    - sharing of the interim findings of the review process to allow commenting and feedback from the patient and family to be incorporated.

- There was inconsistency in the quality and frequency of communications with the patient and their family. This includes written correspondence as well as verbal communications. A common concern was the level of empathy, respect in the nature and tone of communications and levels of planning with the patient and their family about what mode of communication was best and with what frequency.
- Families reported there was not sufficient transparency about the process.
- There was a deficit in the availability of independent support or advocacy for patients and families.
- There were concerns about the timeliness and amount of information provided about the plan for the review process and its intended conclusion date.
- They described HSC organisations across the region were unable to apologise for the harm that had occurred. In their words, it was not enough to say, “sorry, we are at fault”. Rather, the apology should say: “Sorry this has happened to you. We will look after you and help you understand what happened”.

- They experienced an unwillingness to seek the testimony of the patient and family members as an integral component of the review process, thus diminishing the status of the patients and their families.
- Many stated that the interim findings of the review process were not shared with the patient or their family members so that they could contribute constructive comments and ensure their voice is appropriately represented and heard.
- There was not a sufficient level of openness and candour about what had happened and why. They described the shrouding of the SAI review findings in technical language which was not accessible and perceived it to be defensiveness.
- There were some who were concerned about potential 'cover-ups' and a lack of transparency in the process, as well as in the report subsequently written.
- Several described Chairs of the SAI review whose communication skills and ability to work constructively with a family were poor.
- Several were not confident in the independence of Chairs of the SAI review.

Of particular note was the view expressed by Cause NI, a charity that specialises in offering practical and emotional support to families whose loved ones have experienced harm as a result of serious mental illness or suicide. They considered that the current requirement within the SAI procedure, for the investigation of all deaths that have occurred as a result of mental illness (where the individual who dies was known to Mental Health Services in the preceding 12 months), was not the best approach. It was suggested SAI reviews would be most appropriate in those cases where it was suspected there were care deficits preceding the death.

The Expert Review Team reflected, that overall, the expressed views of patients of families in Northern Ireland regarding their experiences of involvement, were similar to findings of independent reviews and inquiries elsewhere in the UK, such as the Care Quality Commission (CQC) review, '*Learning, Candour and Accountability 2016*[7], the *Mid Staffordshire NHS Foundation Trust Inquiry* and *The Report of the Morecambe Bay Investigation.* It was therefore disappointing that in Northern Ireland, more progress had not been made in implementing best practice in how HSC organisations work with families after unexpected harm.

The Expert Review Team was impressed with the attitude of staff who expressed a willingness to have greater engagement and involvement with the patient and their family in the process. Most staff appreciated that patients and families are an important component of a successful approach to learning from harm. They reported feeling constrained by an overly bureaucratic process, which they perceived placed completion of arbitrary timescales and narrow performance targets above the requirement for meaningful involvement.

The most significant barriers to achieving meaningful involvement of patients and their families were described as:

- Uncertainty about what staff could and could not say to a family and what constitutes an acceptable level of disclosure.
- How to achieve realistic expectations with a patient and their family about what the SAI process can and cannot deliver.

- The time allowed for the delivery of the SAI process, and the time available to an SAI review panel chair, who would have additional managerial or frontline clinical duties and which is not conducive to meaningful patient and family engagement.
- The availability of dedicated support for patients and their families through the SAI process. Without support, it is difficult for Chairs of SAI reviews to also attend properly to the needs of the patient and family.
- Absence of constructive guidance on how to capture family involvement and engagement within the SAI review report, exacerbated by lack of space within the review report template to record the level of family involvement.
- Staff were concerned about legal issues and reported anxiety about how to describe the findings that then might result in a claim for damages. A small number of staff described instances where legal services have requested modifications to a report which diluted the findings of the SAI review panel.

The Expert Review Team is clear that concerns regarding future claims for damages must not interfere with conduct of an SAI review or with the integrity of the resulting report. It is wholly unacceptable that report authors could be asked by a manager or by legal services to dilute their findings. Furthermore, such action should have serious implications for health professionals who have breached their professional duty of candour.

However, there are good reasons for a legal services team to review an internal SAI review report document:

- To sense check the use of language.
- To test the strength of the evidence base underpinning the report's findings and conclusions.
- To determine a report's readability.

Feedback made to a report author in the context of the above must be considered and acted upon.

Across the HSC, it was not the cultural norm to share interim findings of an SAI review with a patient and their family. Enabling the patient and family to have a voice in the report, to comment on the report content, and to influence the content and tone of the final report appears not to be a primary consideration. Ineffective and insufficient patient and family engagement can cause further harm. Families report having experienced some of the following adverse effects:

- Increase in stress.
- Delay in starting the grieving process.
- Post-traumatic stress disorder.
- Loss of income.
- Feelings of anger.
- Loss of life enjoyment.

The Expert Review Team considered that, for many families, it is possible to avoid causing further harm if HSC organisations engage in a compassionate process. The

founders of the Harmed Patients Alliance[8], a campaign group founded to raise awareness of harmed patients and families, effectively communicate the kind of compassion families need following healthcare harm.

"In the aftermath of our loss, we needed healthcare to fully acknowledge and thoroughly understand our experience of what had happened to our children and the impact it had on us. We needed answers to all of the questions that we had, that were important to us, and we needed those regardless of whether anyone else felt our question relevant or important. We needed staff to be supported to give us honest accounts of their actions and their reflections. We needed a collaborative approach to reach a truthful and evidence-based explanation of events. We needed help and support to understand what all the processes were that were happening and how to engage with them. We needed the system to learn and to see meaningful change, but we also needed the system to help us heal, recover, and restore our trust. Meaningful engagement coming from a place of care could have provided that."

Harmed Patients Alliance

4.2.1 Working with patients and their families in a way that delivers a restorative process and maintains candour

The Expert Review Team determined that the Department of Health with associated stakeholders must describe the region's statement of intent regarding how patients and families are involved in the SAI review process and the core objectives in relation to patient and family involvement for which each HSC provider must evidence achievement.

Examples of objectives relating to patient and family involvement are:

- Families and patients are supported as active partners in the review process as much as they wish to be engaged, including the involvement of an appointed advocate.
- Patients/families experience a compassionate and empathetic approach, which is demonstrated by the nature and frequency of contact throughout the review process.
- The voice of the patient and family is heard, their testimony captured, and they have the same status as any professional contributing information to the review process.
- The patient and family has a named source of support, outside of the review panel. The role of this individual is clearly defined, including the basis authority to act as advocates in the best interests of the family.

- Questions asked by the patient and family are responded to fully, with honesty, integrity and candour.
- The patient and family are encouraged to contribute to the terms of reference for incidents identified as requiring in-depth review.
- Patients/families are taken through the interim findings of the review and are provided with enough time to read, comment on, and influence the content of the final report.

In the event of new information becoming available after the conclusion of an SAI review, or if there is a change in conclusion or material findings from such review, then this information must be shared with the patient/families as soon as possible.

How individual HSC organisations undertake to deliver the objectives should be for them to determine. However, what is required from all HSC organisations is clear evidence that they have achieved the objectives. In particular, they should provide evidence that patients and families are given the same opportunity for involvement in an SAI review as the staff and others involved in an incident. This evidence should be validated by patients and families who have experienced unexpected healthcare harm of the nature that warrants an SAI review. The Expert Review Team considered that a co-production model for development and further improvement of the SAI procedure, involving frontline staff and patients and their families, should be adopted going forward.

4.3 Staff Engagement (staff engaged in the care and management of the patient who experienced harm)

Every SAI review must involve the collection and analysis of a sufficient amount of information from multiple sources. This requires the active engagement of staff involved in the care and treatment of the harmed patient and the engagement of a wider sphere of individuals who have experience in the field and understand the system at work.

The purpose of the SAI review process is to:

- Find out what happened.
- Understand how and why it happened.
- Implement any appropriate early remedial actions to address any identified deficits in care.
- Identify areas for improvement in order to support the delivery of safe patient care.
- Implement appropriate improvements based on the findings of the SAI review.

In circumstances where patients have been harmed, it is understandable that frontline staff may feel vulnerable and experience emotional pain, as well as feelings of anger, shame, fear, sorrow or regret.

To enable HSC staff to fully inform the review process, they must feel safe to do so. They must also have confidence in both the competence the appointed review panel and feel secure that the information they provide will be used fairly.

What staff employed within Health and Social Care trusts across the region had to say

Comments about the SAI procedure and its implementation:

In the online survey completed by HSC staff:

- 89% (179) said they agreed, or strongly agreed, that SAI reviews were an essential activity for a learning organisation.
- 74% of respondents (149) said SAI reviews generated improvement for safety within their organisations.
- 64% (129) said they agreed or strongly agreed that they were aware of more than one improvement resulting from an SAI review.
- 61% (123) said outcomes from SAI reviews were regularly discussed at team or service meetings.

While the survey results cannot definitively conclude whether or not SAI reviews enabled the collection of quality information upon which to formulate evidence-based findings, face-to-face meetings conducted with staff in HSC organisations did, however, provide a useful insight into the experiences of staff involved in SAI reviews.

The information gathered at staff focus groups, for example, highlighted that the principle of a 'just culture' was not embedded across the region.

Staff consistently reported:

- Insufficient openness about the process and the standards of conduct expected of the SAI review panel members.
- Insufficient communication about the progress of an SAI review and why it was being conducted. The key lines of enquiry, progress, findings, and recommendations were frequently unknown by staff who had been involved in the care and treatment of the patient to which the SAI review related.
- The experience of the review felt like it was designed to apportion blame.
- Terms of reference for SAI reviews did not suggest they were grounded in a constructive or learning process.
- There was variable engagement in the process, with some staff unaware the SAI review was even being conducted, only to find out at a later point in time. Some staff described an over-emphasis on the collection of written submissions and a lack of detailed exploratory conversations being conducted by SAI review panels.
- Some staff described insufficient notice of, or information about, SAI panel meetings or interviews staff were asked to attend.
- Some staff did not have an opportunity to read the interim findings before these were finalised in the SAI report.

- Some staff said they were not able to respond to any criticisms made in the SAI report before it was signed off as completed.

Regarding the constitution of the SAI review panel, and how those panels operated, the following concerns were described by frontline staff who participated in this review:

- Concerns about the appropriateness of members of the panel in terms of technical and subject matter competency and insight.
- Concern about the lack of factual accuracy checking by review panels, both in terms of the sequence of events leading to the incident under review, but also regarding the accuracy of notes of face-to-face meeting. Staff said that this meant they were unable to correct the SAI review panel's misinterpretation of words spoken at interviews, or during panel meetings.
- Some staff described too narrow a field of focus by SAI review panels, with little consideration of the system within which frontline staff work. For example, workload, workplace design, task design, skill mix, staffing issues, team dynamics, and cultural factors, leadership and factors which may contribute to an incident.

Although negative experiences were reported, some staff reported a more positive experience and had been involved fully throughout the SAI review. These staff reported that they felt they had been involved throughout the SAI review, in terms of being kept up to date with progress of the SAI review and were able to contribute to the learning from the SAI review.

During discussions with the Expert Review Team, frontline staff reflected on the support mechanisms available to them in coming to terms with the SAI event and its subsequent review. Although we received many comments about a lack of support, a small number of staff did share positive experiences of being supported by both managers and colleagues. These staff highlighted that the people who had provided the support, had themselves been previously part of a SAI review. The overwhelming message from all focus groups across all Trusts was that staff had experiences of inadequate support as they went through the SAI process.
Frontline staff acknowledged that it was not the role of the chair of the SAI panel or the Trust staff member who oversees the review to provide appropriate support for staff as their role was to deliver an effective, unbiased review process. However, they did consider that better quality support ought to be forthcoming from:

- Their own line managers.
- Independent providers of psychological support.
- Their employer via staff supports and counselling services.

In several focus groups, the Expert Review Panel members were struck by the level of emotion expressed by staff who had participated in an SAI reviews. It was evident that these staff had not been through a supportive, reflective process of learning.

4.3.1 Achieving a way of working with staff that delivers a supportive, learning-orientated process within a 'Just Culture'.

The Expert Review Team determined that the Department of Health, working with appropriate stakeholders, must set out, in its strategic direction, its expectations for how staff in HSC organisations and those they report to are engaged and when participating in an SAI review. As with family engagement, the principles for effective staff engagement must be developed and defined before an effective process can be designed.

An example of a statement of success could be:

'*Staff are treated well, their voice is heard, and they actively contribute to the SAI review process.'*

The core objectives for HSC organisations which will ensure this is delivered could be:

1) Staff experience a compassionate and empathetic approach.
2) The voice of the staff involved in an incident is heard, including their experience of the incident, and the context in which it occurred.
3) Staff are well informed throughout the review process.
4) Staff are treated fairly and equitably, in line with the principle of a 'just culture', including having the opportunity to read any criticisms made about them and to respond.
5) Staff involved in the incident (and other key staff) are given the opportunity to read the interim findings of the SAI review panel and to provide feedback in relation to factual accuracy, tone, and style.
6) Staff involved in the incident and service in which the incident occurred are actively engaged in designing the action plan to deliver measurable and sustained improvement.

Again, individual HSC organisations should determine for themselves how to deliver these objectives but should be able to evidence achievement of the objectives. This evidence should be validated by staff that have experienced the SAI process. Perspectives of staff who have delivered the SAI process should also be gathered and evaluated. The Expert Review Team again advises that a cooperative approach be adopted for involving frontline staff, patients and their families in designing of these improvements.

4.4 Staff Engagement (staff with experience undertaking SAI reviews)

A robust SAI review requires staff delivering the process to have the right technical knowledge, along with a range of non-technical skills and attributes. At the time of this review there was no competency framework in place to ensure the required competencies to deliver the review process. It cannot be assumed individuals have these skills simply because of their professional background or seniority. Implementing an effective approach for SAI reviews will require upskilling of staff before it can be practised and evaluated.

For the implementation of the review procedure to be effective and for optimal learning to be achieved, a structured and feasible policy framework needs to be embedded alongside cultural change.

The consistent messages provided to the Expert Review Panel from staff engaged in the delivery of the SAI procedure and its implementation were:

- It was challenging to undertake the SAI reviews alongside their pre-existing professional duties. There was no protected time for this, nor any account taken of their day-to-day workloads or frontline patient care duties.
- There was insufficient supervision and mentorship by experienced reviewers who hold the necessary technical and non-technical skills and attributes.
- There was a lack of training in conducting SAI reviews and related methodologies.
- There were challenges in engaging with staff involved in the care giving, such as established off duty rotas, the need to provide a 6–8-week lead time to medical staff before meeting with them, challenges in locating agency and locum staff, and the delay between the incident occurring and the SAI review being commissioned.
- Communication with all relevant parties was described as a persistent challenge.
- The classification of an SAI, and how it was determined that an incident met Level 1 or Level 2 criteria, was difficult for staff to understand. There was not always full understanding that the current procedure directs reviews should be conducted at a level appropriate and proportionate to the complexity of the incident and significance of event under review rather, that the impact or outcome for the patient. Most staff considered that the criteria for classification were not clear.
- The current approach of imposed regional terms of reference does not support an effective review practice. Staff understood effective reviews require the right technical questions to be asked about the patient's care and treatment; this is not supported by the current process. When asked why the terms of reference were not changed to something more relevant, staff reported that they did not believe they had the authority to do so.
- The regional report template did not support the formulation of an evidence-based, well-structured or readable report. Participants reported that the design of the regional template made it difficult to reflect the level of an engagement that an SAI review panel may have achieved with the family. Overall, the template was considered to be not fit for purpose.
- Recommendations were a particular source of concern for participating staff, with many reporting their perspective that recommendations often did not get implemented due to a lack of resources. Staff also displayed some frustration members of review panels felt obliged to make recommendations even if they suspected that nothing would happen as a result.

In addition to the above, staff with experience in conducting SAI reviews provided insights into the review methodology of Root Cause Analysis (RCA) and the extent to which learning is implemented. The information provided by staff indicated that there is confusion about what constitutes an RCA method. The fact that many staff believed completion of the regional report template constituted a valid review and an

RCA is concerning. Staff did not demonstrate an informed understanding of what constituted a review and were not aware of the broad range of tools and approaches they could employ to deliver this. The tools that participating staff were aware of were simple chronology, the 'five-whys' technique, and the 'fishbone' diagram.

The Expert Review Team was left with an impression that HSC Trusts across Northern Ireland are using the language of RCA without an embedded understanding of what this means, or where RCA fits into a structured and auditable review. The regional guidance does not address this, nor does it provide practical advice on how to conduct a review to an acceptable standard.

The Expert Review Team could not be confident that across the HSC Trusts, consistent systems based learning was happening, and that changes were embedded or that there was a robust system in place for sharing learning beyond the investigating organisation. The issuing of regional learning letters by the HSCB was referred to, but most frontline staff were not aware of this and only two of those interviewed had ever seen a learning letter.

Staff with experience as an SAI reviewer understood why staff asked to provide information to the review panel may suspect the existence of a 'blame culture'. They considered that most of the staff they interviewed often appeared anxious about the process and were sometimes defensive when questioned. Some staff who had undertaken several SAI reviews considered that the level of anxiety among staff being interviewed had increased over time.

The Expert Review Team considers from their assessment of the 66 review reports that the language used in SAI review reports might also contribute to a sense of blame. For example, root causes of incidents were described as 'human error', which may unfairly suggest that an individual member of staff is responsible. This is further compounded by the lack of deconstruction of events from a systems perspective, meaning that the true root causes and contributory factors which underlie errors in care and treatment are not identified, placing an unreasonable weight of responsibility on frontline staff.

Staff acting as SAI reviewers on behalf of their employer also considered the way the media in Northern Ireland reported on incidents that had reached the public domain. Subsequent media interest and commentary fuelled their feeling of a blame-driven approach and culture, alongside concerns about medico-legal consequences.

As with staff involved in care delivery, those who had an experience of conducting SAI reviews also believed that there was a lack of constructive support. Staff asked to chair SAI review panels were particularly concerned. They considered that there was no account taken of the true time required to deliver the role well, or how the time required conflicted with their other professional responsibilities. Some staff reported having to write SAI reports in their own time and late into the night, which then impacted their wellbeing and concentration levels at work the next day.

The Expert Review Team considers this situation to be wholly unacceptable. If the objective is to learn and improve safety, the system cannot overload staff already working at full capacity. Failing to provide protected time to lead the SAI review

process infers that it lacks importance. In the rail, marine, and airline industries, where an incident merits careful analysis, only trained individuals with time to undertake the work are appointed to the task.

The lack of administrative assistance for review chairs was also cited by staff as evidence of lack of support. There is considerable administration associated with the conduct of an SAI review. The Expert Review Team considers that it is not appropriate for a frontline clinician, who has been asked to lead an SAI review process, to also be responsible for administering it.

4.4.1 How to ensure chairs and members of SAI review panels are equipped to deliver the job adequately and with enough time

The Expert Review Team considers that the first step in achieving a sustainable situation across the region is to review how decisions are made regarding the level of SAI review required. This should be informed by:

- The frequency by which the incident type occurs.
- Whether there is a safety review already ongoing to explore and address any safety issues.
- Whether the conduct of the review is likely to deliver more learning than has already been achieved by previous reviews.
- Whether there is a safety improvement plan already underway.

It is widely recognised that many individual reviews involving the same incident type often do not lead to tangible safety improvements. Therefore, the practice of defining the need for an SAI review on the basis of adverse patient outcomes should be discouraged and is not in line with the current guidance contained within the SAI procedure which states,

"SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event".

An approach that allows a sensible period of time for the early assessment of 'what happened', and consideration of early information gathered about the care and incident, might enable a more structured and evidence-based approach to deciding which cases require an in-depth systems analysis. Treating the review as a process, where reviewers and chairs can determine an evidenced-based stop point, might be more successful than a static approach which assumes that all incidents can be treated the same. One of the expert review panel members has supported several NHS Trust mental health teams to implement such an approach. As a result, mental health teams reported a reduction in the number of in-depth reviews, greater engagement from staff and a formalised process whereby the review is led by the team lead; now recognised to be an important aspect of the process.

A more flexible approach is required to enable families to understand the process and what it can deliver. For example, it can deliver learning and provide answers to questions but it cannot provide justice.

In terms of the time allocated to conduct an SAI review, it will always be necessary to stipulate timescales, but it is important that they are realistic. They must allow at least to six-months for complex cases, and it would be reasonable to require a structured project management approach that can be monitored and quality assured.

The second step is to define the core competencies required of:

- People acting as review leads and/or chairs of review panel.
- The subject advisors supporting the process.

Furthermore, a regional training curriculum and certification process must be agreed. All training providers across the region should meet the minimum content requirement in order to enable competency achievement. For such an approach to work well, all HSC Trusts and independent providers responsible for delivering training should be required to demonstrate their competency and knowledge in order to be approved as training providers. Requiring all training providers to apply to be on a regional register or preferred provider list would support the achievement of this.

Finally, to support the implementation of a training curriculum it was considered that a mentorship and coaching approach could also be adopted. A person independent of the HSC Trust in which the incident occurred could provide external support to the lead reviewer/chair. This has the added advantage of providing an independent quality assurance check of the process and its outcomes.

4.5 SAI Reports: The extent they demonstrated a reasonable standard of review and positive contribution to patient safety in Northern Ireland

As previously outlined in the methodology in section 3.0, the Expert Review Team reviewed 66 SAI reports as part of this review.

In undertaken the review of reports, it was evident to the Expert Review Team that having two separate report templates for Level 1 and Level 2 reviews is not working. The design of the templates also does not support staff to write up their findings in a way that delivers confidence in the standard of the review or in the appropriateness of the level of review undertaken. Furthermore, the templates are designed in a way that limits important information being included, such as the questions that have been asked by patients and family members.

Upon assessing the report of a significant adverse incident review, the expectation is that it demonstrates that an effective method has been used to underpin the review. Indicators of an effective methodology are:

- The methods, tools and techniques used by the SAI review panel are clearly stated and appropriate to the incident under examination.
- The evidence upon which findings and conclusions are based have been clearly triangulated.
- An appropriate range of subject advisers have been engaged in the review process

- The SAI review report outlines the key elements of the processes and procedures relevant to the expected standards of care and treatment.
- There is a clear account of:
    - what happened
    - where policy, process or procedural expectations were met
    - where there was a deviation from procedural expectations.
- Where deviation from procedural expectations is identified, there is an explanation of:
    - whether the deviations were reasonable and justified based on the presentation of the patient, their clinical needs at the time, and the unfolding situation
    - whether the deviations were not reasonable and therefore not justifiable.
- In the instance of a non-justifiable deviation from the expected standard of care, there should be an indication of whether this contributed to or caused the harm to the patient, and whether the deviation represents a breach in standards to such an extent as to pose an ongoing threat to the safety of another patient should it reoccur.
    - In all such instances, a report should outline a human factor and systems-based explanation of how and why the deviation(s) occurred.
- Recommendations should address the most significant factors identified which contributed to or directly caused the incident.

In addition to the above, all significant adverse incident reports should deliver the following:

- Clarity about the questions posed by the family. The answers to these questions should be included in the findings section of the report.
- A good standard of writing with correct use of grammar, punctuation, and syntax. There should be no abbreviations, unless already in common usage in Northern Ireland.
- A readable report written in non-technical language.

4.5.1 Expert Review Team Findings following review of 66 significant adverse incident reports, comprising Level 1 and Level 2 reviews

The Expert Review Team found that all HSC Trusts utilised the relevant regional templates for the Level 1 or Level 2 review reports. Therefore, the Expert Review Team's findings are as much a reflection of the design of the templates as the quality of the reports assessed.

Style and structure of the reports

The Expert Review Team considered the presentation of the review reports and there was consensus that both report templates would benefit from a basic front page that simply states the name of the reviewing organisation, the title of the report and the publication date. It was proposed that any demographic information required for regional collection purposes could be accommodated within an appendix.

In both the Level 1 and level 2 report templates, space is provided to record 'what happened'. Mostly, this was comprehensively completed. However, in many reports, the sequence of events was recorded in too much detail and at the expense of the detailed analysis expected in the findings section of both reports, accepting that the Level 1 report is intended to be more succinct than the Level 2 report.

In the Level 1 report, there is no 'findings' section but instead, a section titled 'why it happened'. This title is erroneous. It implies that 'why' is determinable and automatically infers that the incident was preventable. It does not promote a balanced, constructive, analytical process.

In the Level 2 reports, there was a 'findings' section, but this was not structured. There were no uniform subheadings to guide a report author about what they should be recording. For example:

- Evidence that shows that expected standards of care were delivered as intended.
- Evidence of deviations from the expected standards of care.

Some reports made statements of policy and procedural compliance but did not say what these were and did not present an evidence base for the reported levels of compliance.

Some review reports stated their findings in relation to human factors, such as team elements, education and training. However, in the majority of instances the Expert Review could not link these findings to a systematic analysis of these areas of concerns in keeping with the approach of the National patient Safety Agency.[9] This indicates that the review panel, the author of the SAI review report and those signing off the reports did not fully understand how to effectively implement a human factors approach.

Some reports reviewed by the Expert Review Team did outline deviations in the care and management of the patient but did not make clear the significance or seriousness of these in relation to the patient outcome. As stated above, rarely was this accompanied by any structured or evidence-based explanation regarding how and why these deviations occurred. As a result, there was a lack of outcome-focused recommendations within the reports reviewed.

In stating the above, the Expert Review Team is not inferring that staff who undertook the reviews or wrote the reports were failing to deliver what was required of them, rather, the lack of structure and quality of the reports is a consequence of:

- A lack of investment in those tasked with leading the reviews in terms of their knowledge, skill base and time required to do the job adequately.
- A report structure that is not fit for purpose (Level 1 and Level 2 templates).
- A lack of effective quality assurance of reports at senior management levels across HSC Trusts.
- A lack of empowerment in HSC Trusts to adopt a more comprehensive approach and a better style of report, based on the principles outlined in regional policy and guidance.
- A lack of an effective quality assurance process within each HSC organisation and at a regional level. There appears to be no reliable process through which reports are peer reviewed to ensure delivery of an acceptable standard of review, including outcome-focused recommendations. Nor are they quality assured with a view to ensuring that there is a standard of report writing suitable for sharing with patients and their families.

Expert Review Team findings in relation to specific indicators of a robust SAI review

These are the findings from the Expert Review Team's structured assessment of the 66 review reports.

Indicator 1: The methods, tools and techniques used by the review panel are clearly stated and appropriate to the incident under examination

The following list describes what was found to be commonly recorded in terms of the methodology and approach to reviewing SAIs:

- The patient's notes were reviewed.
- A tabular timeline established.
- Relevant staff were interviewed.
- Family was invited to participate in the review.

The above elements are not sufficient to be considered a methodology, nor do they provide clarity regarding the approach taken by the relevant review panel. As previously articulated in this report, the primary reason for this is a lack of understanding about what constitutes a fair and reasonable review, with a regional approach that is too limiting and not embracing a tool-kit method.

Indicator 2: The evidence upon which findings and conclusions are based has a clear triangulated evidence-base

None of the reports reviewed satisfied the Expert Review Team that there was a triangulated, and thus validated, evidence-base for what was written in the findings section of the reports. This represents an unacceptable situation. A credible review aims to establish what happened, how it happened and why it happened.

An SAI Review Panel Chair understands the importance of triangulating and validating information and understands the dangers of not delivering this standard of practice. The SAI reports reviewed demonstrated a region-wide lack of adherence to

defendable review practice. This is mostly due to a lack of training, an unclear competency framework and insufficient professional supervision.

Indicator 3: An appropriate range of subject advisers have been engaged in the process

Regarding the independence and appropriateness of subject advisers, in 93% of reports this was either unclear or absent. Regarding relevant experience of subject advisers, this was unclear in 45% of the reports reviewed. The lack of clarity was in part influenced by the design of the regional report template which did not require precision in the recording of this information.

Indicator 4: The key elements of processes and procedures relevant to the effective care and management of the patient's condition are recorded

This was missing from almost all reports reviewed. It is not a current requirement of the regional report template, and its absence underlines the lack of appreciation about what is necessary for a structured and credible review.

Each report should give a clear account of:

1) What happened.
2) Where policy/process/procedural expectations were delivered as expected.
3) Where there was deviation from policy/process/procedural expectations and an explanation for such deviations.

Although there was a clear account of what happened, few reports provided an analysis that enabled the reader to know where expectations were delivered, where they were not, and where the design of the process for care delivery and management was incomplete.

This is a significant shortcoming in the SAI protocol which does not require systems based analysis as part of its approach to conducting SAI reviews or within its regional report template.

Reports of reviews must determine:

- What was expected.
- Where the evidence supports that the standard of care was delivered as expected.
- Where the evidence shows deviation from what was expected.
- Where the evidence shows there was a pre-existing deficiency in the design of care and treatment requirements and associated systems and processes.

Where deviation from policy, process or procedural expectations is identified, there is an explanation of any or all of the following:

- Whether the deviations were reasonable and justifiable based on the presentation of the patient, their clinical needs at the time and the unfolding situation.

- Whether the deviations were not reasonable and therefore not justifiable.

Where deviations in care standards and the care and treatment delivered were identified, there was little evidence regarding the reasonableness of such deviations. It is accepted across all domains of clinical practice that sometimes it is necessary to do things differently than what is outlined in policy and procedure. Clinical professionals are trained to apply their clinical skills and to have a clear reason why a different approach in any given situation is right for the patient under their care. It is possible to make a correct decision at the time care is delivered to alter the normal plan and for this to be later contemplated as a contributor to an incident that occurred later. The rights and wrongs of these decisions must be carefully contemplated, alongside the application of principles such as the substitution test (that is, what would a similarly qualified group of professionals, providing care under the same/similar set of circumstances, reasonably have done). There was no evidence from the reports reviewed that these core principles have been applied.

The situation is uncomplicated if the review panel and the care team agree that an unjustifiable deviation occurred. The problem arises when there is a difference of opinion between the care team and the SAI review panel. In all such instances, the SAI review panel must apply the substitution test.

There was no indication in any of the reports reviewed as to whether the care teams had agreed or disagreed with the findings and conclusions of the SAI review panel.

Many report authors and SAI review panels tried to draw conclusions regarding contributory factors and causal factors. However, there was a lack of robustness in the evidence-base on which such important conclusions were being made. In some cases, where a finding of causality had been made, it was clear from the content of the report and the Expert Review Team's clinical knowledge that the conclusion of causality would not stand up to independent scrutiny. It is the lack of a robust evidence base for such conclusions that contributes to the widely-held view, supported by some members of staff during focus groups, that a culture of blame pervades reviews.

Regarding the human factors and systems-based analysis, report authors and the review panels clearly tried to undertake this analysis and present its outputs in the review report. However, based on most of the reports assessed by the Expert Review Team, there is a lack of understanding about how this needs to be approached, and how the findings need to be structured and presented. The design of the regional report template will have further compounded this.

Indicator 5: Recommendations to address the most significant influencing factors to the identified contributory and causal factors

The quantitative assessment of the 66 SAI reports reviewed by the Expert Review Team revealed:

- There was a lack of clarity about whether the report made recommendations. This was found in 14 (21%) of the SAI reports.

- Recommendations were only made in 26 (39%) of the SAI reports, but what they were trying to achieve was unclear.
- In terms of whether there was a correlation between the incident, the report content, and the recommendations, in 30 (45%) of the SAI reports this was clear, in 32 (48%) it was unclear, and in 4 (6%) it was difficult to make a judgement about this.
- In terms of the appropriateness of recommendations, in 22 (33%) of the SAI reports the recommendations seemed reasonable, but in 40 (61%) they did not. In 4 reports (6%) it was difficult to make a judgement about this.
- Regarding any correlation between recommendations and the subsequent action plan, this was clear in 29 (44%) of SAI reports while in 36 (55%) it was not. In 1 report (2%) it was difficult to make a judgement about this.

In no report was there evidence that a structured approach was taken to the formulation of recommendations. The regional guidance on SAIs does not describe any requirements for this and neither do the regional report templates.

An example of a structured approach to recommendations is:

- Clear identification of the intended recipient of the recommendation.
- A clear statement of what is required.
- A clear statement about what the recommendation should deliver.
- A clear statement of what risk the recommendation is meant to contain.
- A clear statement of the scope of the recommendation (local, regional).

Indicator 6: Regarding the non-technical aspects of SAI reports

SAI review reports should adhere to the following non-technical requirements:

- Clarity about the questions posed by the family and the answers to these questions.
- A good standard of writing, with the correct use of grammar, punctuation, and syntax, with no abbreviations, unless already in common usage within the population of Northern Ireland.
- A readable report, written in non-technical language.

Each of the reports was assessed in relation to these factors. Regarding the level of family engagement and understanding, it is the Expert Review Team's perspective that most SAI review reports did not deliver any evidence, or at least convincing evidence, of compliance with candour.

The standard of writing was variable as was the use and non-use of technical language.

Regarding the degree of satisfaction a patient and family might have with the report presented, the lay members of the Expert Review Team considered that they would be satisfied with 16 (24)% of SAI reports reviewed. They considered that they would not be satisfied with (23) 35% of the SAI reports and were unable to determine an opinion of their satisfaction with the remaining 27 (41%).

Regarding the inclusion of evidence that patient and/or family questions had been asked and responded to during the SAI review process, there was evidence in 15 (23%) of SAI reports reviewed that this had happened. In 44 (66%) of SAI reports, there was no such evidence, while in 7 (11%) of SAI reports it was unclear.

Regarding readability and comprehension of SAI review reports, the lay members of the Expert Review Panel considered most reports 89 of 132[3], (67%) as easy to read in terms of structure and flow, but this dropped to 26 of 66 (39%) in terms of ease of comprehension of report contents.

Wider Consideration from Structured Assessment of 66 SAIs

On consideration of the implications of the overall findings of the structured assessment of the 66 SAI review reports, the Expert Review Team considered the necessary steps to ensure SAI reviews and their reports are of good quality, readable, respond to family questions and provide evidence an acceptable standard of review.

They agreed on a number of general issues that need to be addressed regarding the procedure and its implementation, if the overall standard and credibility of the SAI report, which sets out the findings, conclusions and recommendations of the significant adverse incident review process, are to improve. These include:

- A regional framework that makes clear what the approach to learning from unexpected and unintended harm is intended to deliver; that is, what are its measurable markers of success.
- A regional approach to SAI reviews that delivers recognised international good practice in the science of review.
- A reasonable amount of time to conduct an effective review and include the patient and family in the process in an empathetic, meaningful, and respectful way.
- A single, new report template and regional style guide that enables a consistent approach to SAI reviews across the region but is flexible enough to allow SAI review report writers to remove and add sections to the template.

There is no single activity that will achieve the above. The Expert Review Team wish to make clear that re-writing the regional standards will not achieve the standard of practice that harmed patients and their families are rightfully demanding of this specialist field across the HSC. This is a standard of practice that is comparable to other industries where the activity of reviewing and learning from unexpected harming incidents deliver the core components necessary for an evidence-based review, undertaken by investigators who are skilled for the job, so the right lessons are learned and the right safety improvements are implemented.

[3] The denominator in this indicator is 132 as there was not consensus. 132 reviews were undertaken 2 of each 66 reports. One by each lay reviewer.

It is the Expert Review Team's assertion that there must be a comprehensive recalibration of the approach to the requirement for, and delivery of, SAI reviews across Northern Ireland.
A new approach must achieve:

- Greater flexibility in an approach that focuses on the opportunity for learning and safety improvement.
- A lower number of in-depth reviews. Where early assessment indicates that this depth of review is necessary, there should then be capability and capacity in the system to do this well.
- A process by which individuals and/or organisations who want the opportunity to deliver 'Investigating Well' training to HSC staff, are asked to undertake an assessment process so that it can be determined that they have the right knowledge and skills to deliver such training. This would preferably then lead to a regional register of preferred providers from which individual HSC Trusts can source training.
- A register of individuals and organisations who are authorised and have been assessed as competent to lead the review of unexpected harm events that meet the threshold for an in-depth fully independent review - for example, mental health homicide, removal of a body part in error, in-patient suicide.

Northern Ireland is in the envious position of having only six HSC Trusts. This provides an opportunity to reset the compass in a way that is not possible in regions with larger populations. Achieving this reset and designing a fit-for-purpose approach to reviewing and learning from SAIs will require unified and cooperative work across all involved organisations. Furthermore, it will require frontline senior clinicians to be prepared to provide straightforward, peer-to-peer assessment, reflection and feedback to colleagues in neighbouring Trusts about the care and treatment provided to patients when the outcome constitutes unexpected and unintended healthcare harm. This is a core element of professionalism and clinicians of all disciplines need to meet this challenge head-on. It should not be the case that trusted independent clinical opinion has always to be sought from outside of Northern Ireland.

5.0 Conclusion

The work undertaken for this review has, alongside other related projects, determined that the SAI procedure and its implementation across Northern Ireland is not working as intended.

It frequently fails to:

- Answer patient and family questions.
- Determine where safety breaches have occurred.
- Achieve a systemic understanding of those safety breaches.
- Design recommendations and action plans to reduce the opportunity for the same or similar safety breaches in future.

Patients and their families are not fully enabled to engage with the process as partners and their questions are not always sought. They do not always receive open, honest and straightforward answers to their questions. The witness testimonies of patients and families are not routinely collected and, when they are, they are not treated as they should be; that is, as evidence in the same way staff testimonies are treated. The current situation is not tenable and must change.

Frontline staff, who come to work to help and support patients to achieve the best quality of health they can, consider the current process to be blame-orientated and not learning-orientated. It does not embrace the basic principles of a credible review process, a reasonable expectation of fair treatment, or the right to know of any criticism that is to be made and its relevant evidence-base. Staff are most frequently engaged as passive recipients to the process, which is not a good platform for learning and positive change.

The SAI review reports largely do not evidence a defendable approach to the review and identification of learning arising from unexpected patient harm. There are several contributory factors, including:

- Staff asked to lead the reviews are mostly asked to do this on top of pre-existing work commitments, including frontline patient care duties.
- The level of training provided to staff that are tasked with leading SAI reviews is insufficient and is not informed by regionally agreed competencies or a core patient safety training strategy or curriculum.
- The regional timescales allowed for undertaking a complex review, including meaningful engagement with a patient and their family, are unrealistic and lead to a bureaucratic process.
- The regional report templates are not designed to support the delivery of a quality, evidence-based report.

It is worth noting that since this review was commissioned, a number of Public Inquiries, patient recall and lookback exercises have been initiated in Northern Ireland. The Expert Review Team considers that such lengthy inquiries and large-scale pieces of work could be avoided by a robust system for deriving and implementing learning from SAIs. Ineffective systems and processes for review

and identification of learning emerging from SAIs, not only damage public confidence and trust in the SAI process, but also adversely impact on the trust of patients, their families and the public in the healthcare system as a whole.

There is now an important opportunity to achieve better for patients, for staff and for Health and Social Care services across the region. It is patently evident that continuing as we have been is not an option. The Expert Review Team has made five recommendations that, if implemented, should transform the current approach to learning from and preventing recurrence of harm within Health and Social Care in Northern Ireland. The RQIA look forward to working in partnership with DoH, PHA, HSC Trusts, patients, families and carers to deliver on a new and improved regional system for optimising the learning from adverse incidents which occur in Health and Social Care services and ensuring every opportunity is seized to improve the safety of Health and Social Care services.

6.0 Recommendations

The following recommendations are intended to deliver a new regional policy for reporting, investigating and learning from adverse events.

Recommendation 1:

The Department of Health should work collaboratively with patient and carer representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.

Recommendation 2:

Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.

Critical success factors

Appendix D provides an example of the critical success factors the Department of Health may wish to use to commence the work of redesigning the region's approach to learning from SAIs.

An example of a critical success factor and its core objectives:

- Families and patients are supported as active partners in the review process as much as they wish to be involved, including the involvement of an appointed advocate.
- Patients/families experience a compassionate and empathetic approach, which includes the method and frequency of contact throughout the review process.
- The voice of the patient and family is heard, their testimony is captured and they have the same status as any professional contributing information to the review process.
- The patient and family have a named source of support outside of the review panel. The role of this individual is clearly defined, including their authority to act in the best interest of the family.
- Questions asked by the patient and family are responded to fully, with honesty and integrity.
- The patient and family are encouraged to contribute to and influence the terms of reference for incidents identified as requiring in-depth.
- Patients/families are taken through the interim findings of the review and they are provided with enough time to enable them to read, comment on and influence the content of the final report.

How individual HSC organisations deliver these objectives is for them to determine. However, what must be required from all HSC organisations is evidence of achievement and an equal opportunity to be involved. This must be validated by patients and families who have experienced unexpected healthcare harm of a nature that warrants a dedicated review.

The Expert Review Team recommends that a co-production model, involving frontline staff, patients and their families, be adopted regionally to shape any way forward.

Implementing this recommendation will achieve:

Meaningful involvement of patients and families as partners in the SAI review process. This should incorporate a restorative process delivered within a culture of learning and improvement. The incident of harm and its resulting impact is one which the patient and their family must manage and live with. Therefore, it is essential that the patient and their family are at the centre of the review process if their trust in the Health and Social Care service concerned is to be retained.

This recommendation should address the risk of:

Further loss of public confidence in the systems of learning from healthcare harm and, importantly, risk of unnecessary harm to patients/families.

Recommendation 3:

The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.

What is required:

RQIA has found throughout its inspection and review work, widespread practice, where adverse outcome for the patient often drives the requirement for a Level 2 or Level 3 review. This practice must change. Not all unexpected harm, irreversible harm, and unexpected deaths are attributed to mistakes in the care or treatment provided.

Clear guidance is necessary which includes the implementation of a system of early, structured case assessment, taking place within one to two weeks of the incident occurring. This will deliver a greater degree of clarity regarding the degree of variance from expected care and treatment standards, and, on this basis, a proportionate decision can be made regarding the subsequent level of review required.

The Expert Review Team suggests:

- In all cases where there is concern that an identified variance may have contributed to the outcome for the patient, an in-depth examination of those variances is required.
- Where a serious breach in the expected standards of safe care is identified, an in-depth examination is warranted – even if the variance itself is not considered to have contributed to the patient's outcome.
- Where the incident represents issues known to have been previously examined individually, that consideration is given to conducting a structured, in-depth, whole system review rather than repeating another individual incident review which, by its nature, is unlikely to include systems-based learning and improvement.

In all the above suggestions, it is expected that there will be involvement and engagement with the harmed patient and their family.

Other considerations that should be incorporated into a decision-making process:

- It should be considered whether a further Level 2 or Level 3 review will achieve more learning than has already been achieved by a previous review.
- It should be considered whether a safety improvement plan, regarding issues relevant to this SAI, is already underway. If yes, then the value of an individual incident review should be determined. Consideration must be given to incorporating this case into the pre-existing safety improvement project.

Implementing this recommendation will achieve an approach that:

- Is proportionate.
- Makes appropriate use of public funds.
- Allows review panels to focus in-depth reviews on those cases where there is the greatest opportunity for learning and improvement.
- Enables the relevant clinical teams and service managers to retain ownership of incidents that do not reach the threshold for a level 2 or 3 review. This ensures recognition of the skill, competence and integrity of staff that are entrusted with the delivery of safe patient care.

In summation, this recommendation should address the risk of perpetuating a situation where the volume of level 2 reviews required exceeds the capacity and capability to deliver to a credible standard. The resulting proportionality will also support measurable improvements in safety and quality. This will also serve to address the risk of prolonging the dissatisfaction with the process that has been expressed by patients, their families, and frontline staff.

Recommendation 4:

The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by 'just culture' principles and a clear evidence-based framework that delivers measurable and sustainable improvements.

Recommendation 5:

The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.

What is required:

There are several issues that must be addressed if the overall standard of how serious incidents are reviewed and learnt from is to improve. These include:

- A regional framework that makes clear the key factors for success[4], against which each Trust/DoH (SPPG) is performance managed.
- A regional approach that delivers international good practice in the science of review. The development of a standard operating procedure that focuses on the practice of investigating rather than performance targets would support this.
- A process that embraces a just and fair culture where staff are supported through a constructive learning process and not scapegoated should deficiencies in systems or processes be found.
- A quality assurance system that makes explicit the accountability of senior managers within each Trust/DoH (SPPG) organisation, alongside a mechanism for holding them to account for SAIs signed-off as acceptable.
- A regional training curriculum, competency framework, certification or accreditation process and mentorship programme.
- Investigators of SAIs must demonstrate that they have the competencies to do so and have completed a programme of training in line with regional curriculum requirements.
- Educators/trainers and mentors must demonstrate that they have the right knowledge and competencies. Furthermore, they must complete an assessment process in order to be included on a region-wide approved provider register. Only providers on this register can provide review training to Trusts/DoH (SPPG).
- A fair and reasonable amount of time to conduct a credible review must be provided. This must include time to engage and involve the family/patient in an empathetic, meaningful and respectful way.
- A single new report template and regional style guide must be designed. This must facilitate a consistent approach to report formulation and presentation, with enough flexibility to allow a report writer to adapt it to meet the needs of the review conducted.

[4] That is the critical success factors and the core objectives for each success factor are agreed, and adopted by all Trusts and HSCB.

A new approach must achieve:

- Greater flexibility in approach, that focuses on the opportunity for learning and safety improvement.
- A lower number of in-depth RCA reviews. However, where early assessment indicates that this depth of review is necessary, there must then be the capability and capacity in the system to do this well.

Implementing this recommendation will achieve:

An approach to learning from harm that HSC staff and the public can have confidence in, in terms of:

- Learning lessons.
- Measurable safety improvement.
- Transparency.
- Alignment with the core principles and hallmarks of a robust review process.
- Restoration and reconciliation.

This recommendation should address the risk of:

A system of learning that is overwhelmed by too many reviews, few of which lead to measurable improvements in safety or learning of any significance. This will enable the HSC Trusts to develop a flexible and innovative approach to learning from harm; one which engages the patient and their family in the process and mitigates the risk of perpetual mistrust.

There is no single activity that will achieve the above recommendations. There must be a comprehensive recalibration of the approach to the requirement for, and delivery of, SAI reviews across the region.

Appendix A: SAIs by Category and by HSC Organisation

	SAI Level	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NIAS	Primary Care	Total
Maternity related	Level 1	2	5	3	0	4	0	0	14
	Level 2	0	0	1	1	0	0	0	2
Sepsis	Level 1	1	0	2	0	0	0	0	3
	Level 2	0	0	0	1	0	0	0	1
Choking	Level 1	0	0	1	0	0	0	0	1
	Level 2		1	0	0	0	0	0	1
Never Event	Level 1	1	0	3	0	1	0	0	5
Reference to Private Hospital/Nursing Home	Level 1	1	1	0	0	1	1	0	4
Person with a learning disability who died from a treatable condition	Level 1	0	0	0	0	0	0	0	0
Primary Care	Level 1	0	0	0	0	0	0	4	4
Reference to a person with a learning disability in Residential Care	Level 2	0	0	0	1	0	0	0	1
Other Level 1 SAIs	Level 1	0	0	1	0	0	3	0	4
Other Level 2 SAIs	Level 2	5	3	2	11	4	0	0	25
Other Level 3 SAIs	Level 3	1	0	0	0	0	0	0	1
Total SAIs reports to be assessed		**11**	**10**	**13**	**14**	**10**	**4**	**4**	**66**

Source: Information provided by HSCB and HSC Trusts. Categories suggested by DoH

Appendix B: Other Organisations that were offered the Opportunity to Input Into this Review

Organisation
Medicines & Healthcare products Regulatory Agency (MHRA)
Northern Ireland Adverse Incident Centre (NIAIC)
Health and Safety Executive Northern Ireland (HSENI)
Police Service for Northern Ireland (PSNI)
Safeguarding Board for Northern Ireland (SBNI)
Northern Ireland Adult Safeguarding Partnership (NIASP)
Information Commissioner Office (ICO)
British Medical Association (BMA)
General Medical Council (GMC)
General Dental Council (GDC)
Northern Ireland Medical and Dental Training Agency (NIMDTA)
Pharmaceutical Society Northern Ireland (PSNI)
Northern Ireland Social Care Council (NISCC)
Royal College of Nursing (RCN)
Nursing and Midwifery Council (NMC)
Health Care Professional Council (HCPC)
Northern Local Medical Committee (NLMC)
Eastern Local Medical Committee (ELMC)
Southern Local Medical Committee (SLMC)
Western Local Medical Committee (WLMC)
UNISON
Unite the Union
Northern Ireland Public Sector Alliance (NIPSA)

Appendix C: Improvements Suggested by Staff

During the engagement process, staff were asked to share any suggestions they felt would improve the SAI review process or patient and family engagement. Staff suggestions were used to formulate the following suggested improvements.

Suggested improvements to the SAI process

Classification of incidents

- The identification of incidents requiring an in-depth review must be driven by a structured assessment, which identifies:
    - a significant learning opportunity
    - the presence of significant care lapses, or care concerns
    - the depth and range of family questions

  Eliminating the determination for an in-depth review based on incident type and/or patient outcome alone can minimise the number of reviews with little impact on improving safety.
- Incidents involving suicide should not automatically be classified within the SAI process.

Timescales for Conducting SAI reviews

- Overwhelmingly, HSC staff consider that the timescales for conducting SAI reviews need to allow greater flexibility and take account of the complexity and the needs of the patient and family.
- A structured timescale approach that outlines the importance of capturing factual accounts and situational context within the first 48 hours post-incident, and early capture of information from families followed by a realistic period to allow an initial assessment of the information before determining what subsequent review is required, along with its depth and approach.

Terms of Reference

- The terms of reference for SAI reviews should be specific to the incident and referred to as key lines of enquiry to reflect a more learning-based approach.
- Terms of reference must include patient and family questions, where the patient and family have questions.
- The practice of pre-determined terms of reference that are used for all SAIs should desist as it provides no meaningful structure for the review process.

Staff Involvement

- Staff said that to achieve a ‘just culture’ and optimal learning they needed to be more involved in the process, specifically:
    - Their team leaders need to be involved in decisions over what to review, at what depth, and why

- Involved staff need an early invitation to capture a full account of what had happened and the situational context of the day, shift, or relevant period
- There needs to be a shift away from only reviewing documents to engaging involved staff in conversation about what had happened
- More group learning approaches could be utilised, such as after-action review
- Providing feedback on a high quality draft of the review report, that their comments are listened to and taken account of by the review panel
- In formulating recommendations
- In contributing to the design of action plans
- In participating in a post review learning event.

Communication with Staff

- Staff involved in an incident should receive notification that an SAI has been requested and be provided with a copy of the agreed terms of reference or key lines of enquiry, as well as information about who is conducting the review.
- Staff involved in an SAI ought to expect their team leader to receive update reports regarding the progress of the review so that the whole team is informed about this.
- Several staff thought a website or shared area should be established to keep those staff involved in an incident up to date on the progress of the SAI review while maintaining confidentiality.

SAI Review

- Currently, the SAI process is perceived as a negative review that does not support a 'just culture'. It must be mandated that the aspects of care that met or exceeded care standards, as well as those aspects that could have been improved, are reported on. This includes interventions that may have mitigated the impact of the incident.

SAI Review Panel

- Where it is identified that there were, or may have been significant care lapses, staff considered a dedicated SAI review panel from outside the Trust was required. This includes the lead reviewer and the subject advisors/field experts. Staff considered that such a team needed to be appointed by an external agency such as the HSCB/PHA.
- There should be a set of competencies, skills and knowledge required of the chair of an SAI review panel/lead reviewer, and the subject advisors/field experts asked to work with this individual.

Independence

Staff recognised that achieving complete independence was not feasible. However, they considered that:

- The lead reviewer/chair should not come from the service involved in the incident.
- Mentorship should be available for lead reviewers/chairs to support them in maintaining objectivity and impartiality.
- Ideally, a non-clinician with the right investigatory skills and competencies should chair the SAI review panels.
- A lay person or trained family advocate should be included in the SAI review panels. This would support meeting family needs and writing a report that is understandable by a non-technician.
- Optimal use of interventions such as web-conferencing and remote web-based interviews could be utilised to support involvement of independent technicians without the excessive cost often associated with this.

Staff Support

- Staff involved in an incident must be given protected time to prepare and attend interviews or meetings during the SAI review.
- Staff involved in an incident must be given the opportunity for pastoral/psychological support to deal with traumatic incidents.
- A rapid team debrief post incident must become normal practice.
- All SAI teams must include an administrator to support its smooth delivery and to ensure that the time of frontline, professionally qualified staff is used appropriately.
- Corporate teams responsible for patient safety must have the necessary competencies required to provide support and mentorship to SAI leads/chairs.
- Staff asked to lead SAIs must have received a minimum of two days training, plus mentorship and coaching support so that they can lead the process competently.
- Staff required to conduct the initial reviews of incidents before a decision is made to progress to SAIs need to know how to conduct a structured review, and what information is required to do this competently.

Advocacy

- Northern Ireland needs to engage with patient advocacy organisations to develop a system where lay people can become accredited advocates for families following patient safety incidents.
- Publicly funded independent advocacy should be available for patients/families that require this and where there are concerns about the adequacy of care and/or treatment offered.

Recommendations

- Staff need protected time to participate/lead in Quality Improvement Action plans emerging from SAI reviews.
- Multidisciplinary staff should be brought together to help develop outcome-focused recommendations. This should not be the sole domain of the SAI review panel.

- Recommendations from SAI reviews should be benchmarked against core criteria, and the teams and services involved in the incident must be invited to comment on the appropriateness of the recommendations made.
- When contemplating whether a recommendation is or is not accepted and how it is treated, due consideration must be given to pre-existing safety and quality improvement projects already underway or planned.
- Recommendations from SAI reviews need to be outcome-focused and drive action plans that deliver measurable and sustainable improvements in the quality and safety of care.

Learning

- There must be more formal processes for disseminating learning from SAI reviews. The Oxford Model developed in the 1990's and successfully utilised by Mersey Care NHS Trust is an example of this.
- Each Trust must be required to demonstrate not only what it has learnt but how it has improved. This will drive disseminated learning.
- RQIA and other regional bodies must show how the learning within individual Trusts is captured and used for learning across Northern Ireland.

SAI Review Reports

- Feedback from all key staff involved should be considered in the finalisation of an SAI review report. This assures factual accuracy and greater engagement by frontline professionals.
- A meeting with all staff associated with the incident, and who provided information to the SAI review panel, should be conducted to enable findings, conclusions and recommendations to be discussed and agreed.
- The SAI review report template should be revised to include a section that allows greater articulation of patient and family engagement.

Action Plans

- How action plans are developed must be in line with good practice, rather than copying and pasting recommendations into an action plan template. This does not deliver sustainable or measurable change.

General

- The practice of retrospective recordkeeping in the 72 hours post incident needs to be enabled. Where this is not possible for whatever reason, accounts of involvement must be collected.
- SAI reviews should focus less on assigning blame and scapegoating, and instead embrace the principles of a ‘just culture’ and justifiable accountability.
- The SAI process should be reviewed to examine how best to review future incidents in a more proportionate way.

Suggested improvements for patient and family engagement

Information for Patients/Families

- Patients/families should be better informed of the SAI review process. For example, there could be better quality information leaflets available, or a video or podcast explaining the process on the DoH or RQIA's website.
- The SAI process must be explained to patients/families before the process commences so they can have realistic expectations.

Communication with Patients/Families

- There must be clear standards of how a patient and family should be communicated with during the SAI process, with patients/families asked for formal feedback at the end of the process via a questionnaire or online survey tool. This should also accommodate requests for anonymity.
- The terms of reference/key lines of enquiry must be shared with patients/families prior to an SAI review commencing, and these must include the patient and family questions alongside technical clinical/process-based questions.

Patient and Family Engagement

- Trusts must demonstrate their commitment to the SAI process and to the patients/families affected by SAIs by ensuring senior management are actively involved in communications with families. This is particularly important at the start and end of the process.
- Staff must receive training from experienced advocates and families who have experienced the SAI review process so they know how to achieve and maintain positive engagement with a family.

Appendix D: Examples of Critical Success Factors

The factors listed below are examples of critical success factors (CSF), previously developed by an HSC organisation in the UK and provided to this review by Maria Dineen, member of the Expert Review Team. This list is not intended to serve as a definitive list; rather, its purpose is to provide an initial starting point for a wider conversation about what the critical success factors could look like in Northern Ireland.

Critical Success Factor 1:

We consistently value and engage meaningfully with patients and their families through the entire review (including complaints) process.

The core objectives for this CSF are proposed as:

- Patients/families experience a compassionate and empathetic approach.
- The voice of the patient and family is heard.
- The patient and family are well informed throughout the process.
- Questions asked are responded to with honesty and integrity.
- Patients/families are provided with the opportunity to contribute to and /or influence the terms of reference for incidents identified as requiring in-depth review.
- Patients/families are taken through the draft review report, and provided enough time to enable them to read, comment on and influence the content of the final report.

Critical Success Factor 2:

We consistently value and engage meaningfully with staff throughout the entire review (including complaints) process

The core objectives for this CSF are proposed as:

- Staff experiences a compassionate and empathetic approach.
- The voice of the staff involved in an incident is heard. This includes their experience of 'the day', and the 'context' in which the incident occurred.
- Staff involved are well informed throughout the review process.
- Staff are treated fairly and equitably, in line with NHS Improvements Just Culture Guidance.
- Staff involved in the incident, and other key staff informants to the review, are facilitated in reading the draft report and providing feedback on it relating to factual accuracy, tone and style.
- Staff involved in the incident and service(s) in which the incident occurred are actively engaged in designing the action plan to deliver measurable and meaningful improvement.

Critical Success Factor 3:

We will consistently show that measurable improvements in standards, safety and quality occurs, is sustained, and known about by staff.

The core objectives for this CSF are proposed as:

- There is a corporate action planning/lessons learnt group that acts as a repository for those issues identified in one division, but which have wider implications for other services / divisions within the Trust. A central approach will ensure these issues are assessed and addressed corporately.
- Within each division the safety governance group, lessons learnt and recommendations arising from reviews are a standing agenda item.
- Recommendations are targeted towards i) the local team ii) the local service/division and iii) corporate wide. Further they are mostly addressing systems improvement and not individual practice.
- There is an action planning method/approach that facilitates engagement of staff involved in service delivery and sets out clearly the range of activities required to deliver the intent of the recommendation.
- All action plans include how success is to be measured and at what frequency to assure sustainability.
- Recommendations are formulated to make clear their intent (i.e. what needs to be achieved if they are accepted and implemented).
- Staff are aware of the improvements implemented in their service and division as a consequence of reviews conducted, and more widely across the organisation.

Critical Success Factor 4:

Incidents will be reviewed proportionately i.e.: right level, right depth, and right breadth of review according to the volume and magnitude of errors (if any).

The core objectives for this CSF are proposed as:

- The Trust has an achievable and defined method/process through which harming incidents that meet the threshold for Duty of Candour (i.e. moderate harm and above) are assessed to determine the depth of review required and with what degree of independence.
- The Trust has a clear categorisation system for incidents that meet the threshold for Duty of Candour (and above) so that there is clarity between those that occurred despite good care, and those that were caused by mistakes in care delivery. (E.g. Category A means care and treatment was appropriate, and category D means there were several lapses in care and treatment that may have contributed to the outcome).
- The Trust assigns the review of cases where there may have been a contribution to the harm because of mistake to a case reviewer who has the right competencies to lead and deliver a more complex review.

- Terms of reference for reviews are bespoke and make clear the relevant technical questions that must be asked and answered, alongside any family questions that have been posed.
- The Trust has a review framework, and approach, that allows a range of methods and tools to be employed to meet the discrete requirements of each review.
- The Trust has in place a process to enable early preservation of information including memory capture, so that the assessment of incidents and any subsequent review is well informed and can be explored to the right depth and breadth.

Critical Success Factor 5:

Reviews are conducted using appropriate methods and tools, and in line with good project management principles, assuring delivery within an agreed and realistic timescale.

The core objectives for this CSF are proposed as:

- The Trust will have enough staff trained to undertake the case screening element of the review journey within 10 working days of incident occurrence.
- The Trust will have enough staff trained to a higher level of knowledge and competency to delivery those reviews that are categorised C or D (i.e. care/ management a bit 'hit or miss' or serious lapses are identified).
- The Trust will commit to a stepped review process including clear boundaries for the review arising from carefully formulated terms of reference that make clear the necessary technical questions as well as including family questions.
- Staff asked to act in a case screening or lead reviewer/case reviewer capacity will have the necessary adjustments made to their pre-existing diary commitments so that they have a fair amount of dedicated time to deliver the review project.
- Specialist advisors will be allocated to the appointed case reviewer in a timely manner so that avoidable delays do not occur.
- The Trust will ensure for all category C and D reviews that there is reasonable administrative support provided to the case investigator so that working practices are as efficient as possible. (Category C and D - i.e. care/ management a bit 'hit or miss' or serious lapses are identified).

Critical Success Factor 6:

Review reports are consistently produced and meet the following standards:

- Well written.
- Understandable by a non-technician.
- Reasoned (i.e. evidence and not opinion orientated).
- Clear findings, conclusions and recommendations.
- Answer all family questions where it is possible to do so.
- Accessible.
- Validated.

The core objectives for this CSF are proposed as:

- The Trust has a practical approach to proof reading reports that includes insights from:
    - a technical advisor
    - a lay person
    - someone who has good grammar, and spelling
    - someone who is good at formatting documents, using 'smart report' technology.

- The Trust has a well-designed report template that includes:
    - acknowledgements
    - contents list
    - an executive summary
    - introduction (case over view and context of care, as well as outcome and reasons for the review)
    - a family section
    - a findings section (what was delivered to a reasonable standard, what could have been improved, any significant or serious lapses in care standards.)
    - what has changed / improved since the incident
    - what additional lessons learnt arose from this review
    - conclusions
    - recommendations
    - appendices

- Both the patient / family and the staff involved are provided with the opportunity to read and comment on the report when in good draft format. Their comments are listened to and incorporated into the final report document as far as it is possible to do so. Where it is not, they are advised of this and why not.
- Review reports are written empathetically and compassionately.
- Review reports are written in plain language so they understandable by all readers.
- Staff required to write review reports have a mentor who can support the development of their writing and presentation skills.

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Patient Safety Incident Response Framework

Version 1, August 2022

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What is PSIRF?

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is **not** an investigation framework that prescribes what to investigate. Instead it:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes. To do so, information is collected and synthesised from a wide variety of sources, including wide stakeholder engagement.

A patient safety incident response planning exercise is used to inform what the organisation's proportionate response to patient safety incidents should be. The PSIRF approach is flexible and adapts as organisations learn and improve, so they explore patient safety incidents relevant to their context and the populations they serve.

The principles and practices within the PSIRF embody all aspects of the NHS Patient Safety Strategy and wider initiatives under the strategy, including the introduction of patient safety specialists, development of a national patient safety syllabus, development of the involving patients in patient safety framework and introduction of the Learn From Patient Safety Events service. The NHS Patient Safety Strategy sits alongside and supports the NHS Long Term Plan.

Who does PSIRF apply to?

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services

Secondary care providers that are not NHS trusts

Organisations that provide NHS-funded secondary care under the NHS Standard Contract but are not NHS trusts or foundation trusts (eg independent provider organisations) are required to adopt this framework for all aspects of NHS-funded care and may apply this approach to their other services for consistency. These organisations may not need to undertake the full analysis required for patient safety incident response planning (eg due to limitations on data availability), but processes such as stakeholder engagement in preparing plans are required.

Primary care

Primary care providers may wish to adopt this framework, but it is not a requirement. Primary care providers that wish to adopt this version of the framework should work with their integrated care board (ICB) to do so.

Further exploration is required to ensure successful implementation of the PSIRF approaches within primary care. The National Patient Safety Team will work with a small number of primary care early adopters to explore how the PSIRF can be adapted to this sector.

Achieving effective learning and improvement using PSIRF

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if systems and processes that support compassionate engagement and involvement of those affected by patient safety incidents (patients, families, and staff) are in place.

Compassionate engagement and involvement mean working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. When a patient safety incident investigation (PSII) or other learning response is undertaken, organisations should meaningfully involve those affected, where they wish to be involved. Organisations must have policies to support this to happen and should consider how they will meet the needs of those affected. Detailed guidance and standards are available in Engaging and involving patients, families and staff following a patient safety incident.

2. Application of a range of system-based approaches to learning from patient safety incidents

The PSIRF promotes a range of system-based approaches for learning from patient safety incidents, rather than methods that assume simplistic, linear identification of a single cause.

Organisations are encouraged to use the national system-based learning response tools and guides, or system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.

Those leading patient safety incident responses (learning response leads) and those involved in the oversight of learning and improvement emerging from patient safety incident response require specific knowledge and experience. These requirements are detailed in the patient safety incident response standards.

3. Considered and proportionate responses to patient safety incidents

Organisations have finite resources for patient safety incident response. The PSIRF supports organisations to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a PSII to learn and improve. Some incident types will also require specific reporting and/or review processes to be followed. These requirements are detailed in the Guide to responding proportionately to patient safety incidents.

The PSIRF sets no further rules or thresholds (other than those set out in the Guide to responding proportionately to patient safety incidents) to determine what needs to be learned from to inform improvement. Incident response activity may include investigation of an individual incident where contributory factors are not well understood, or a thematic review of past learning responses to inform the development of a safety improvement plan. If an organisation and its ICB are satisfied risks are being appropriately managed and/or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type, and efficacy of safety actions is being monitored, it is acceptable **not** to undertake an individual

response to an incident – other than to engage with those affected and record that the incident occurred.

4. Supportive oversight focused on strengthening response system functioning and improvement

All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a common understanding of the aims of this framework, to provide an effective governance structure around the NHS response to patient safety incidents. The PSIRF expects ICBs to facilitate collaboration at both place and local system level.

The PSIRF requires regulators and ICBs to consider the strength and effectiveness of NHS providers' incident response processes. Accountability for the quality of learning responses to individual incidents sits with provider leaders. Providers are not required to seek sign off for incident response reports from their ICB; however, they must be open with information relating to patient safety incidents and findings from incident responses, including formal reports, to support continuous development of an effective incident response system. Further information is given in Oversight roles and responsibilities specification.

What are organisations required to do?

Organisations are required to apply this framework in the development and maintenance of their patient safety incident response policy and plan.

An organisation's patient safety incident response policy should describe its overall approach to responding to and learning from patient safety incidents for improvement and identify the systems and processes in place to integrate the four key aims of PSIRF. It should describe how those affected by a patient safety incident will be engaged, what governance processes for oversight are in place and how learning responses are translated into improvement and integrated into wider improvement work across the organisation. The policy should also outline how patient safety incident response integrates with other activities such as clinical governance, HR and

complaints management, and underline that the remits of different response types are distinct and must be kept so. A national policy template is available.

An organisation's patient safety incident response plan should specify the methods it intends to use to maximise learning and improvement and how these will be applied to different patient safety incidents. It should be based on a thorough understanding of the organisation's patient safety incident profile, ongoing improvement priorities, available resources and the priorities of stakeholders including patients and local Healthwatch. A national plan template is available.

Both documents – the policy and plan – should align with and be integral to the organisation's wider approach to safety improvement and should be published on the organisation's website.

Plans should be updated regularly based on new learning, an organisation's changing risk profile and ongoing improvements. In this way, incident response becomes part of a wider safety management system approach.

Involvement of patient safety partners

The NHS Patient Safety Strategy promotes the involvement of patients, families, and carers as partners both in their own care and in the wider oversight of healthcare. Such involvement in oversight is of specific value in the development of an organisation's patient safety incident response policy and plan. Patient safety partners should also play an important role on incident response oversight committees. More information is provided in the framework for involving patients in patient safety.

PSIRF and inequalities

Some patients are less safe than others in a healthcare setting. The PSIRF provides a mechanism to directly address these unfair and avoidable differences in risk of harm from healthcare:

- The PSIRF's more flexible approach makes it easier to address concerns specific to health inequalities: it provides the opportunity to learn from patient safety incidents that did not meet the definition of a 'Serious Incident'.
- PSIRF prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans.
- Tools in the patient safety incident response toolkit prompt consideration of inequalities during the learning response process including when developing safety actions.
- Engaging and involving patients, families and staff following a patient safety incident gives guidance on engaging those with different needs.
- The framework endorses a system-based approach (instead of a 'person focused' approach) and is explicit about the training and skill development required to support an approach. This will support the development of a just culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

How to use the PSIRF

This framework describes the four main aims of PSIRF in relation to responding to patient safety incidents.

It is supplemented by the detail in the following documents:

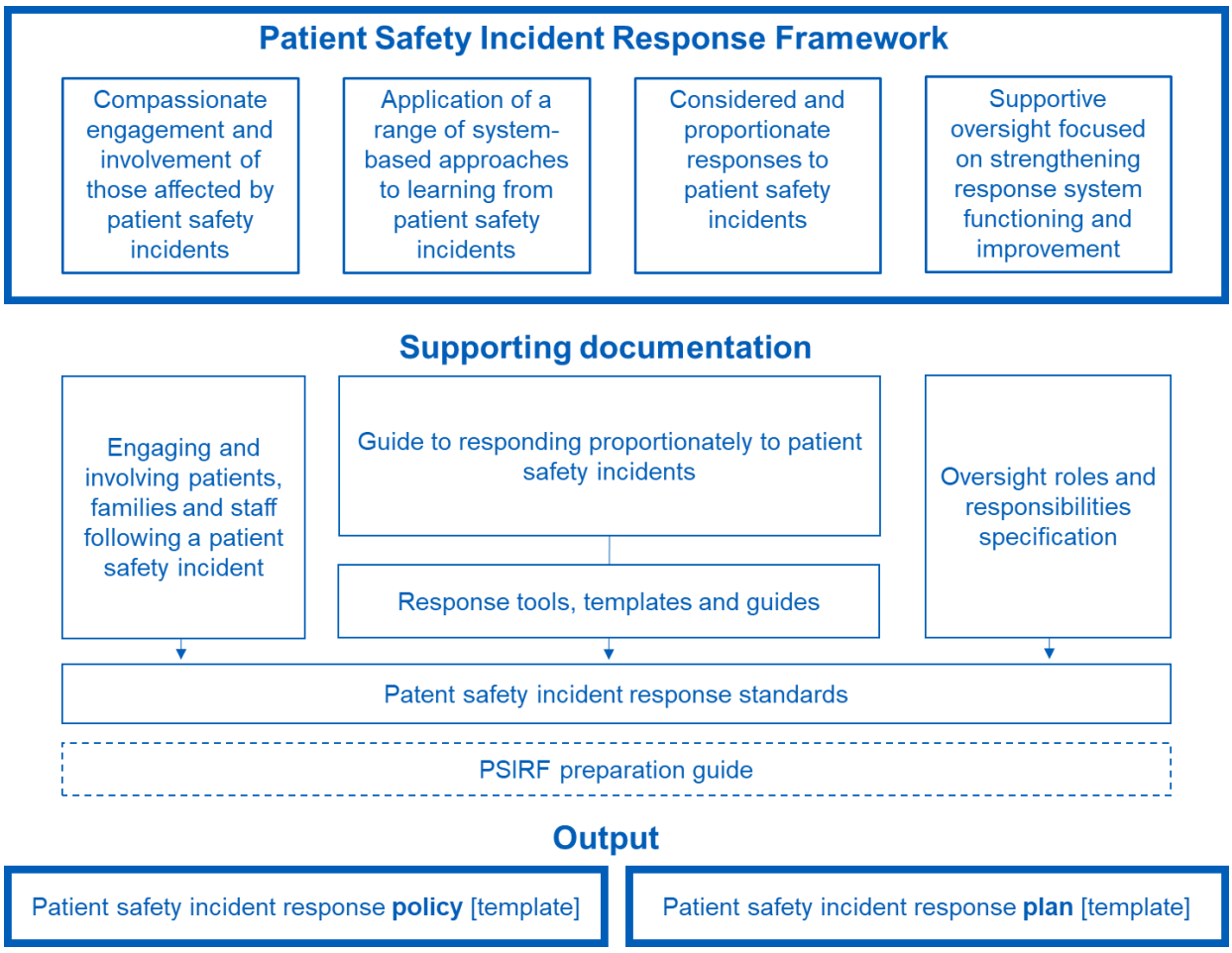
1. A comprehensive preparation guide that describes the steps organisations should take to prepare for and implement the framework. This includes national templates for developing a local patient safety incident response policy and plan.
2. Detailed guidance on engaging those affected by patient safety incidents and, with agreement, involving them in the learning response process.
3. A guide to responding proportionately to patient safety incidents including planning, response tools, guides, and report templates.
4. A detailed specification for the roles and responsibilities for those overseeing patient safety incident response.

5. Patient safety incident response standards including training requirements.

Organisations should use this guidance, together with relevant local information, to inform and maintain the corresponding sections of their local policy and plan as needed.

Figure 1 provides an overview of the framework and associated documents.

Figure 1: Overview of the Patient Safety Incident Response Framework documentation



Links to other processes

This framework describes how the NHS manages patient safety incidents, including how it plans its response activities for the purpose of improving patient safety and how it engages with those affected. This framework and the response activities it supports explicitly exclude activities that apportion blame or determine culpability, determine preventability, or identify cause of death.

Some patient safety incidents may also require a **separate** response that is not focused on learning for patient safety improvement. For example, some incidents where a patient dies may be subject to investigation by a coroner to determine how, when and where they died. Others may involve the police where there is a reason to think criminal activity may have taken place. Some incidents will lead to concerns about an individual's fitness to practise or ability to do their job, and so may be considered by the employer or a professional regulator.

Where a response is required that is not focused on learning for patient safety improvement, relevant referrals should be made to ensure it is conducted entirely separately. Care must be taken not to conflate and combine patient safety incident response activity with other remits.

What next?

The implementation and impact of PSIRF is being evaluated via a National Institute for Health Research (NIHR)-funded study that started in May 2022.

The National Patient Safety Team will use the evaluation findings together with national indicators of effectiveness to inform future iterations of PSIRF in formative and summative manner, to enable the NHS to continue to improve its approach to patient safety management. The team will continue to build on the foundations set by PSIRF in developing a safety management system that ensures a methodical and systematic approach to risk management as used in other high-risk industries.

Note of acknowledgement

Seventeen early adopter provider organisations tested the introductory version of the PSIRF alongside their commissioners (now ICSs) and NHS England regional leads. An independent evaluation of the early adopter programme found widespread support for the PSIRF; all recommendations from this were carefully considered by the National Patient Safety Team when revising PSIRF documents. The experience of early adopters and insights gained from the early adopter programme have also informed this revision.

We would like to thank our early adopters, patient safety partners and wider stakeholders who have generously given their time to share their experiences of the PSIRF. This revised framework would not have been possible without their help, constructive feedback, and ideas.

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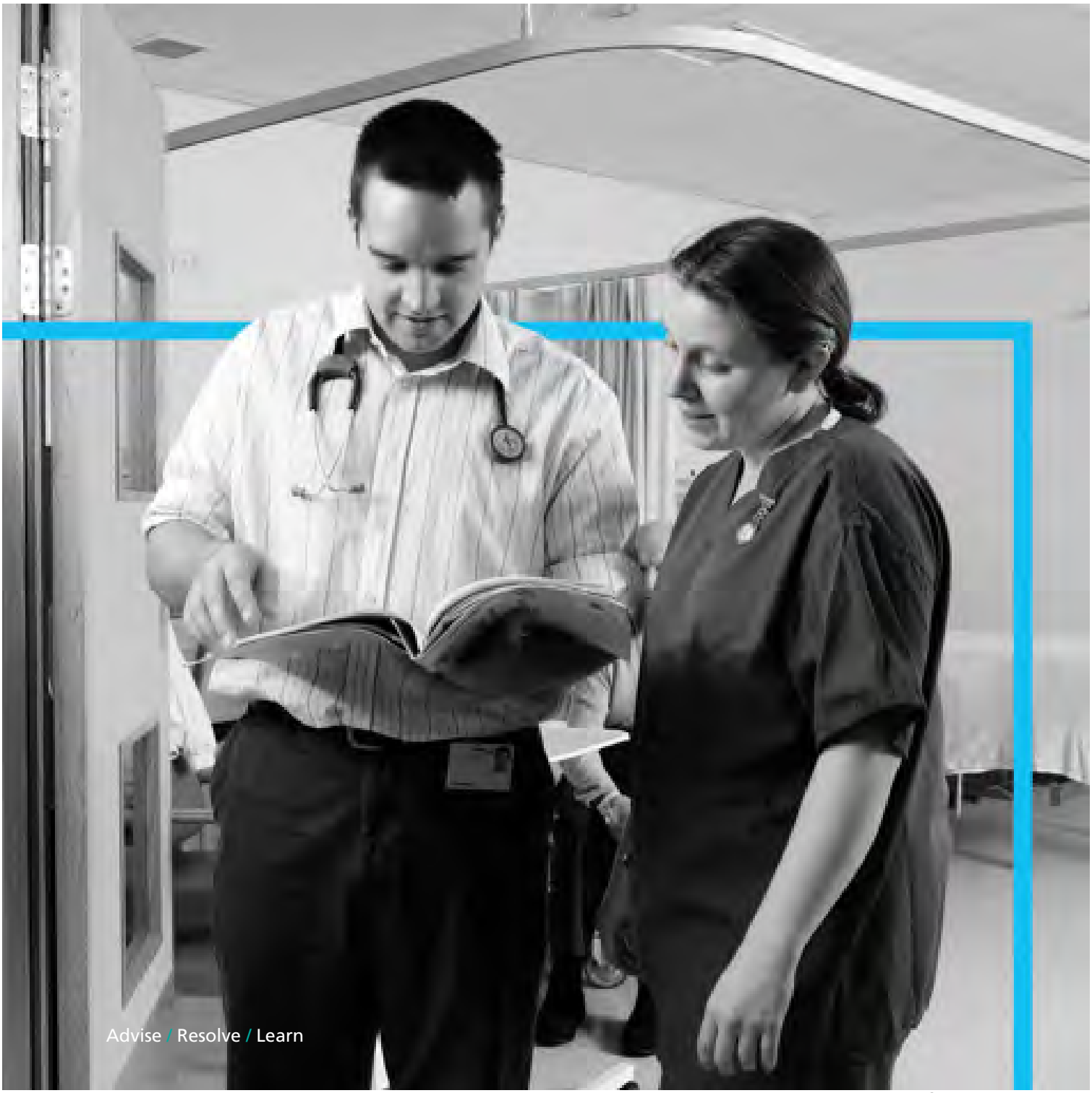
NHS Resolution

Being fair

Supporting a just and learning culture for staff and patients following incidents in the NHS



Advise / Resolve / Learn

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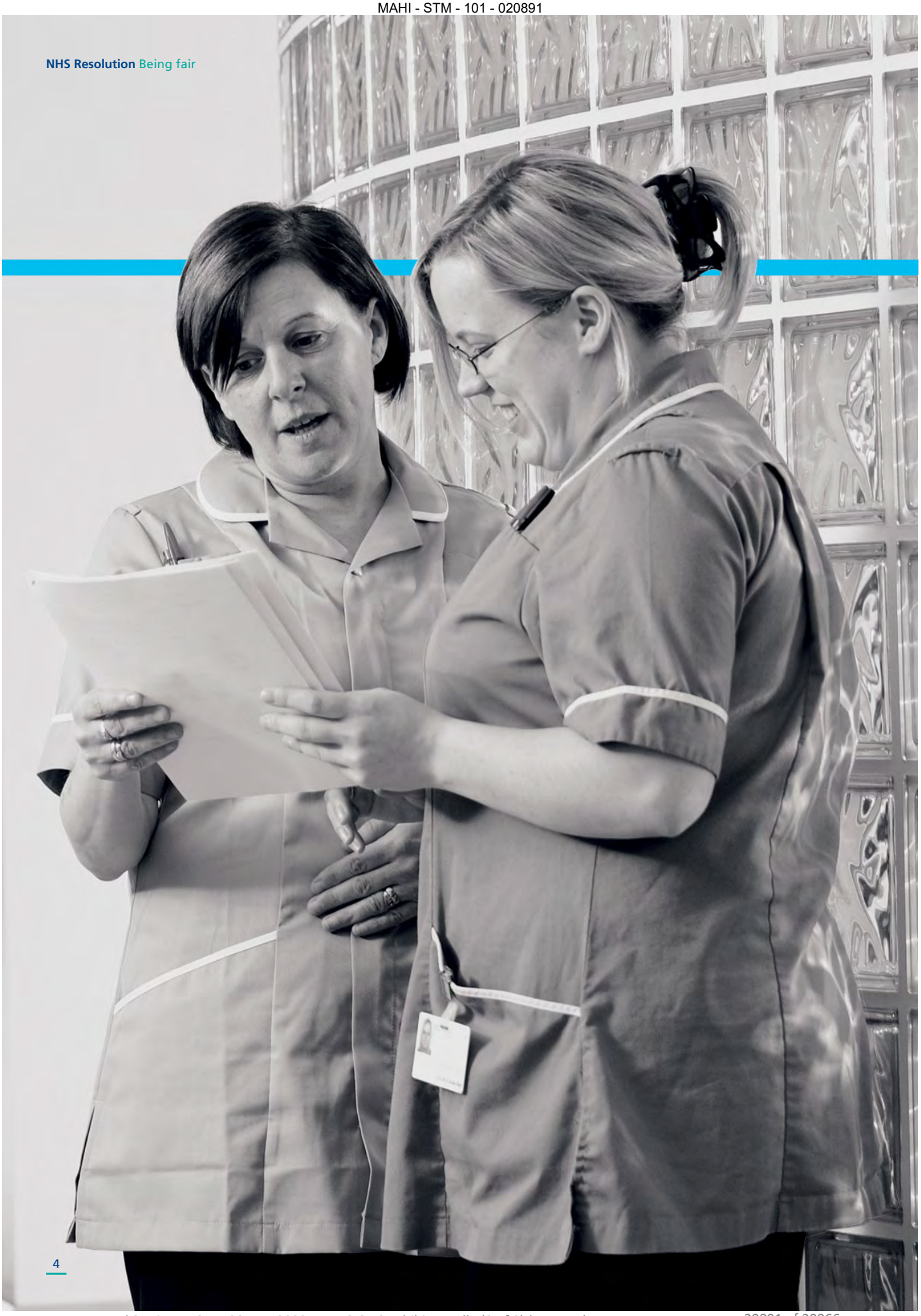
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Key messages

A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability.

The vast majority of people who work in health and social care wish to provide the very best care they can, given the circumstances they are working in. There is very rarely intent by staff to provide care that did not go as expected or planned. While this guidance is predominantly about how staff are treated, this is with the intent to ensure that the benefits of a just and learning culture for staff will have a significant and positive impact on patients and their families.

All actions should be understood before being judged and staff should be supported to learn from their actions. Furthermore they should be asked for their advice and help to design the systems that could help change things for the better.

Those responsible for managing incidents should use the science of human factors, including investigative techniques, skills, expertise and methods that help us fully understand what happened in order to learn from errors or harm in the future.

We recommend using a balanced approach to safety, i.e. that we learn from when things go wrong and learn from when things go right. If we progress this thinking then the definition of safety shifts from 'avoiding something that goes wrong' to 'ensuring that everything goes right'. Then we can help people succeed under the varying conditions so that the number of intended and acceptable outcomes is as high as possible.

A resilient organisation helps staff work safely every day. Resilience also provides the ability for an organisation to sustain its operations under both expected and unexpected conditions.

In order to achieve a just and learning culture when care has not gone as expected or planned, three questions (Dekker 2017) should be asked:

- **who is hurt?**
- **what do they need?**
- **whose obligation is it to meet that need?**

A Just and Learning Culture Charter is provided (see example 1) for you to adapt and adopt which includes many of the key messages that organisations can consider.

Co-designing the solution to developing a just and learning culture

A roundtable workshop of HR directors, regulators, NHS arm's length bodies and some patient safety experts was convened by NHS Resolution in February 2018 to explore the concept of developing a just and learning culture and to share best practice.

Participants discussed the need for:

- Linking patient safety with staff engagement, health and wellbeing
- The balance of learning, accountability and responsibility
- An understanding of why or whether a disciplinary investigation is the right response following an incident
- Use of the science of human factors and the latest thinking on creating a just culture
- In addition, a focus on behavioural change and understanding more about a 'safety II' approach in terms of learning what works and the specific aspects of working in health and social care, i.e. the difference between how work is actually done and not the work that people (leaders, policymakers, regulators) imagine is or could be happening
- Identifying what good practice looks like
- The importance of role modelling and leadership by example
- Creating ways in which staff can be listened to and using staff stories at Board level and other senior leadership meetings
- Building a strong partnership with 'staff side'/staff representatives and involvement of staff diversity networks
- Tackling incivility and the bullying culture within health and social care
- Where appropriate, using third-party advice (e.g. Practitioner Performance Advice service – within NHS Resolution).

The overarching aim of the group was to provide the NHS with the latest thinking together with guidance on how to replace blame with learning, and to ensure that there is equity for all staff and a proportionate response to concerns about performance or behaviour for all staff, regardless of race, ethnicity, disability or sexual orientation.

Central to the approach in the future, the group agreed three aims:

1. To prioritise learning about how to minimise the conditions and behaviours that can underpin or lead to error rather than apportion individual blame.
2. Build a consistent approach for all staff, no matter what profession or what background.
3. A determination to avoid, wherever possible, inappropriate suspension, exclusion and disciplinary action unless there is wilful intent.

What we need is a restorative just culture (Dekker 2018) that is about repairing and building trust and relationships when things have not gone as planned. This means we need to develop working practices that move people away from fear and blame, including tackling incivility and bullying, and addressing the health and wellbeing needs for staff to help them work safely. Ensure everyone's needs are met, no matter who they are. Treat everyone fairly, no matter what their background is, and help them speak up.

To create a just and learning culture the group considered a need for:

- All staff, patients and their families to be provided with appropriate support at all times
- To ensure that the culture is restorative for all and not retributive or adversarial (Dekker 2018 and 2017)
- A challenge in the current thinking and a change in mindset in relation to healthcare and how it could be safer, with a focus on learning rather than blame and with a focus on creating the right conditions to help people work safely by truly understanding what work is like and not how it is imagined to be (Hollnagel 2013)
- An emphasis on ensuring that new staff (whatever their background, and especially if trained overseas) are supported and are aware of the organisation's values and the behaviours they should expect for themselves and from others
- An acknowledgement that excessive and inappropriate disciplinary action may be taking place in respect of staff from all backgrounds and especially, unwittingly or otherwise, those from BAME (black, Asian and minority ethnic) backgrounds
- Reduce the need for inappropriate disciplinary investigations
- Using staff data related to disciplinary action, suspensions and exclusions to check if any patterns of high (or disproportionate) levels of disciplinary action exist and why, and whether, over time, they are reducing
- Early intervention by trained and committed senior staff to distinguish between blame and accountability based on a thorough understanding of human factors, patient safety, the restorative just and learning culture, and behavioural psychology
- Speedy interventions to determine whether any form of disciplinary investigation is needed and timely resolution for all
- The use of a tool such as a triage approach, checklist or prompts simply to help reflection and challenge prior to any disciplinary action– and to use these with caution to ensure that they do not lead to an inappropriate focus on the individual or individuals, i.e. that they in themselves do not perpetuate a blame culture in some way
- Accountability of decision makers throughout the system to learn.


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Examples of practices used across the NHS

The following are just a few examples of what people are doing in the NHS as a way for others to see the kinds of ways in which a just and learning culture could be built.

Organisations are at different stages, and are still learning about what works. There are a variety of approaches being taken, with no single approach recommended over another (further examples of best practice may also be helpful to consider).

However the use of an agreed tool or framework by organisation is helpful in supporting a more consistent approach towards all staff groups.

Example 1 - Just and learning culture charter.

Example 2 - Restorative approach: Mersey Care NHS Trust and the use of a restorative approach adopted from and influenced by the work of Professor Sidney Dekker (2017).

Example 3 - Triage system: Barts Health NHS Trust and the use of a triage system to determine whether disciplinary action is necessary or inappropriate.

Example 4 - A just culture guide: NHS Improvement 'just culture guide' which also acts as an aide memoire for people to assess the appropriate response when something goes wrong (NHS Improvement 2018).

Example 1

Just and learning culture charter

The following is a suggested 'Just and Learning Culture Charter' for organisations to adapt and adopt.

Our organisation accepts the evidence that we will provide safer care and be a healthier place to work if we are a learning organisation. Humans are fallible; they make mistakes and errors.

1 Patients' physical and mental health must remain the paramount concern of any treating health professional, whether or not there is a dispute over treatment or a clinical error is alleged to have been made.

2 Clinical incidents have a real and deep impact on people's lives. Patients (or their partners or relatives) who have been affected have a right to explanations and to seek apologies, assurances and/or financial compensation for injuries caused where appropriate.

3 The vast majority of things that do not go as planned are due to unintentional acts and choices, and only a tiny minority are as a result of intentional acts, recklessness or wilful behaviours. Processes should be designed to support the vast majority of staff to help them work safely.

4 We need to take the blame out of failure. This means changing the mindset and the language associated with safety – from blame to learning. However, this does not mean an absence of accountability. Accountability is about sharing what happened, working out why it happened, and learning and being responsible for making changes for the future safety of staff and patients.

5 We will always want to understand why things don't go as planned in order to redesign systems and processes to minimise the chances of them happening again in future, and support individuals to work safely.

6 We will learn about what works well, and why, in order to replicate and optimise these behaviours and processes.

7 We will publish guidance summarising the fundamental principles of a just and learning culture which will be applied at all levels of our organisation, from the executive to the frontline.

8 We will recognise that people are less willing to speak up if they are afraid of being punished or prosecuted. We will build a culture where individuals feel able to speak up, offering different levels of access (e.g. freedom to speak up guardians) and ensure that when they do speak up they are fully supported within the organisation.

9 All people in contact with our organisation – employees, contractors, patients, relatives and the public – are encouraged, and sometimes even rewarded, for providing essential, safety-related information.

10 As part of our just and learning culture we will ensure that people are clear about where the line must be drawn between acceptable and unacceptable behaviour. As an organisation we recognise that incivility, rudeness and bullying are damaging both to staff wellbeing and patient safety, and we will seek to address these issues. That means being respectful, civil and kind.

11 We will ensure that all our staff recognise that inappropriate responses may disproportionately impact on some groups of staff, notably BAME staff.

12 People must be confident that their identity, or the identity of any person implicated in any report they make, will not be disclosed without their knowledge, unless this is required by law.

13 If a more formal investigation is required, we will ask what happened and why, and what can be learnt. A decision will be reached within a locally agreed reasonable timescale. When we investigate when things go wrong, we will try to recognise and minimise natural biases we all have, such as hindsight, outcome and confirmative bias. At all stages the emphasis will be on learning, not blame, and on why it happened rather than 'who did it'.

14 When a concern is raised or an investigation is required we will have in place clear governance to ensure that investigation reports are followed up, setting out which actions are being taken to address error-producing conditions in the future.

15 Those who report concerns will be notified in a timely way of the steps taken in response. Where patient care was compromised, the family will be told in a timely way in accordance with our duty of candour.

16 While we recognise that disciplinary action may be necessary, we will ensure suspension is rare and is never a knee jerk response to whatever has happened.

17 Our organisation recognises that there will be circumstances where referral to a professional regulator may be appropriate for some staff in certain circumstances within the thresholds set by the regulator. When that happens, it will only be done in accordance with our principles of learning and never as an additional punishment.

18 We recognise the importance of engagement with staff on this issue - linking patient safety to staff health and wellbeing, and recognising the contribution that frontline staff can bring. As an organisation we will emphasise the importance of staff wellbeing as a foundation for helping people to work safely. We will ensure that advice given by Occupational Health will be followed in a timely manner.

19 We will encourage and expect all staff to continually consider what factors can affect behaviour and performance, such as design of systems, processes, products, equipment and environmental factors. We will also consider factors including fatigue, workload, team relationships and communication on working safely.

20 We recognise the importance of role models and leading by example for senior leaders at executive level. Reports on progress in moving towards a just and learning culture will be a part of all leadership meetings, and shared with staff and patients appropriately.


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Example 2

Mersey Care - a restorative approach

The approach adopted, and influenced by the work of Dekker, S. (2017), emphasises:

- The importance of language
- The risk of hindsight bias
- Change of focus from policies that punish to policies that assist practice
- A focus on informal approaches over formal procedures
- A fair balance of justice, forward looking accountability and intervention - just culture
- Working with staff-side in partnership working
- Ensuring that staff feel it is safe to speak up, with specific mechanisms to support this
- The importance of sharing learning, anonymised if needed
- Refresh of the trust values and drawing on human factors science; introduction of new value of support, which includes encouragement to raise concerns so to learn from experience.

Analysis of the Trust's (disciplinary) cases has shown that the Trust has a high volume of disciplinary investigations, with over 50% of investigations resulting in there being no case to answer. Attention was therefore focused on the initial stages of the process and how the Trust determined that an investigation was required.

Mersey Care introduced template documentation which, they state, was probably one of the most significant factors in reducing cases. Whilst the documentation itself is simple, it encouraged those responsible for making the decision to ensure the appropriate information had been obtained and considered, before deciding to instigate formal proceedings, and the rationale was then clearly documented.

Where possible and appropriate, the Trust worked to make sure that those who may be subject to disciplinary investigation were able to contribute information to the process. The HR team advise managers with gathering appropriate information in the initial stages, but the focus is very much on investigating and understanding the incident first, changing questions from 'who' to 'what' to get to a place of understanding.

There has since been a significant reduction in disciplinary cases. One of the four clinical divisions saw a 64% reduction in disciplinary cases between 2016 and 2017. Having a level of psychological safety, where issues can be raised and addressed before they escalate, is a major factor in improving both patient and staff safety.

In September 2018, the Trust completed a research study with Professor Dekker and Art at Work on identifying and evaluating the economic benefits of restorative practices. It was found that the introduction of restorative practices has coincided with many qualitative improvements for staff. The report highlights an estimated assumption of the economic benefit of restorative justice to be approximately 1% of the total costs and approximately 2% of the labour costs. These are estimates and are based on a relatively narrow window (a two-year period).

Example 3

Barts Health NHS Trust – pre-disciplinary checklist

At Barts Health NHS Trust, a pre-disciplinary checklist is used which has led in its first 12 months to a considerable reduction in the overall volume of disciplinary investigations and a significant narrowing of the likelihood of white and BAME staff entering the disciplinary process.

A number of other Trusts have used similar approaches which stress the importance of having informal conversations at the very beginning, with a focus on learning rather than formal investigations which tend to focus on finding who is to blame. The precise format varies, but the principles are similar.

This checklist is to be used by the reviewing manager **BEFORE** a decision to formally investigate a worker is made.

The following triumvirate applies, where a decision is then made to establish that an investigation is appropriate and that all appropriate steps have been taken to cultivate a culture of learning from an incident rather than punishment.

- **Site Director of Nursing and Midwifery**
  Nurses and Midwives
- **Site Medical Director**
  Doctors
- **Site Operational Director**
  All other Staff Groups

Have you asked yourself the following questions (1-6) before making a decision to formally investigate the individual concerned?

1 **Is it a capability or conduct issue?** (Y/N)

2 **If a conduct issue, does the conduct of the employee sit within the list of gross misconduct stated in the non-exhaustive list at the end of the Disciplinary Policy?*** (Y/N)

- a. Did the worker intend to cause harm? (Y/N)
- b. Did the worker come to work drunk or was there any other noticeable impairment to their judgement or competence? (Y/N)
- c. Did the employee knowingly and unreasonably increase risk by violating known safe operating procedures? (Y/N)
- d. Would another similarly trained and skilled employee in the same situation act in a similar manner (the 'James Reason substitution test')[1] (Y/N)

3 **Have you reviewed the worker's knowledge against their skills and determined if the worker knew of the rule or performance standard? If so, which of these applies?**

- i. The worker does not have the knowledge of what to do and so can't in practice (Y/N)
- ii. The worker knows in theory but can't in practice (Y/N)
- iii. The worker knows how to and can in practice, but isn't (Y/N)
- a. Have you done a preliminary investigation to understand the situation well? (Y/N)
- b. Have you ensured you have taken statement(s) from the employee involved and given them an opportunity to present their version of events? (Y/N)
- c. Have you exhausted the informal route? (Y/N)
- d. Have you maintained consistency in dealing with this situation regardless of the employee's banding and protected characteristics? (Y/N)

4 **How well have you reacted to this situation? Have you as a manager...**

- a. Read the situation well (Y/N)
- b. Got the employee's attention (Y/N)
- c. Created the right relationship with the employee (Y/N)
- d. Raised the concern informally with the member of staff in the same way you would with any other employee (Y/N)
- e. Actively observed or identified which of 3i, ii, iii, 2c applies? (Y/N)

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* Questions 2a to 2d would be applicable in cases of Serious Incidents (SI)

[1] James Reason provides a decision tree for determining culpability for unsafe acts - Reason, J (1997).

5 How open have you been in taking an overview of activities and impact

a. Have you ensured the employee understands the situation well? (Y/N)

b. Have you ensured they have understood the rationale for applying the Disciplinary Policy? (Y/N)

c. Do they understand the 'pause and review process' and the next steps involved in this? (Y/N)

d. Have you checked if the employee is aware of various support mechanisms such as Trust Employee Assistance programme, OH, HR, and Union? (Y/N)

e. Have we positioned praise or blame? (Y/N)

f. Have we ensured they agree with the conclusion? (Y/N)

g. Have the next steps been discussed with the employee? (Y/N)

6 Given that our Trust's values and disciplinary policy emphasise improvement and learning, not punishment, have you:

i. Considered whether the employee has shown any remorse and understands the implications of their actions? (Y/N)

ii. Have you considered 'plea bargaining' in the Disciplinary Policy?** (Y/N)

iii. Have you followed Trust values whilst dealing with this situation? (Y/N)

7 Referring to question 3, if evidence is strong then:

- If the employee does not know how, so can't in practice, then a development plan is required
- If the employee knows in theory, but can't in practice, then a development plan is required
- If the employee knows how to and can in practice, but isn't, then continue with formal investigation for disciplinary action.

Finally, have you determined that, by carrying out an investigation for disciplinary action against this individual, it is consistent with how other employees have been treated for the same or similar misconduct/action? (Y/N)

** 'Plea bargaining' exists for where an offence arises and the individual admits to the offence; they can therefore accept the sanction (warning) without a long drawn out investigation and hearing. The manager must ensure the sanction is in line with the level of warning given in other related hearings to ensure consistency. It is a way of avoiding a formal process but not the sanction and can therefore only be considered for a first offence (because if it happens again then the individual hasn't learnt the lesson from the first incident).

Example 4

NHS Improvement – just culture guide

NHS Improvement published a guide in 2018 to encourage managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way. This guide updates and replaces the incident decision tree (IDT) developed by the National Patient Safety Agency (NPSA) around the work of James Reason, an expert in human error and its drivers.

NHS Improvement state:

- The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame
- Supporting staff to be open about mistakes allows valuable lessons to be learnt so that the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this guide will be a powerful tool in promoting cultural change
- This is our best current understanding on how to apply the principles of a just culture in practice, and that this is a live area of both academic and practical debate.

We will revisit and update this guide, as necessary, as our understanding develops.

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. The guide:

- Asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counterproductive
- Helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are treated equally and fairly no matter what their staff group, profession or background. This has similarities with the approach being taken by a number of NHS trusts to reduce disproportionate disciplinary action against black, Asian and minority ethnic (BAME) staff.

The guide can be used at any stage of a patient safety investigation. It does not replace the need for a patient safety investigation and it should not be used routinely. It should only be used when there is already some suspicion that a member of staff requires some management to work safely.

NOTE: A just culture guide will be reviewed later in 2019 in light of any recommendations from the Professor Sir Norman Williams Review.

A just culture guide

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

For further information:
https://bit.ly/2R0hb4J

Scenarios to support training in using a just culture guide

To help with the training, we have developed a series of case scenarios that facilitators can use to walk people through the tool.

For further information:
https://bit.ly/2KakPYX

Background to guidance

Section 1

Introduction and purpose

This paper sets out the case for a just and learning culture for everyone working in and receiving care across health and social care.

It provides the current context, considers the harmful impact on staff working in a blame culture, and assesses the latest thinking and evidence base for what good looks like. The theory and evidence around a just and learning culture are backed up by examples from organisations that have started on the journey to shifting the emphasis from blame to learning when care has not gone as expected or planned.

This paper is intended to start a conversation about what we could do differently across health and social care. It offers help for health and social care organisations who are considering the steps they could take in order to create a just and learning culture in their organisation no matter how big or small.

The paper applies as much to a small community team or general practice as it does to a large teaching hospital trust. While the conversation is predominantly about how staff are treated, this is with the intent to ensure that the benefits of a just and learning culture for staff will have a significant and positive impact on patients and their families.

This is about creating and supporting a just and learning culture for all in health and social care.

Section 2

Context and theory

Over the last two decades there has been a concerted effort to make healthcare safer (Woodward 2017), but there is still much to do.

The current data we have, together with a range of healthcare reports and inquiries over the years, have highlighted the need for improvements in how we learn about how to make care as safe as it could be (Kennedy 2001; Francis 2013; Berwick 2013; Kirkup 2015). This requires us to improve our learning about how day-to-day care is delivered, how it feels to work for frontline staff, and ways in which they need to adapt and adjust what they do to keep patients safe.

This means learning how care is delivered, not how we imagine it is delivered, but exactly how it is done on a day-to-day basis. It requires us to improve our learning about what is working well and what doesn't go as planned or expected (Hollnagel 2013). Underpinning this learning is a culture which is kind, respectful and which enables people to speak out openly, and to share issues, concerns and ideas without judgement (Dekker 2018).

A learning organisation is where everyone facilitates a culture that helps to continually transform and improve that organisation (Argyris, Putnam and Smith 1985; Senge 1990). A learning organisation that has safety at its heart studies all aspects of care. This, in turn, uses that knowledge to help people redesign the workplace; for example systems of work, the way equipment is placed and stored, the infrastructure and staffing needed, and processes of how care is delivered.

The mindset should always be to design systems that support the individuals within those systems to work safely. It also, importantly, includes learning about how people behave and what supports safer behaviours and decision making. This includes understanding the significant links between the health and wellbeing of staff and safer practice.

The latest thinking in safety is based on decades of research in human factors, sociology, psychology, cognitive systems engineering and other sciences. It reflects the development and balance of both restorative practices and accountability (Hollnagel 2013; Shorrock and Williams 2017; Woodward 2017; Dekker 2018).

If safety is both a state where as few things as possible go wrong and a state where as much as possible goes right (Hollnagel 2013), then organisations and leaders need to:

- be mindful of the potential for things not to go as planned; to understand the potential for risk and harm; and to take steps to prevent and minimise the impact
- seek to learn when things don't go as planned; learn so that things can be changed to the system and change things to help people work safely
- seek to learn from the day-to-day and from when we get it right in order to replicate this and optimise what we know we already do well.

There is a growing body of evidence that demonstrates that a way forward is to **embed a just and learning culture**. A checklist, or charter or framework provides the foundation for helping people create a just and learning culture; culture change cannot be achieved by these tools but they will help organisations to evolve, and grow in order for a just and learning culture to be embedded into every interaction people make.

Leaders, therefore, have the responsibility for role modelling the right behaviours to create and maintain a safe and supportive environment for both the patients and staff that is fair, open and able to learn. This includes employing and devolving decisions to embed safe practice among experts. This can be achieved by bringing together different professions, teams and departments to hear from everyone, no matter how disparate their views. It is vital that the changes needed to embed safe practice involve those who work at the 'sharp end' of the organisation and that those who receive care are truly listened to and asked how things should be done.

Ask the people who do the work every day and discover how the world looks from their point of view – both staff and patients (Dekker 2018). People should be seen as the solution to harness, not the problem to blame (Dekker 2018).

A just and learning culture also requires us to understand much more about the science and application of human factors. This should involve exploring the conditions in which people work in order to design the systems and processes to help work be as safe as it can be. It involves learning about why human beings behave as they do and what factors can affect their behaviour and performance, including design of systems, processes, products, equipment and environmental factors such as noise. It also includes an understanding of the impact of factors like fatigue, workload, team relationships and communication on working safely.

The study of human factors also helps us to understand how we should investigate when care has not gone as expected or planned in a way that seeks to minimise natural biases such as hindsight, outcome and confirmation bias (Shorrock and Williams 2017).

Turning to a just and learning culture, there are different views as to what this actually means. David Marx (2017) writes about identifying the different behaviours that are exhibited in the workplace. He describes how humans are erroneous, risky or reckless and he talks about how, by truly understanding these different behaviours, we can then respond appropriately and proportionately to these behaviours.

The term human error has been used for over three decades and is now accepted as a common explanation for 'when things go wrong' such as mistakes, slips, lapses and so on (Reason 1997). Some people also try to distinguish between each of these. There is a view that, by using the term 'human error,' it focuses the mind purely on the human being as the cause and not the circumstances that led to the error occurring.

Marx (2017) suggests the following:

1. **Human error** is inadvertent action or inadvertently doing other than what should have been done and it should be accepted that this is what we do as humans, that we are fallible and therefore people who are erroneous should be consoled and supported.
2. **Risky or 'at-risk' behaviour** is when people make choices that could increase risk, or where risk is not recognised or where risk is believed to be justified. This includes what are often referred to as violations of policies or procedures and can also include forms of negligence. Marx writes that staff who exhibit risky behaviour should be asked about their actions in a non-judgmental way first before seeking immediately to blame and sanction – there may be very justifiable reasons for these behaviours and these need to be understood and learnt from.
3. **Reckless behaviour** is when people make choices that are considered reckless, i.e. putting people at an unjustifiable risk of harm. This could also include intentional acts, and a willful and conscious disregard to a substantial and unjustifiable risk. These people, Marx suggests, should be sanctioned in some way, but there also still needs to be learning from why people behaved in the way they did and the choices they made.

Dekker (2014; 2017) believes that it is more helpful to distinguish actions and choices as being either unintentional (the vast majority) or intentional (the very rare).

He and many others believe that the vast majority of people who work in health and social care wish to provide the very best care they can, given the circumstances they are working in, and that there is no intent to provide care that did not go as expected or planned. And that such incidents are unintentional and there is no intent whatsoever to harm anyone. In all these cases, the actions and choices made should be understood before being judged and people should be supported to learn from them. Furthermore they should be asked for their advice and help to design the systems that could help change things for the better.

However, this does not mean an absence of accountability. The very rare person who does make an intentional act of harm should be dealt with responsibly and referred to external bodies, including the relevant professional regulator(s) and the police.

The terms 'blame' and 'accountability' are often used interchangeably; this can lead to opportunities for learning to be missed. Brenner (2018) provides the following definition: *'Blame is to be accountable in a way deserving of censure, discipline, or other penalty … accountable does not mean "blame-able".'*

Brenner (2018) also states that accountability means to be answerable and responsible for an activity, and the terms accountability and blame differ as follows:

Learning versus punishment
If blame is the goal, any investigation tends to stop after the 'culprit(s)' have been identified and the opportunity for learning is lost.

Climate of fear
Where staff express fear of accountability; this can be a strong indicator of a blame culture.

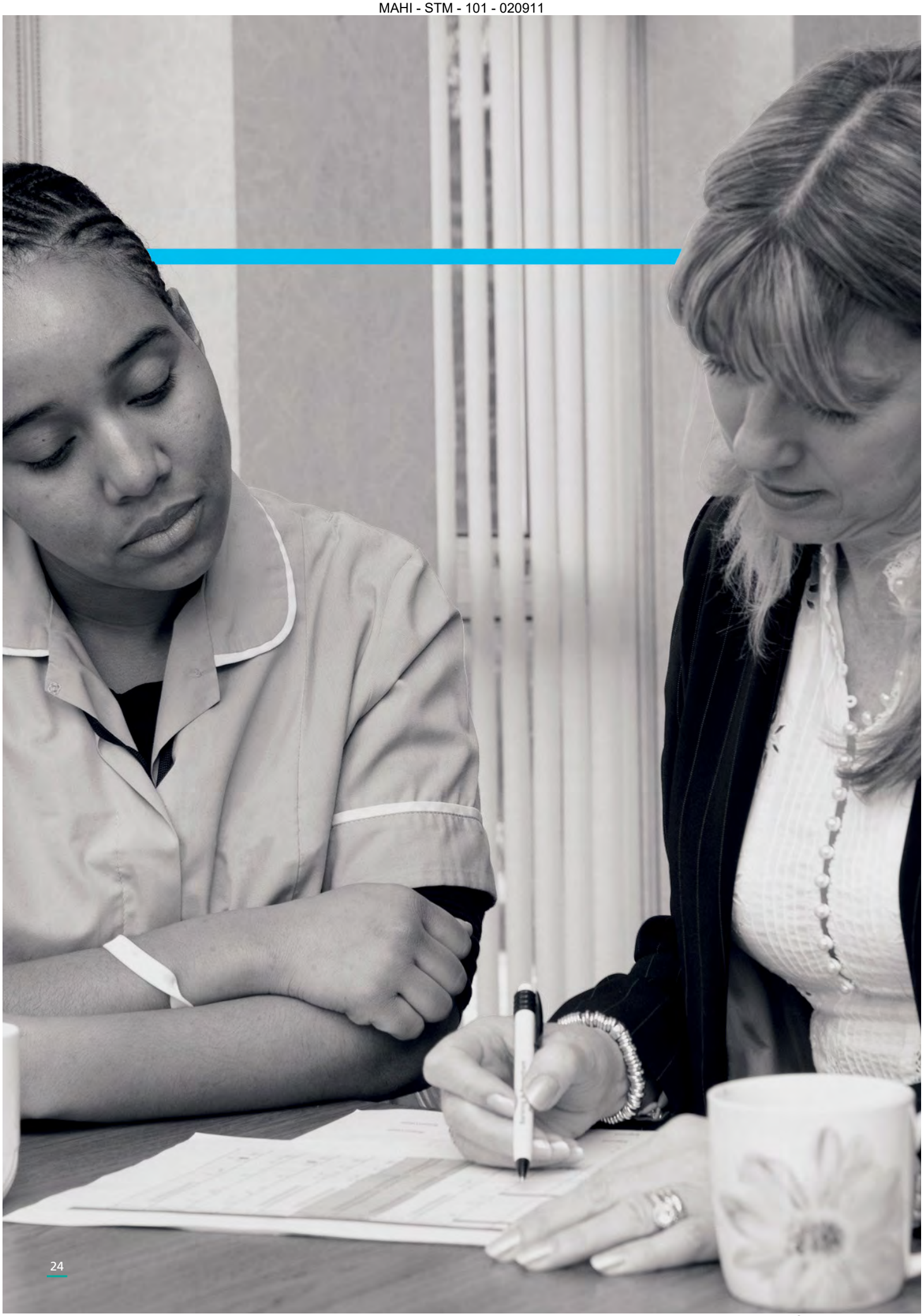
Organisational chart altitude distribution
Where accountability for actions is mainly focused at the bottom of an organisational structure; it is where blame is likely to be assigned.

Acknowledging interdependence
Recognising that all those accountable for an incident will commonly result in a long list, as incidents are usually linked to system failure and not individuals.

Dekker (2017) suggests that, in order to achieve a restorative just and learning culture in the aftermath of when care has not gone as expected or planned, three questions should be asked:

- **who is hurt?**
- **what do they need?**
- **whose obligation is it to meet that need?**

These are three very powerful questions that refer to everyone: the staff involved, the patients and their loved ones.



Section 3
Impact on staff

Inequity

A just and learning culture requires a balance of learning with accountability and assurance that staff and organisations take responsibility for making changes to help people work safely. Threats to this kind of culture are apparent when staff are inappropriately blamed or face suspension following an incident, or are subjected to disciplinary action and sometimes dismissed. Too often people involved in complaints, incidents and claims are not supported, and instead they potentially face disciplinary processes which can lead to a culture of fear of speaking out.

In addition, research has shown that different individuals can also experience inequity and discrimination, and suffer disproportionate levels of disciplinary action, in particular black, Asian and minority ethnic (BAME) staff groups. This can impact not only on the individuals involved, but on the teams they work within, and even the wider teams across the organisation and subsequently on the patients they care for.

In researching the causes of disproportionate disciplinary action in the NHS against BAME staff, Archibong and Darr (2010) found, in their report for NHS Employers, that:

'...line managers found it difficult to deal with issues relating to disciplinaries and there were often inconsistencies in the application of disciplinary policies… It was perceived that managers were more likely to discipline B(A)ME staff over insignificant matters and that disciplinary concerns involving staff from minority ethnic backgrounds were not always considered to have been dealt with fairly and equitably by human resources managers.'

ESR (Employee Staff Records) data show there is very significant variation between NHS Trusts regarding the likelihood of staff being disciplined or suspended.

- In 2016-17, NHS Trusts in England (98.7% n=232 of 235) reported that almost 16,000 staff entered the formal disciplinary process. 1.3% of white staff (n = 11,857) and 1.7% of BAME staff (n = 3,854) did so (NHS Equality and Diversity Council 2017)
- According to the NHS ESR data, it is more likely that some staff will enter disciplinary investigations in some trusts compared to others. In addition, it is, on average, 1.24 times more likely (2017-18) that BAME staff will enter the disciplinary process (i.e. be subject to a formal investigation) than their white counterparts across trusts in England (NHS Equality and Diversity Council 2019)
- In 30 trusts (13%) more than 2% of white staff entered the disciplinary process and in 77 trusts more than 2% BAME staff did so
- This is an improvement on the previous year (2016-17) whereby it was on average 1.37 times more likely that BAME staff entered the disciplinary process
- In 70.1% of trusts, the likelihood of BAME staff entering the disciplinary process was more than for

white staff and in 59 (27.6%) trusts, the likelihood of BAME staff entering the disciplinary process was more than twice as high as for white staff (Equality and Diversity Council, 2019).

There might be a number of reasons why this is the case, including:

- All staff, including some BAME staff recruited recently from abroad, may not be adequately trained, managed or supported during and following their induction
- An excessive focus on blaming individuals rather than seeking to address the conditions, factors and possible system causes of the alleged performance or conduct issues, which might impact disproportionately on BAME staff. This may be because of "protective hesitancy", whereby some managers find it difficult to have honest, informal discussions with some staff, notably with those from BAME backgrounds, which may increase the likelihood of those staff facing formal investigations rather than informal discussions (Archibong 2010)
- A variety of biases and attitudes by people (intentional or otherwise) influencing which individuals become subject to disciplinary investigations rather than deploying learning conversations where this would be more appropriate (Archibong and Darr 2010)
- Some jobs that BAME staff undertake may, irrespective of ethnicity, be those most likely to experience disciplinary actions being invoked.

Fear

When things have not gone as expected, there is a fear of being blamed, fear for future employment and fear of what colleagues, families and friends will think (Shorrock 2017).

Recent high profile cases have significantly heightened this fear, particularly among junior doctors. The fear is compounded by feelings of isolation, with the potential for significant impact on individual staff members (Kliff 2016). There are numerous cases cited of employees being suspended and prevented from contacting anyone as soon as an incident happens or a complaint is made, irrespective of the potential outcome. This is now considered a key threat to a just and learning culture, as Lady Justice Hale pointed out in Gogay v. Hertfordshire County Council (2000): *'…even where there is evidence supporting an investigation, that does not mean that suspension is automatically justified.'*

Involvement in incidents and complaints can also significantly impact on individuals' health and wellbeing. A UK study showed an association between staff involved in complaints procedures and risks of depression, anxiety and suicidal ideation (Bourne 2015). The association is likely to be impacted by the length of the disciplinary process. Professionals describe feelings of misery and insecurity, both during the process and in its aftermath. Another study reported that disciplinary action involving doctors can result in anger, guilt, shame and depression, and future 'defensive practice' (Cunningham 2011).
In addition the emotional and psychological impacts of disciplinary proceedings and regulatory processes cause

immense stress on physical and mental wellbeing, including physical symptoms of short-duration migraines, skin rashes, irritable bowel syndrome, cardiovascular diseases and strokes (Bourne 2015).

Incivility and bullying

A further threat to a just and learning culture is the way people behave towards each other on a day–to-day basis, in particular rudeness, incivility, lack of kindness and even bullying.

There is growing understanding of the issue and impact of incivility and rudeness in the workplace. Incivility is defined as 'the exchange of seemingly inconsequential and inconsiderate words and deeds that violate conventional norms of workplace conduct' (Porath and Pearson 2013). It may be the slightest thing, a sneer, a look of annoyance, being ignored in the corridor, being put down in a meeting or the use of belittling language. It can escalate to be much worse, such as humiliation in front of others and lead to bullying.

In healthcare this is adding to a culture of fear and is preventing people from speaking up. It also affects morale, and staff health and wellbeing. The impact on staff is considerable, and can affect cognition, and equally reduce safety, effectiveness, quality of work and productivity by the affected staff member(s) as well as those who observe this behaviour. Incivility is therefore harmful to both staff and to patients (Turner 2018).

Sadly, the scale and impact of bullying in healthcare is well documented. Almost a quarter of NHS staff report being bullied at some point in the previous twelve months. Bullying and harassment can impact in a number of ways. A climate of fear can lead to a lack of openness and willingness among staff to report errors or even share concerns through anxiety of the consequences. This inevitably leads to a less safe environment for patients. The impact on the workforce can be significant, leading to staff members experiencing high levels of stress, unhappiness and burnout and, ultimately, leaving the profession.

There is a recognised relationship between a positive workplace, learning from excellence, gratitude and appreciation, and improved patient care. It is vital that leaders and organisations work towards creating a positive culture that recognises and rewards success and kindness. What is needed is a culture where everyone, no matter where they are within the hierarchy, is respectful, kind, caring and civil towards one another.

Section 4
Claims

Claims related to staff stress and bullying

The last five years have seen a number of claims notified to NHS Resolution (see Table 1) in relation to staff stress and bullying. The defined costs below do not account for any associated costs for sickness absence, any replacement staff costs to cover duties or resources for investigation and management.

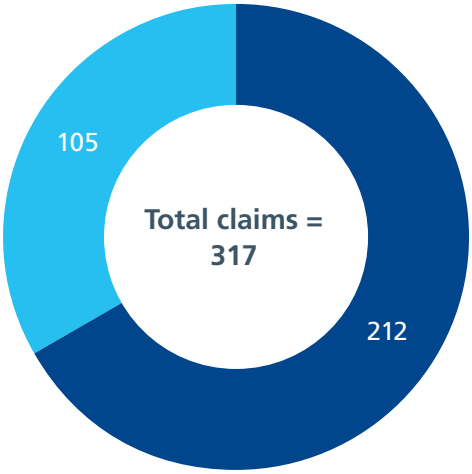
The cost alone does not illustrate the emotional impact and consequences to the staff member, the organisation in which they work, the patients that they may have to care for, and their colleagues and family members.

Table 1: Numbers of all claims by date of notification and annual cost

Notification Year	Number of Claims	Total Claims Value (£)
2013/14	67	3,096,707
2014/15	81	3,022,488
2015/16	68	6,624,735
2016/17	57	4,890,787
2017/18	44	9,844,286
Grand Total	**317**	**27,479,003**

- All claims notified to NHS Resolution. The figures represent the value of the claims registered. Some 91 cases are under investigation, in 92 cases damages were paid and in 134 cases damages were not paid
- There is commonly a time lag from the incident to the claim being notified as a claim to NHS Resolution and then resolved
- These 317 claims cover a range of incident dates, with over 50% of them being in the years 2013 to 2018.

The majority of staff members making these claims were employed in NHS organisations, the majority being from Acute or Foundation Trusts which included 36 mental health organisations (Table 2).



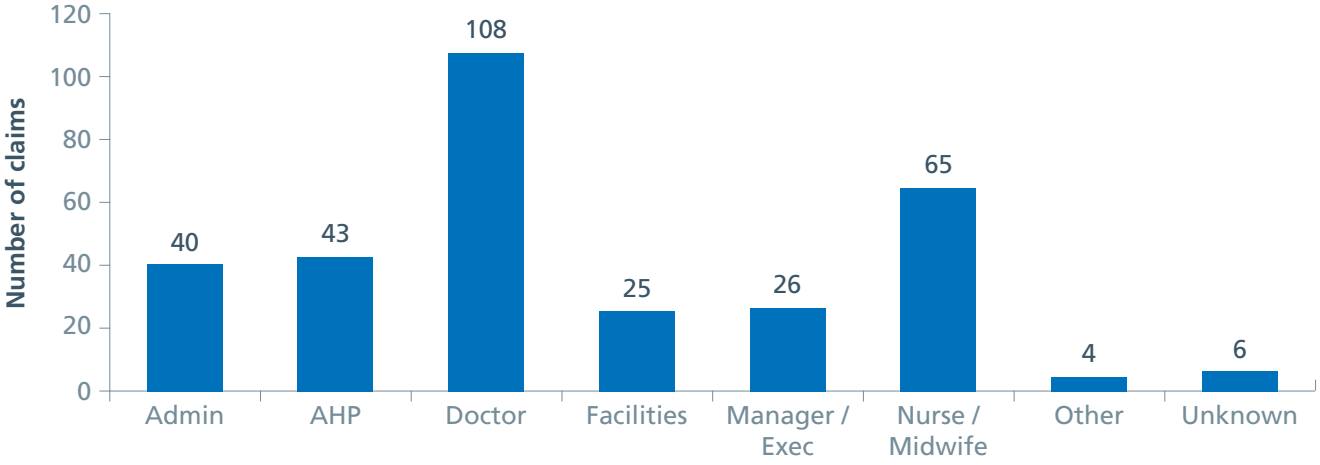
Of all 317 claims, 212 were from women and 105 from men.

Table 2: Number and value of claims by type of NHS organisation

Organisation Type	Number of Claims	Total Claims Value (£)
Foundation Trust	155	13,794,280
Acute Trust	131	10,885,969
Special Trust	14	1,490,617
Community Trust	11	997,070
Clinical Commissioning Group	6	311,068
Grand Total	**317**	**27,479,003**

The 317 incidents covered a whole range of staff, illustrating the extent of the issue and highlighting that it can affect staff at any level or role within an organisation (Figure 1).

Figure 1: Claims notified to NHS Resolution 2013 to 2018 (n=317)



The numbers are significant and are driven by a range of avoidable factors in relation to how staff are supported. These include:

- Failure to follow policies effectively relating to investigations and workplace stress
- Failure to follow advice given by Occupational Health and conduct a timely investigation, grievance or appeal
- Failure to provide a safe system of work and have regard for staff members' mental health and personal safety
- Failure to follow recommendations set out in the investigation report which caused the staff members' trust and confidence to be undermined
- Failure to carry out suitable or sufficient assessments of the risks to the staff members' mental health
- Failure to implement any adequate preventative or protective measures for the safety of staff members.

Descriptions of harm within these claims include:

1	Work-related stress – staff member was subjected to bullying and abusive behaviour by a consultant
2	Work-based stress resulting in suicide
3	Stress at work caused by workload and lack of resources
4	Staff member felt they were obliged to work excessive hours leading to suffering a stress-related illness
5	Following the death of a patient and subsequent investigation by the Trust, staff member felt isolated during suspension. This resulted in a significant psychiatric injury compelling them to seek early retirement
6	Depression, anxiety and work-related stress resulting from changes in role
7	Stress arising from failure to pay regard to complaint by staff member regarding staffing levels

Section 5

Suspension, exclusions and professional regulation

Suspension / exclusion

The National Audit Office (NAO 2003) examined suspension in the NHS and the cost of disciplinary action taken in 2003. While this audit was over 15 years ago, the findings related to the impact of suspensions or exclusions are still relevant today.
The NAO found (in the year prior to publication, i.e. in 2002) that 1,000 clinical staff were suspended for, on average, 47 weeks for doctors and 19 weeks for other clinical staff. The cost estimated in terms of lost staff time, replacement staff, and administrative costs was in excess of £40 million per year.

Also in 2003, Hoel et al. examined the internal costs of one specific but typical local government employment relations case. The case involved the bullying of a graphic designer. It is argued that a disciplinary case is likely to have similar costs. Excluding lost productivity and the costs of any lump sum settlement, ill health early retirement, litigation or external legal advice or subsequent litigation, their calculation of the cost was £28,109 (or £44,125 in 2019 prices) (Hoel et al. 2003).

For the NHS, the amount of time and energy wasted on poor, unnecessary or inappropriate disciplinary investigations, suspensions, hearings, appeals and legal costs is considerable. In 2012, almost a decade after the NAO published its report on suspensions, the Court of Appeal felt obliged to flag their own concern stating:

'the almost automatic response of many employers to allegations of this kind to suspend the employees concerned, and to forbid them from contacting anyone, as soon as a complaint is made, and quite irrespective of the likelihood of the complaint being established… They will frequently feel belittled and demoralised by the total exclusion from work and the enforced removal from their work colleagues, many of whom will be friends. This can be psychologically very damaging. Even if they are subsequently cleared of the charges, the suspicions are likely to linger, not least I suspect because the suspension appears to add credence to them. It would be an interesting piece of social research to discover to what extent those conducting disciplinary hearings subconsciously start from the assumption that the employee suspended in this way is guilty and look for evidence to confirm it' (Crawford & Anor v Suffolk Mental Health Partnership NHS Trust 2012).

The Practitioner Performance Advice service at NHS Resolution (formerly known as the National Clinical Assessment Service, NCAS) can be contacted for advice where a healthcare orgnisation is considering excluding, suspending or restricting a practitioner's practice. Where patient safety is considered to be at risk or where there are allegations of serious misconduct, we work with healthcare organisations to help them consider the options available to them to understand and address the concerns, and to help ensure that their decisions are reasonable and proportionate to the circumstances. Where exclusion, suspension or restriction is thought to be appropropriate we will continue to work with the healthcare organisation to routinely monitor the position and advise on good practice, taking account of local and national policy requirements.

Professional regulation

Referrals to professional regulators may be a further measure taken as a result of what employers believe may be concerns about fitness to practice. These have been increasingly subject to public scrutiny with some regulators acknowledging the importance of a focus on learning, not blame and an increasing acknowledgement of the risks of discrimination (NMC 2018).

The cost of cases involving a referral to a professional regulator may be considerable. The NMC reported that *'through efficiencies to our processes in 2016–2017 the average cost of a hearing fell from £25,000 to £18,000'* (NMC 2017).

However the costs to employers (and staff) include so much more than the cost to the professional regulator. They will include:

- staff cover costs (agency, locum, replacement costs)
- the likelihood of 'presenteeism' costs – where sick staff carry on working rather than taking time off to recover
- the cost of other staff affected by the suspended member of staff leaving (increased effort, increased workload, increased stress and decreased morale)
- the cost of management and other people's time preparing for the case
- the considerable cost of legal advice
- replacement costs if the staff member leaves
- productivity costs.

Conclusion

The aim of this paper is to help leaders of all health and social care organisations to understand how they can support staff when things don't go as planned. The paper provides the latest thinking, ideas and prompts which will, in turn, help to drive a just and learning culture within health and social care.

It is also hoped that this paper will lead to an avoidance of inappropriate disciplinary action against staff, including in particular those from BAME backgrounds who appear to be disproportionately subject to such action.

The paper has highlighted why this is important and demonstrated some of the impacts on staff when support is not in place and the need to ensure consistent, equitable approaches across all staff groups regardless of the profession or setting.
It has summarised some of the evidenced ways this can be done and shares examples where a few NHS organisations have implemented practices that emphasise learning rather than blame.

It is hoped that this paper will start the conversation which will lead to a significant change in mindset and attitudes to the prevailing practices in large parts of the NHS to benefit staff and patients.

A just and learning culture is for all: staff, patients and organisations. It is not only about safety; it is about how we treat each other, every day.

When things do not go as planned, patients' physical and mental health, and wellbeing will always be of paramount concern to healthcare staff. This is embedded in the questions that Professor Dekker suggests: who was hurt, what do they need and whose obligation is it to meet the need?

At the heart of this are the rights of patients and their families to an apology, an explanation and to be involved in any subsequent reviews or investigations. They also have the right to seek assurances and financial compensation where appropriate.

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