Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Working Together to Put Things Right – Implementation of Recommendations from the Inquiry into Hyponatraemia-Related Deaths (IHRD) – Update Report – December 2019

16 December 2019

Contents

Overview

This is our fourth update on how we are planning to implement the recommendations of the Inquiry into Hyponatraemia-Related Deaths.

It is much longer than the previous three and goes into considerable detail on progress on many of the actions we plan in order to put things right. This does make it a little harder to read than previous updates. However we believe that publishing this level of detail is important. How our health and social care system operates affects every citizen. Having access to all this information will help any organisation or individual to submit their own evidence to help shape the final outcome.

Most of the recommendations made by Mr Justice O'Hara's Inquiry can be implemented in the absence of an Executive and Assembly. This is because they are operational matters which can be dealt with within the Health and Social Care system.

In these cases the end product will be a circular issued to Health and Social Care organisations advising them of the detail of the actions which they, their Board and their workforce should take to implement individual recommendations or groups of recommendations. When necessary these circulars will be accompanied by new or updated regional guidance documents which have already been developed by the programme, co-produced by stakeholders.

The circulars will also lay down the timeframe within which the new arrangements are to be fully implemented and set out the evidence they will need to provide to show that implementation has been successful. This will therefore give organisations all the information they need so that they can report back on what they have done to ensure that the recommendations have been put in place.

For those that do require Ministerial and Executive approval a different process is in train. In these cases detailed proposals are being drawn up, some of which may include an analysis of different options for enacting recommendations.

This will enable a Minister and the Executive to make decisions on policy which in some cases will involve legislation. In other cases the Minister may issue the proposals for wider consultation if this has not already taken place[1].

This update shows the progress to date on most of the recommendations. For this reason details of the individual recommendations being considered by each workstream have been reproduced at **Appendix 1.**

1 At the point in time when policy proposals are ready for consultation it would normally be a Ministerial decision to issue those proposals for consultation. If a Minister is not in place the Permanent Secretary will be required to make a decision under the NI (Executive Formation and Exercise of Functions) Act 2018 (EFEFA) whether or not the proposals can issue for consultation. This decision can only be made after the content of the proposals are known. An added complication is that some of these proposals e.g. for an Independent Medical Examiner, are likely to span across the policy responsibilities of more than one Department.

Co-Production and Involvement

When we set out to respond to the Inquiry we decided to take a co-production approach, one that involved a wide range of stakeholders.

We brought together more than 200 people from different backgrounds to work through how best to implement the recommendations.

They include service users and carers, representatives of the voluntary and community sector, people from health and social care organisations and their staff, non-executive directors of health and social care organisations, and department staff. Every one of them brings a unique perspective on the challenges we are working through whether through their expertise or, in the case of service users and carers, their personal experience.

This approach has brought huge benefits and has been critical to our work. However there have also been challenges along the way. It is therefore important that we learn from them for the benefit of future work.

Towards the end of the programme all taking part will be working together to produce a “lessons learned” report on our performance to help others learn from our experiences. A significant element of this will be a focus on co-production and involvement and how this form of working might be improved for the future.

One focus for us will be to see what could be done to speed up this method of working. We’ll be looking at how a future programme like this might be set up faster, and also how its work could be speeded up without in any way constraining the debate and discussion that is so important for the right policies to be agreed.

During the course of our work several participants have left the programme due to retirement or other reasons. Where possible they have been replaced, but the result is that rather more than the 200 figure quoted have been involved. Many of them contribute on a voluntary basis – a big commitment.

An important task for us will be to see how we can improve our approach to make it easier for people to stay with this kind of programme. To that end we’ll be working with those who have left as well as those who remained to see what we can learn. We’ve also been gathering feedback from all those involved at every stage of the programme, which will also be fed into a lessons learned report.

One crucially important issue that programmes like this face is that people who don’t work in government or the Health and Social Care sector need help to both to understand the complexity of how they work and how policy and legislation is developed.

It is therefore vital to provide them with help to understand these issues so that we level the playing field as much as possible when we come to discuss and debate what needs to change. The challenge here is to do this in a timely manner so it does not unduly delay the work.

In practice, given the number of recommendations, this programme was always going to take time to deliver. Some of the key lessons for us revolve around allowing group members sufficient time for familiarisation, learning and discussion. Time to:

- accumulate knowledge and understanding about the issues they are being asked to consider;
- ensure that the information that groups are presented with is from a variety of sources and where possible externally developed so that group members can have confidence in the robustness of the material;
- allow different stakeholders to present their views throughout the process and to actively seek and encourage input from a variety of stakeholders who may have different perspectives; and
- explore different avenues and options about how to move forward.

The 'Lessons learned' report will also focus on the involvement events we have held, both in terms of organisation and content.

We will want to share those lessons as widely as possible.

In the meantime, the programme and all of its Workstreams and Sub-Groups remain open to receive submissions at any time from any stakeholder, individuals or groups, who wish to put their views, ideas and evidence forward to be considered against individual recommendations. Anyone or any organisation wishing to make a submission to the programme can do so by emailing lhrd.implementation@health-ni.gov.uk and highlighting in the email the recommendation or recommendations they wish to submit on.

The Service User and Carer Liaison Group (SU&CLG)

The need for a service user and carer voice to strengthen implementation

The Service User and Carer Liaison Group (SUCLG) was put in place to support service users and carers who are involved in the Hyponatraemia Implementation Programme. The group is focused on how to continue to enhance the co-production of the Hyponatraemia programme and support the understanding, development and implementation of the recommendations that remain so important to all of us.

Service Users and Carers involved across the Hyponatraemia workstreams, know that co-production is a very different approach to developing policy. We realise that there are lessons to be learnt in this approach and whilst in practice, it takes time to develop relationships to truly involve and co-produce, a real difference is emerging. Service Users and Carers within the programme are striving to provide a reality check for discussions; we are pushing for change; encouraging the need to do things differently; asking the awkward questions; building partnerships with our HSC colleagues and all the while, undertaking these challenges with a truly independent voice.

Many of us have been involved in other HSC strategic programmes of work before. However, there is a feeling that this programme is moving to a new partnership working level and we are all pushing at new boundaries. All members in the workstreams have faced the complexities and challenges of developing new policy, new directions and the shaping of new outcomes. With this understanding, the workstreams are considering how the recommendations will be taken forward for implementation.

A key role of each workstream is to look at what **assurance** there will need to be in place as the recommendations are implemented. We realise co-production doesn't stop at the programme policy level, this must continue right through the HSC Trust implementation phase and we need to help guide, shape and support this into practice. At this stage, SUCLG members are pondering these questions:

- What will assurance look like for involvement and how will we be assured it is happening?
- In the near future, when the first product of the workstreams are rolled out across the HSC Trusts, what will be put in place to assure everyone that real, meaningful involvement is actually taking place?
- How will people who use the services be involved?
- How will we know that this involvement is effective?
- What support will those involved get to help prepare them for the work to come?

Further promotion and wider engagement in our work is so important, as evidenced by the recent involvement events with the Patient and Client Council Membership Scheme which informed the work around the Duty of Candour for HSC.

As Service Users and Carers, the foundation for our involvement comes from the HSC Reform Act (2009) which places a legal duty on the HSC to involve and consult us. We all need to consider what assurance and good practice is needed to support the whole system, to involve those using services and their family carers. Active and informed involvement should not be a 'have to' or a 'must do' exercise, or happen just because the law says so. It must be because the system, its staff and management, recognise and truly believe, that involvement and co-production with service users and carers will lead to an improved health service for all, with quality care as its focus.

Workstream 1 - Duty of Candour

This workstream is responsible for 11[2] actions arising from 5 IHRD recommendations. Three of these recommendations[3] have been allocated to the 'Being Open' sub-group, the most important of which is

Recommendation 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

Current position

Implementation of a Duty of Candour will require legislation and so therefore must await the return of an Executive and Assembly. In anticipation of this the workstream is developing a policy consultation document setting out proposals and possibly different options for a statutory Duty of Candour by the end of March 2020.

Although the legislation will take time, that does not mean progress cannot be made.

The short-term aim will be to drive cultural change through the 'Being Open' sub-group by developing guidance, support and protections around openness in healthcare settings for organisations, staff, the general public and service users and carers.

This should mean that we will all see evidence of a more open and transparent approach to delivering health and social care **before** any legislation is passed. Therefore, once introduced, any legislation would seek to build upon and strengthen the culture developed through the guidance, support and protections introduced by the 'Being Open' sub-group.

What Being Open Means:

The Workstream and the sub-group have been working very closely together and hold joint meetings every few months. The two groups have commissioned research, sought submissions from external stakeholders and held a wide range of engagement events. The result is a Conceptual Framework which outlines the proposed approach to openness and candour.

It is important to ensure that openness and candour is not limited to situations when things go wrong. Achieving genuine cultural change means that it should apply to everything that we do within the entire system, how staff work with each other and with patients and carers day to day.

The policy to be developed around this framework will set out the expectations on organisations, staff, patients/service users and family members/carers to cover:

1. **Routine openness** – the day to day expression of openness and candour, and how this will be enabled and experienced by staff and patients;

2 Recommendations 1(i), 1(ii), 1(iii), 1(iv), 1(v), 1(vi), 1(vii) 2, 3, 4, 6 – see Appendix 3, Table 1
3 Recommendations 3, 4 and 6

2. **Openness to promote learning** – the expression of openness and candour when something untoward has happened, but no harm has been caused. While there is an expectation of learning across all three contexts, the focus of this one is on learning and the dissemination of learning;

3. **Openness when something has gone wrong and serious harm or death has been caused** – this is where the statutory duty of Candour will specify that information should be offered in a timely way with a "full and honest explanation of the circumstances". Other statutory requirements will require that the information should not mislead by omission and that individuals and organisations should not prevent others from exercising their responsibilities under candour**.**

The resulting policy will detail the rights and responsibilities of organisations, staff, patients and carers in relation to openness and candour in all these contexts.

It is planned to publish the draft overarching policy on openness and candour along with the detailed proposals for a statutory Duty of Candour. The draft policy will include an initial high level piece of guidance which sets out the key principles which underpin a culture of openness in the Health and Social Care sector.

This will be the first in a series of pieces of guidance on supporting a culture of openness aimed at HSC organisations, staff, the general public, and service users and carers. We aim to have the policy document and the first piece of high level guidance developed by March 2020.

Alongside this work the Being Open sub-group is already reviewing guidance and material developed by other workstreams against how they contribute to an overall culture of openness. The group is currently reviewing four documents which deliver on, or partially deliver on, between 12 and 20 recommendations:

a) **Board Effectiveness - Board Handbook** – a guide for Board members on how to scrutinise the quality and safety of services and which promotes a culture of openness within HSC bodies and with service users and their families**;**

b) **What to expect when you are involved in a Serious Adverse Incident** – a guide for service users which places new responsibilities on HSC bodies against 8 IHRD recommendations;

c) **Lookback guidance** – a guide for HSC bodies conducting reviews of historical cases where there is a concern about the quality of care. It includes specific guidance on engaging with the patients and families affected as well as with the general public. It promotes a strong culture of oversight by the Board of the HSC bodies involved in any such review; and

d) **Proposals for implementation of Recommendation 72** – which stipulates that 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.

Evidence and Involvement

The workstream and sub-group have been gathering in evidence from a wide variety of sources. All of this material can be viewed on the IHRD website at:

https://www.health-ni.gov.uk/articles/ihrd-get-involved-duty-candour

Research

A number of research papers have been commissioned to assist discussions, primarily to better understand both how other jurisdictions approach candour and to identify the legal issues that will impact upon this policy area.

Call for evidence

In February 2019, the DoH published the research commissioned to date by the Duty of Candour Workstream and its Being Open sub-group, and asked for submissions of additional research or information from stakeholders. 14 submissions were received and have been shared with the groups for consideration. All organisational responses have also been published on the DoH website.

Involvement workshops

During the months of May, June, and September nine workshops were held to ask key stakeholders: "What does a Duty of Candour mean for Health and Social Care?" At these workshops attendees discussed the potential barriers to implementing the recommendations in relation to a Duty of Candour, and considered the issue of criminal liability for breach of the duty.

These events included:

- six workshops across all five HSC Trust areas with over 400 staff from a range of grades and disciplines;
- two workshops with service users at PCC Membership Events; and
- two workshops with the Community and Voluntary sector convened by NICVA.

The feedback from these workshops has been analysed and published on the DoH website. It, along with feedback from future events, will be reviewed in order to ensure that the views of all key stakeholders are taken into account when developing proposals to implement the recommendations.

Further involvement and engagement events, including workshops, are ongoing and include:

- Primary Care, including General Practitioners;
- Independent Health and Care Providers;
- Service Users and Carers;
- The Social Work and Social Care sector;
- Dentistry; and
- Pharmacy.

Some of these events will have already take place by the date of publication. A summary and evidence from each event will also be published on the IHRD website.

The Duty of Candour workstream and the Being Open sub-group have also engaged with a number of stakeholder groups. The purpose was to raise awareness, seek advice on best mechanisms to engage with particular sectors, and explore proposals to implement the recommendations. Some of these engagements have been specifically related to the statutory Duty of Candour and/or being open. In others, the chairs of the workstream and sub-group have been involved in meetings about the overall implementation programme.

Those involved to date include:

- Representative bodies for health and social care professionals;
- Regulatory bodies for health and social care professionals;
- Health and social care organisations, including HSC Trusts and their boards;
- Oversight bodies, such as the NI Public Services Ombudsman and the Human Rights Commission;
- Political representatives;
- Chief Professionals and policy leads within the Department of Health; and
- Community and voluntary organisations.

Anyone who wants to submit evidence to the workstream or sub-group or to issue an invitation to the workstream to speak at events can do so by emailing the programme at: **Ihrd.implementation@health-ni.gov.uk**

Anne Murray is on the Being Open sub-group

Anne left her job in the financial services industry after a family bereavement to retrain as a counsellor in the voluntary sector. She worked part time so that she was able to care for her mother. But then she had a subarachnoid brain haemorrhage. During her recovery she was still her mum's main carer until she died in 2014. It was a challenging time for Anne, during which she says she experienced both the best and the worst of health care.

She said: "I don't know what it's like to be part of that huge, highly pressurised machine on which we all rely so much.

"However I have my own experience of being the receiver of health and care services, and at times that has been excellent and at other times, the opposite."

When her mother died she complained about her care. There was an investigation which led to an apology and reassurances that changes would be implemented. Yet Anne still had concerns. She did not follow these up at the time because she felt exhausted by the whole complaints process.

Over the years the concerns grew in importance to her – she became worried the same mistakes could continue to be made and other older people would suffer.

She said: "I did go back just recently to raise these concerns and I was dealt with in a timely, open and honest way. I was listened to and steps were taken to address them. I was told the Trust wants to learn. Five years on, I finally feel I can put those matters to rest."

Anne says she was deeply moved by the tragic deaths that led to the hyponatraemia investigation, adding: "The issues uncovered during the investigation could relate to any member of the public of any age group.

"But being open and honest is not as straightforward as it sounds. Like most people, I thought just how difficult can it be to tell the truth when mistakes are made? Of course, that's much too simplistic. There's no magical formula that can change the ingrained culture of huge organisations."

"Many factors are at play which prohibit that change - among them fear - fear of the consequences of admitting mistakes, litigation, possible loss of reputation, job etc. Staff need to be supported to be open and honest when things go wrong because it can take a lot of courage."

Anne said 12 months into the programme she has more questions than at the beginning as her understanding of the complexities around the subject has deepened.

She added: "But one thing is clear. To change the culture of an organisation, those at the top must lead by example. They must be open in all their dealings and run services that not only strive to provide excellent service, and be honest when mistakes are made so lessons can be learned, and the same mistakes are not made again. What's needed is a learning culture and not a blame culture."

Anne also believes the public must be consulted. "We need to ask what would openness and honesty look like to us when we use the hospital, the GP surgery, the dentist, pharmacy services, community-based nursing, care homes etc?"

"How can we be sure we get the information we need when we ask for it? What support is needed to help us challenge information we believe to be incorrect or incomplete?"

"Mistakes are made, as health care workers are human, often working under tremendous pressure. What would we want to happen if things go wrong? Who would be there to help us through the process?"

"It's important to ask these now because when something goes wrong, we are often at our most vulnerable and worn out."

Anne also wonders whether being told everything is always in peoples' best interests. "Are there times when being candid would be unwelcome, when hearing the complete truth about something could even be harmful?

I'm sure we all know someone, or perhaps even ourselves, who have decided in advance that a bad diagnosis is something they don't want to know about. And how does that grey area look in black and white guidelines?"

Workstream 2 - Death Certification Implementation Working Group (DCIWG)

The workstream is responsible for 22[4] actions from 18 IHRD recommendations.

Three sub-groups will take forward 19 of the 22 workstream actions. Three remaining Recommendations, 43, 48 and 49 will be dealt with by the main workstream, as follows:

Recommendation 43: A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.

Recommendation 48: The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.

Recommendation 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.

Proposals on how these three recommendations should be implemented have been developed by a task and finish group. It is now drafting a circular covering the implementation of recommendation 43 and guidance in relation to Recommendations 48 and 49 which will then be issued by a circular. These will all be ready to issue in the first few months of 2020.

The Preparation for Inquests [and Litigation] Sub-group

This sub-group is responsible for 7[5] IHRD recommendations.

It has finalised details of the approach to six of the seven recommendations.

a) **For Recommendations 36, 51 and 52** it is drafting a regional policy and Working Practice Agreement on the role of Trust staff in the preparation of statements etc. for Coroner's Inquests. This will need to be agreed with the Coroner's Service. It is also drafting an accompanying protocol for HSC staff setting out the expectations of them in relation to these three recommendations;

b) **For Recommendation 50** it is progressing proposals for an amendment to the Department's guidance to the HSC on Early Alerts; and

c) **For Recommendations 53 and 95** – it is drafting a protocol on legal privilege setting out the expectations of HSC staff in relation to these two recommendations.

4 Recommendations 36, 43, 44, 45, 46, 47(i), 47(ii), 47 (iii), 47(iv), 47(v), 48, 49, 50, 51, 52, 53, 54, 59, 60, 87, 95, 96 – See Appendix 3, Table 2.

5 Recommendations 36, 50, 51, 52, 53, 95, 96

The Independent Medical Examiner Sub-group

The Independent Medical Examiner (IME) sub-group is responsible for one recommendation **(Recommendation 87)** which states: "The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner."

Considerable research on similar arrangement in other jurisdictions has been undertaken and the group has agreed an initial description of the role of an IME as follows:

- *When someone dies of natural causes, a doctor who has treated them must complete a certificate stating the cause or causes of death. This certificate is then given to an individual, usually a family member, to register the death at the local registrar's office. Once the death has been registered, the funeral can take place. Currently, there is no scrutiny of the information contained on the certificate completed by the doctor and hence there is no assurance that the underlying cause of death is acceptable or that the Coroner has been notified appropriately.*

- *An Independent Medical Examiner is an experienced doctor who will review the certificate to confirm that details of the deceased are correct, that the certifying doctor is qualified to complete the certificate and that the stated cause or causes of death are reasonable. The review will also include a discussion with the certifying doctor and potentially family members of the deceased.*

- *The Independent Medical Examiner will be a "second pair of eyes" and will help to ensure that the stated causes of death are reasonable, that deaths are appropriately referred to the Coroner when required and that any issues around the treatment or care of an individual can be identified at an early stage.*

Independent Medical Examiners have already been introduced to review deaths in Scotland, England and Wales and the sub-group has studied how these systems operate and how these might apply in Northern Ireland. Members of the sub-group have visited site offices in Edinburgh and Sheffield and the Senior Medical Reviewer in Scotland has met the sub-group to provide information and advice on what happens there and how they introduced their system in May 2015.

Bearing in mind that it is our custom to complete the funeral process within 2-4 days of any death, one of the greatest challenges will be to develop a mechanism that allows the certificate to be reviewed and the discussion with the certifying doctor to have taken place within that timeframe. It is essential therefore to ensure that the Independent Medical Examiner has access to both the certificate and clinical records very quickly.

The sub-group has carried out an exercise focusing on hospital deaths which identified how access to the certificate and clinical records might be possible. It showed that sufficiently detailed records (excluding mental health records) are available on an existing regional IT system to provide real time access to sufficient information to help discharge the IME role. The group is considering how this system might be used to underpin a full and permanent IME service in a way which is consistent with statutory provisions designed to safeguard access to patient records (GDPR[6] for example).

6 General Data Protection Regulation.

A second exercise began in November to allow the sub-group to identify the practicalities of reviewing the certificate, locating the certifying doctor and having a discussion to confirm the details with the certifying doctor. In Scotland, England and Wales, where burials and cremations typically take place some weeks after a death – there is less time pressure on an IME performing these tasks. This second exercise will capture information on how long it typically takes to get in contact with a certifying doctor (for hospital deaths).

It will also provide information on how many certificates are currently completed in line with guidance and the timeframe for the registration of the death and the funeral. The exercise will run between mid-November and mid-December and then used as the basis for planning and preparing for a longer term prototype IME which will operate for several months from March 2020 onwards.

Upon completion, the results will be collated and considered. It is anticipated that in the medium to longer term there will need to be a wide programme of engagement with the public, doctors, registrars, funeral directors, political representatives, local councils, churches and faith groups and the various government departments that will be involved on proposals for a statutory IME system and any interim non-Statutory arrangement which might be introduced prior to legislation.

In order to introduce a statutory Independent Medical Examiner here, we will need to amend existing legislation, which may impact on the policy and legislative responsibilities of up to four Departments (including the Department of Health) and we will need to ensure that there is a strong IT infrastructure that will underpin it. It will also require the development and testing of policies, guidance, training resources to support the role of Independent Medical Examiners. These exercises will provide evidence which can be shared with stakeholders as part of engagements and any subsequent public consultation on detailed proposals for an IME system.

The HSC Bereavement and Pathology Networks Sub-Group

This sub-group is responsible for 11[7] actions from seven IHRD recommendations. Detailed proposals are now in place for almost all of them.

Recommendation 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.

- An amended post-mortem consent form for both Child/Adult and Baby has been drafted to allow for the signature of a second doctor where a limited post-mortem is requested. The second doctor will counter-sign the completed consent form following review of the rationale provided for the limitation of the post-mortem.
- Both amended consent forms have been circulated to stakeholder groups for comment. Comments received have been considered and a final version of each form is in the process of being agreed by the sub-group for introduction.
- The Bereavement Network is working to complete the amendment of the Consent for Hospital Post-Mortem Examination HSC Regional Policy to include the additional requirements outlined in the IHRD recommendations on consent.
- Work has also commenced on reviewing the Information Leaflets for Hospital Consented Post-Mortems for parents and relatives and the consent training package for consent seekers delivered by the HSCT Bereavement Co-ordinators.
- The changes will be reflected in a new Standard Operating Procedure on the Post-Mortem Process for Pathologists which is currently being developed.

7 44, 45, 46, 47(i), 47(ii), 47(iii), 47(iv), 47(v), 54, 59, 60

Recommendation 45

Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.

- A paper outlining the actions to be taken to deliver this recommendation was agreed at the July meeting of the sub-group.
- A new regional Request and Clinical Summary Form for hospital consented post-mortems has been approved and signed-off by the sub-group and the HSCB paediatric stakeholder group.
- The post-mortem consent form checklists have been amended to include the requirement for a completed Request and Clinical Summary Form for post-mortem examination to be provided to the pathologist prior to post-mortem.
- The Bereavement Network is working to complete the amendment of the Consent for Hospital Post-Mortem Examination HSC Regional Policy to include the additional requirements outlined in the IHRD recommendations on consent.
- A review of the training package for consent seekers delivered by the HSC Trust Bereavement Co-ordinators has commenced to ensure it reflects all the changes being delivered.
- The changes will be reflected in a new Standard Operating Procedure on the Post-Mortem Process for Pathologists which is currently being developed.

Recommendation 46

Where possible, treating clinicians should attend for clinico-pathological discussions at the time of post-mortem examination and thereafter upon request.

- A paper outlining the actions to be taken to deliver this recommendation was agreed at the November meeting of the sub-group.
- As all paediatric post-mortems are performed in Alder Hey, Children's Hospital, Liverpool, assurance will be required that the same conditions, in respect of clinico-pathological discussions, are placed on their pathology team.
- Contact details for the Alder Hey Pathology Team is already made available to families along with their 24hr support helpline. The Alder Hey pathologist will also be available to the referring clinician for advice, clinical guidance and support following the post-mortem and at any relevant peri-natal Mortality and Morbidity Review meetings.
- For all post-mortems the post-mortem report template will be amended to include the contact details for the pathologist performing the post-mortem to allow ease of contact.
- The changes will be reflected in a new Standard Operating Procedure on the Post-Mortem Process for Pathologists which is currently being developed.

Recommendation 47

(i) *In providing post-mortem reports pathologists should be under a duty to: satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them.*

(ii) *In providing post-mortem reports pathologists should be under a duty to: work in liaison with the clinicians involved.*

(iii) *In providing post-mortem reports pathologists should be under a duty to: provide preliminary and final reports with expedition.*

(iv) *In providing post-mortem reports pathologists should be under a duty to: sign the post-mortem report.*

(v) *In providing post-mortem reports pathologists should be under a duty to: forward a copy of the post-mortem report to the family GP.*

- A paper outlining the actions to be taken to deliver this recommendation was agreed at the July meeting of the sub-group.
- Work has commenced to amend the post-mortem report template to include the contact details for the pathologist undertaking the post-mortem and to include their GMC number.
- The changes will be reflected in a new Standard Operating Procedure on the Post-Mortem Process for Pathologists which is currently being developed.

This includes all of the recommendation actions to be taken by the pathologist before during and after the post-mortem has been conducted and the pathologist being available, if required, to attend Mortality and Morbidity meetings either in person or via video or teleconference.

- As all paediatric post-mortems are performed in Alder Hey, Children's Hospital, Liverpool, assurance will be required that the same conditions, in respect of post-mortem reports are placed on their pathology team.

Recommendation 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.

- Initial discussions have taken place with agreement by the sub-group of the objective of the recommendation and identification of the key stakeholders.

Recommendation 59

There should be training in the completion of the post-mortem examination request form.

- A paper outlining the actions to be taken to deliver this recommendation was agreed at the November meeting of the sub-group.
- To support the introduction of the Regional Request and Clinical Summary Form for Hospital Consented Post-Mortems (Recommendation 45), guidance will be developed. The guidance will be placed on the Department's website.
- The consent training delivered by the Bereavement Network will be updated to include familiarisation of the new Child/Adult and Baby Consent Forms and awareness of the new Regional Request and Clinical Summary Form.

Recommendation 60

There should be training in the communication of appropriate information and documentation to the Coroner's office.

- Proposals on the actions required to implement this recommendation were discussed at the sub-group meeting in November. A paper will be prepared and brought to the next meeting for approval.

Sharon Wright chairs the bereavement and pathology sub-group.

All of us experience bereavement during our lives and we all need support, not just in coping with grief but also in accessing all the information we need about the death of loved ones. This is especially the case when deaths are unexpected.

Sharon's group is looking at a series of recommendations concerning hospital consented post-mortems and bereavement services. She is a civil servant, working for the Department of Health. Most of the recommendations being considered by this group involve internal HSC processes and working through niche process pathways and definitions. The group includes bereavement experts, representatives from the Coroner's Office, the HSC and a funeral director.

She said: "One of the challenges is looking at the process around hospital consented post-mortems. These can occur when the cause of death is known but families want to know more about the disease or illness which caused the death of their loved one."

An example might be when a mother suffers a pregnancy loss. She and her partner might want more information which might help them in planning a future family.

Sometimes a hospital consented post-mortem can be limited in scope. When families request a limited post-mortem they need to be given all the relevant information before making their decision.

Sharon said: "What is important here is that families have the right to ask questions and this extends to a hospital consented post-mortem"

"Usually these discussions take place during end of life care. And it is vital that it is done sympathetically and supportively, getting all the right points across at this difficult time."

In other cases the Coroner will order a post-mortem to take place and no family consent is needed. When this happens the responsibility for staff is more around explaining why this is necessary and providing support to the bereaved.

Since the tragic deaths which led to Mr Justice O'Hara's report there have been developments in the education, training and resources available to staff who provide bereavement care to families. Information booklets have been developed which sign post families to organisations providing additional support. This work has been driven by the publication and continued implementation of the HSC Strategy for Bereavement Care.

Sharon explained: "Everybody is different, we respond in different ways and have different needs and it is really important that we are all treated as individuals."

The sub-group is also learning from the Public Health Agency's 10,000 More Voices initiative which published a report on bereavement last year based on feedback from those who have experienced the death of a loved one.

Sharon's group is now well advanced in its work, it has drafted a number of documents for comment from stakeholders and hopes to have all its proposed actions completed by the middle of next year.

Workstream 3 - Duty of Quality

The workstream is responsible for 28[8] actions from 23 IHRD recommendations.

Three sub-groups will take forward 27 of the workstream actions with one recommendation (recommendation 9 Leadership) remaining the direct responsibility of the main workstream.

Recommendation 9 states: 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.

The HSC Collective Leadership Strategy[9] was launched by the Department of Health on 18th October 2017. The workstream has commissioned work to examine leadership within the Health and Social Care Sector.

The ALB Board Effectiveness Sub-group

This sub-group is responsible for 8[10] actions from 6 IHRD Recommendations.

It has developed draft guidance on the implementation of **Recommendation 70:** "Effective measures should be taken to ensure that minutes of board and committee meetings are preserved."

The guidance includes a publication scheme which was developed with ALB Board Secretaries and a common approach to the presentation and accessibility of Board information on ALB websites which was tested at a workshop in September 2019. The work has been shared with the Being Open sub-group for its consideration and the ALB Board Effectiveness sub-group aims to issue it shortly to health and social care organisations.

The sub-group has also developed a draft handbook to be used as a resource for all HSC Board members. It has been shared with members of The Northern Ireland Confederation for Health and Social Care (NICON) and the sub-group is running a workshop in December to test the guidance with existing board members. The draft has been shared with the Being Open sub-group and intends to issue it to the HSC early in the New Year. This guidance sets the foundation for the implementation of Recommendations 56, 69 (i), 69(ii), 69 (iii) and 72.

However, implementation of these recommendations is dependent on the implementations of **Recommendation 55 which states**: "Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives." The workstream is working on plans for the development of training resources and the roll-out of training to support full implementation of this guidance. Elements of this training, particularly around Recommendations 69(i) and 72 will also need to take account of the policy proposals developed by the Duty of Candour workstream and Being Open sub-group.

8 Recommendations 8, 9, 34, 40, 41, 55, 56, 67, 68, 69(i), 69(ii), 69(iii), 70, 71, 72, 76, 77, 78, 79, 80, 81, 84, 86(i), 86(ii), 86(iii), 90(i), 90(ii), 92 – Appendix 3, Table 3.
9 https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-collective-leadership-strategy.pdf
10 55, 56, 69(i), 69(ii), 69(iii), 70, 72, 84

Recommendation 84 states that: "All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure."

All six HSC Trusts have established their own oversight groups for the recommendations contained in the IHRD report and are represented on a regional oversight group chaired by the IHRD Programme Manager. As part of the implementation process the Department will be assessing the progress of each Trust against this recommendation. Progress will be monitored in each Trust and reported to the Programme Management Group and the Department's Top Management Group.

Ignatius Maguire, who is a manager with the Northern Ireland Housing Executive has been deeply involved in patient advocacy for the past two decades.

From 2000 he was a member of the Western Health Council until the Health Councils were disbanded in 2009 to make way for the Patient Client Council.

Since then he has volunteered with a series of personal and public involvement initiatives with the Public Health Agencies which are designed to give service users and carers a greater voice in health services.

Ignatius sits on two groups: the Arms-Length Body Board Effectiveness sub-group which is examining how boards of health trusts and other health bodies can perform better, and the Service Users and Carers liaison group which provides a forum for all service users and carers to scrutinise the progress of the entire programme.

His involvement in this work means a lot to him – the Western Health Council had been contacted by two of the bereaved families. Helping to create a better system is therefore unfinished business for him.

He said: "The health service is a tremendous bureaucracy and a lot of people involved in the programme have a health background. I have taken my time to convince myself that there's a clear willingness about changing things.
I was concerned that some people were a little too close to the system – and that there would be a lot of listening to excuses about the way things are. But I have found a willingness and a real sense that people want to get on with it and make the changes that are needed."

And he is encouraged by the fact that there are so many people from outside the system involved in the work. "This is a first for the health service here, a sea change," he says. "Hopefully a lot of good things will come out of it."

He says work on the board effectiveness group is going well. "Scrutiny by these boards has not always been what it should have been, but you could say that of many other bodies."

Ignatius points out that whilst outsiders can help to effect change what is really needed is those people from within – who know the system inside out – to make things happen. And the fact that he has found this to be the case has encouraged him.

However he says there are one or two areas where the recommendations may need to be tempered a little. One example he cites is where Mr Justice O'Hara's report says that press statements should be monitored by a non-executive director. He says this may not be practicable and so therefore this may need to be tweaked.

Overall he says that the report demonstrates the overwhelming need for honesty.

"In the real world it can be hard to deal with the truth – there can be an instinct to hide when things go wrong. But the lesson is that we do need to be open, and when we are not this can obliterate all the good work that we are doing in other areas."

The RQIA Remit Sub-group

This sub-group is responsible for five[11] actions from three IHRD Recommendations. Four of the five suggest new roles for the Regulation and Quality Improvement Authority (RQIA). The Department is currently reviewing how Health and Social Care is regulated. It has developed a 'Principles of Regulation' policy consultation document which it hopes to issue in early 2020. The second stage of the review will look at the specific role and powers of the RQIA and this will include any new remit for RQIA which emerges from the IHRD implementation programme.

Two recommendations link to the proposed Duty of Candour:

Recommendation 8: RQIA should review overall compliance (with the Duty of Candour) and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception; and

Recommendation 86 (iii): The Department should expand both the remit and resources of the RQIA in order that it might scrutinise adherence to Duty of Candour.

The sub-group has identified that under RQIA's existing powers the RQIA could discharge a role in scrutinising openness and candour within the Health and Social Care sector. Articles 5 and 35 of RQIA's founding legislation[12] both offer opportunities for RQIA to discharge this role within the existing statutory framework:

11 8, 34, 86(i), 86(ii), 86(iii) – Appendix 3, Table 3
12 The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

5. - (1) When asked to do so by the Department, the RQIA shall give the Department advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request.

35. - (1) The RQIA shall have the following functions -

(a) the function of conducting reviews of, and making reports on, arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and social care for which they have responsibility;

(b) the function of carrying out investigations into, and making reports on, the management, provision or quality of the health and social care for which statutory bodies have responsibility;

(c) the function of conducting reviews of, and making reports on, the management, provision or quality of, or access to or availability of, particular types of health and social care for which statutory bodies or service providers have responsibility;

(d) the function of carrying out inspections of statutory bodies and service providers, and persons who provide or are to provide services for which such bodies or providers have responsibility, and making reports on the inspections; and

(e) such functions as may be prescribed relating to the management, provision or quality of, or access to or availability of, services for which prescribed statutory bodies or prescribed service providers have responsibility.

The implication of these existing powers is that the RQIA could undertake regular reviews or inspections of compliance by the HSC with Departmental guidance on Openness and Candour once these policies are in place and in advance of a statutory Duty of Candour being legislated for. A further option is for RQIA to report on Openness and Candour as a theme under its ongoing inspection and review programme.

This sub-group's role is to develop proposals and options for what this oversight by RQIA might look like, including any resource implications. It has commissioned research into how the serious adverse incident process and the duty of candour processes are overseen in other jurisdictions. This research will help the sub-group develop options. When it comes to whether RQIA be given powers to prosecute in cases of serial non-compliance or serious and wilful deception this will depend on the sanction recommended by the Duty of Candour workstream.

Two of the actions concern the potential role of RQIA in reviewing Serious Adverse Incidents.

Recommendation 86 (i): "The Department should expand both the remit and resources of the RQIA in order that it might maintain oversight of the SAI process"; and

Recommendation 86 (ii): "The Department should expand both the remit and resources of the RQIA in order that it might be strengthened in its capacity to investigate and review individual cases or groups of cases."

Both need to be considered in conjunction with the SAI workstream. There are also a number of other relevant factors which need to be considered by the sub-group:

a) Proposals to abolish the Health and Social Care Board which currently has a role in the oversight of the SAI process;

b) An ongoing review by RQIA of the current operation of the SAI review process, due to be completed and published by May/June 2020 and which may recommend further changes to the SAI system;

c) Planned changes to the SAI review process and other recommendations in the IHRD report, most of which are being progressed by the SAI workstream.

This sub-group's role is again to develop proposals and options for what the implementation of these recommendations might look like including any resource implications for RQIA.

Recommendation 34 states: "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."

Before Parliament was dissolved for the December General Election a Bill[13] had been prepared at Westminster to set up a Health Service Safety Investigations Body. This opens up the possibility of the type of independent investigation unit based outside Northern Ireland envisaged in the recommendations. However the Bill did not complete its passage before dissolution. We will therefore have to wait to see if the Bill is revived by the new government.

The group will produce a set of proposals around these five recommendations to align with the work of the other workstreams. It intends that proposals around RQIA oversight of Candour and Openness (**Recommendations 8 and 86(iii)**) will be ready to be published by March 2020 as part of a single consultation on both an Openness Policy and proposals for a statutory Duty of Candour.

The Clinical and Social Care Governance Sub-group

This sub-group is responsible for 14[14] actions from 13 IHRD recommendations. It has divided the recommendations into three task and finish groups, covering clinical guidelines, training and analysis and organisational.

They are currently working through these and liaising with other workstreams where they find linkages.

The most important of the 14 recommendations is Recommendation 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."

Most of the others will contribute to delivering on different elements of these 'appropriate governance arrangements'.

13 Health Service Safety Investigations Bill – the bill was not passed before Westminster parliament was prorogued for the December 2019 election. Further progress will depend on new Government at Westminster.

14 40, 41, 67, 68, 71, 76, 77, 78, 79, 80, 81, 90(i), 90(ii), 92

In practice all HSC Trusts, the HSCB and PHA have been subject to a statutory Duty of Quality since 2003 which requires them to have effective systems of clinical and social care governance in place. These requirements were first articulated in a circular[15] issued by the Department in 2002 entitled '**Governance in the HPSS – *Clinical and Social Care Governance: Guidelines for Implementation'***. The Department of Health also issued guidance to the HSC in 2009 called '**Establishing an Assurance Framework: *A Practical Guide for management boards of HSC organisations***'.

The proposal being considered by the group is that Recommendation 71 should be addressed through the development of a suite of three key documents:

a) A handbook for board members (currently being developed by the Board Effectiveness sub-group);

b) An updated version of circular HSS (PPM) 10/2002 - to be developed by the C and SCG sub-group; and

c) An updated version of Departmental guidance on Establishing an Assurance Framework - to be developed by the C and SCG sub-group.

These three pieces of guidance will directly address **Recommendations 40, 41, 67, 68, 76, 77, 78, 79, 80 and 81**.

In addition, **Recommendation 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", should be reinforced by including this requirement in SAI guidance. The sub-group will engage further with the SAI workstream on this proposal.

For **Recommendation 41**: "Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality", the requirement should build on and align with proposals for the implementation of Recommendation 83[16] being developed by the SAI workstream.

Recommendations 90(i) and 90(ii) both relate to the dissemination and implementation of clinical guidelines within the HSC sector. The sub-group is mainly focussed on how they relate to guidelines issued by the National Institute of Care and Excellence (NICE) and the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD). This involves working with the Department of Health on current guidance on the implementation process and cross referencing with guidance issued to meet Recommendation 71.

The final recommendation allocated to this sub-group is **Recommendation 92**: "The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary".

15 HSS (PPM) 10/2002
16 Recommendation 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.

Over the past ten years the Department has issued several pieces of guidance and led the development of new resources designed to minimise the risk to children and young people of Hyponatraemia arising from fluids management. Staff in the Public Health Agency have been developing updated guidance which was issued in December and which will partially cover the recommendation. This guidance documents issued are:

- HSC Competency Framework for Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Babies, Children and Young people; and

- Regional Policy for the administration of intravenous fluids to children aged from birth (term) until their 16th birthday: Reducing the risk of harm due to hyponatraemia.

Carol McCullough, Social and Clinical Care Governance Group and RQIA Remit subgroup.

Carol is an expert both through her own experience and training.

She has lived with chronic kidney disease from childhood and received a kidney transplant in 1987. Carol has also been diagnosed with three inflammatory conditions and the neurological form of Wilson's disease.

She has a degree in Social Policy and has gained an ILM Level 3 Award in Leadership and Management from the Health and Social Care Board/ Patient and Client Council Leading in Partnership course. More recently she completed the Southern Trust Quality Improvement Level 3 Award. An abstract of her work on alternatives to complaints, was accepted for presentation at the International Forum on Quality and Safety in Healthcare, Glasgow in March 2019.

She said: "The Quality Improvement course allowed me to complete work in an area in which I am keen to see improvement - avoiding complaints and alternatives to complaints wherever possible. We need to communicate better, build better relationships and we also need to be able to speak up when we feel we need to speak up."

Carol says that her experience of illness and the skills and knowledge she has picked up from her courses have given her the ability, not just to express her opinions but also to challenge the system when she needs to.

She said: "When working voluntarily as the Northern Ireland Rare Disease Consultation Lead I drafted and coordinated over 30 consultation responses. However, I know that the really important factor in all of this is the culture of the organisation.

"That will be vital to successful implementation. There needs to be a culture of openness and honesty; a just culture where everyone is treated fairly. There needs to be support where possible for the patients and families who have been affected by errors and problems in the health service."

And she added: "There also needs to be support for staff where genuine errors have been made or as a result of flaws in the system. We need to understand the dynamics at work that can affect how we all react. Nevertheless, regulations and policy cannot be misinterpreted to avoid responsibilities. Furthermore, one size does not fit all and there will be times when common sense dictates that policy can cause more harm than good."

She also stresses the vital importance of implementing change effectively. She said: "There is a need to explore how implementation of recommendations can be monitored and scrutinised to give assurance. There needs to be regional consistency and sharing of best practice models. In looking at implementation of recommendations we need to work together to ensure that there are no negative impacts down the line with the way recommendations are presented and may be interpreted."

Carol is passionate about co-production. She added: "I think an important part of co-production is that bringing professionals, patients and carers together further helps us to understand each other- to think about what matters to each of us and help us walk in the others' shoes. Because at the end of the day most of us all want the same thing- a great health service."

Workstream 4 – Paediatric-Clinical Collaborative

This workstream is responsible for 21[17] recommendations.

It ran an event in October which was led by the charity Children in Northern Ireland.

Here service users/carers and Health and Social Care staff including nurses, doctors and other professionals had the chance to find out what children and young people think about treatment and care in their own words.

Parents and carers gave presentations on their experiences too, highlighting what kind of communication and information they need.

It highlighted the importance of listening both to parents and children, because different children, just like adults, have different needs.

Another important message that arose is that parents are experts in their own children and should be listened to by those providing them with treatment and care. Following on from this workshop, there will be further exploration of using patients', carers' and parents' stories to shape the design and delivery of training for Health and Social Care staff.

There were also proposals on a new approach to improve nursing handover in children's wards. These will be considered by the workstream as an option for wider use in the implementation of the recommendations.

Several Recommendations **(17, 23, 24, 26 and 27)** are currently being delivered using paper-based systems. These relate to patient handover, fluid management/balance and detecting the deteriorating patient. These can be improved further when a new electronic health record solution is implemented. The electronic solution will improve access for everyone – both service users / carers and staff. The system called Encompass will provide an electronic health record solution across Northern Ireland for both hospital and community settings.

Planning is well advanced and the contract will be signed early 2020. From June 2020, the Encompass team will be making use of care networks and clinical champions to develop the care pathways required. This will be the opportunity for paediatric staff to make sure that the system will deliver everything that is needed. The system will be rolled out in a phases, beginning with the South Eastern Health and Social Care Trust in September/October 2021 and rolling out to a further Trust every six months. It is envisaged that all Trusts will be operational by the end of 2023.

The workstream has made its final proposals on seven other Recommendations (**10, 12, 13, 18, 19, 21 and 25**) from the 21 assigned to it and plans to ask Trusts to take forward steps to implement these in the New Year.

17 Recommendations 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30

Workstream 5 - Serious Adverse Incidents

This workstream is responsible for 18[18] actions arising from 10 recommendations.

The work, which connects strongly with the work of the Candour workstream and the Being Open sub-group, has concentrated on developing "What you should expect if you are involved in a Serious Adverse Incident" guidance which addresses several recommendations.

This document has been produced with input from many stakeholders. It has been particularly important to hear from service users and carers who have recently taken part in a Serious Adverse Incident (SAI) Review. Their recent experiences have helped the workstream develop its thinking further.

It's vital to remember that service users and carers involved in the SAI process have suffered a loss or harm. They are often distressed. The language used by Trusts and their Review Teams can often be too formal in how it deals with the process. It can add to that distress. It is important to service users and carers that their loss is acknowledged and that their loved one is discussed as a person and not as a case or number. Good communication is vital. There should also be a plan agreed between service users and carers and the staff involved in the SAI review. This can give an opportunity for regular communication with the SAI Review Team so that people do not feel that they are being shut out from the process or kept in the dark.

The workstream has made its final proposals on eleven actions (**33, 37(i), (ii), (iii), (v), (vi), (vii), (ix), (x), 39 and 42**) from the 18 assigned to it including those covered by the guidance above. The workstream plans to ask Trusts to implement these in the New Year.

An important part of implementation will be to help staff understand the changes and to support them. Two regional events for staff will take place early in the New Year to present the work to them. This will help them to prepare HSC staff for the implementation of "What you should expect if you are involved in a Serious Adverse Incident" to improve how service users and carers experience the process. Work is well underway to address the remaining seven actions.

18 Recommendations 31, 33, 37(i), 37(ii), 37(iii), 37(v), 37(vi), 37(vii), 37(viii), 37(ix), 37(x), 38, 39, 42, 66, 82, 83, 91 – Appendix 3, Table 5

Workstream 6 – Education and Training

This workstream is responsible for 6[19] IHRD recommendations.

It is engaging with the Department of Health and the Health and Social Care Board around **Recommendation 57:** "Specific clinical training should always accompany the implementation of important clinical guidelines."

The workstream is also liaising with the Clinical and Social Care Governance workstream in relation to potential overlaps with **Recommendation 90(ii):** "The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include the identification of specific training requirements necessary for effective implementation."

The workstream is in discussion with other workstreams and sub-groups around **Recommendations 62 and 65** in relation to the training of those involved in SAIs. This reflects the position that SAI-related recommendations are being considered by several workstreams and sub-groups.

The workstream is commissioning work to co-produce with children, parents and families a communications skills handbook in relation to **Recommendations 61 and 64**. In support of its work on **Recommendations 61, 62 and 64** the workstream has commissioned research from education and training providers to establish the current provision of education and training in relation to communication skills and the extent to which parents are involved in developing the training and education resources.

For **Recommendation 58:** "HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and Hyponatraemia," the workstream is currently benchmarking what training is being provided across the HSC Sector.

The workstream Chair attended a workshop in October, organised by the Paediatric Clinical Collaborative workstream focussing on making sure the views of children & young people as well as their parents and carers are actively heard and that they can be as involved as they wish in decisions about their treatment and care. Following on from that event the Chair is engaging with several of the attendees about involving them and using their experience to inform the ongoing education of healthcare professionals.

19 Recommendations 57, 58, 61, 62, 64, 65 – Appendix 3, Table 6

Workstream 7 - User Experience and Advocacy

This workstream is responsible for 3[20] actions from 3 IHRD recommendations.

Recommendation 37(iv) calls for "a fully funded independent advocacy service for services users and carers involved in a Serious Adverse Incident to include funded access to independent expert advice in complex case."

Recommendations 63 proposes that "the involvements of parents and the experiences of families and parents should be routinely evaluated and the information used to inform training and improvement."

Recommendation 89 states "the Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department."

The workstream has commissioned research in two stages. The first part outlined what advocacy is available in Northern Ireland and the second part outlined the models for advocacy in other countries. The emphasis of the work was to provide advocacy for service users /carers involved in Serious Adverse Incidents. Everyone should have the same opportunity to be supported to ensure that the lessons to be learned are identified.

The workstream has also considered how advocacy might be provided across all health and social care services. The health & social care sector has a big part to play in supporting service users and carers through advocacy. In addition, the **Patient and Client Council (PCC)** is responsible for delivering and/or providing access to advocacy and for families to engage with Serious Adverse Incident processes. This will be achieved through a 'hub and spoke' model of service delivery, working with other providers of advocacy services.

A system called Care Opinion has been commissioned to provide the On-line User Feedback Service (OUFS) digital platform for Northern Ireland from early 2020.

This will give service users/carers the opportunity to share their experiences of health and care services, **good** or **bad**. Their stories will be passed to the right people in the system to make a difference. That feedback will add to feedback from other systems such as '100,000 voices'. The worksteam is now exploring how best to co-ordinate feedback from these systems to improve services.

20 Recommendations 37(iv), 63, 89.

Workstream 8 - Workforce and Professional Regulation

This workstream is responsible for 7[21] IHRD recommendations.

Telling patients openly and honestly that something has gone wrong with their care is an essential part of a healthcare professional's practice.

It is therefore an issue for professional regulators when considering fitness to practise concerns. Since the public of the Francis Report[22] into Mid-Staffordshire NHS Foundation Trust, regulators have taken steps to significantly strengthen their oversight arrangements in respect of openness and candour. In February 2014, nine professional regulators overseen by the Professional Standards Authority (PSA) established a working group to develop a consistent approach to candour. This work led to the publication of a **joint statement**[23] on 13 October 2014, which was signed and published by all of the regulators except for the Health Care Professionals Council (HCPC). Since then all of the regulators' have developed standards which contain clear candour obligations so that they would all be operating a broadly consistent approach.

The regulators overseen by the PSA currently includes include Social Work England; the General Medical Council; General Dental Council; General Chiropractic Council; General Optical Council; General Osteopathic Council; General Pharmaceutical Council; Nursing & Midwifery Council; Pharmaceutical Society of Northern Ireland; and Health & Care Professions Council. In addition, organisations like the Northern Ireland Social Care Council include requirements within their **Standards of Conduct and Practice**[24] for social care workers to be honest and trustworthy in their dealings with service users, including a requirement to be open and honest with people if things go wrong. In 2015 the Nursing & Midwifery Council and the General Medical Council issued joint guidance[25] on candour for their respective registrants.

These developments are directly relevant to three recommendations being progressed by this workstream.

Recommendation 73: "General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors."

Recommendation 74: "Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment."

Recommendation 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."

In addition guidance issued by, for example, the NMC and GMC sets out the clear expectation that incidents must be reported **(Recommendation 32)** and implicitly expects that staff will participate in processes designed to support the identification of learning **(Recommendation 35)**.

21 Recommendations 5, 7, 32, 35, 73, 74, 75. – Appendix 3, Table 8.
22 https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
23 https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/progress-on-strengthening-approach-to-candour-november-2014.pdf
24 https://niscc.info/registration-standards/standards-of-conduct-and-practice
25 https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand____pdf-61540594.pdf?la=en&hash=EEB52EBEDBFA0EA421F4736F4C36BAB730A9E567

This group of five Recommendations (**32, 35, 73, 74 and 75**) can therefore be progressed through direct discussion between the Department and staff representative groups as part of existing arrangements to discuss the content of regional contracts.

The two remaining recommendations link to and are consequential to work by the Duty of Candour workstream to develop its proposals on a statutory Duty of Candour and guidance on Being Open. These are:

Recommendation 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"; and

Recommendation 7: "Trusts should monitor compliance and take disciplinary action against breach (of Duty of Candour)."

There will therefore be a delay in progressing both recommendations until work on the statutory Duty of Candour is completed.

Workstream 9 - Assurance

This workstream is responsible for one IHRD recommendation:

Recommendation 93: "The Department should review Trust responses to the findings and recommendations of this Report."

Each of the other workstreams and sub-groups have been completing an assurance framework for each recommendation. It sets out what the recommendation is seeking to achieve and the evidence expected in order to provide assurance that the recommendation has been implemented. The Assurance workstream is progressing well with this work and expects to have agreed the necessary evidence for more than half of the recommendations by January.

The workstream will also have a pivotal role in relation to assessing evidence providing by HSC bodies that they have implemented individual recommendations. It will then advise the Department through the Programme Management group of its assessment of progress with implementation by each HSC body.

Recommendations being overseen by the programme

There are three recommendations which are not being considered by individual workstreams. Instead these are being directly overseen by the Implementation Programme Management Group which is responsible for ensuring all recommendations are progressed. Two are addressed to the Department and the third will require the return of an Executive and Assembly to put in place. Here are the details of recommendations together with an update on progress:

Recommendation 85: "that the Department of Health should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare";

Detailed proposals have been developed for the implementation of this recommendation for the consideration of the Departments Top management.

Recommendation 88: "The Department should engage with other interested statutory bodies to review the merits of introducing a Child Death Overview Panel"

The Department has committed to the concept of a structured framework for child death review in Northern Ireland, which makes use of and builds on, where necessary, existing processes for reviewing child deaths. A policy position taken in 2011, placed the location of a Child Death Overview Panel with the Safeguarding Board for Northern Ireland, mirroring arrangements in other parts of the UK which are no longer in place.

While the merits of having an arrangement which facilitates the examination of all child deaths is without doubt, further consideration needs to be given to how best to implement a process of child death review in Northern Ireland in a way which maximises learning. The Department will continue to engage with key stakeholders as child death review proposals develop further.

Recommendation 94: "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."

This is one of the recommendations which will require a Minister in place to progress.

Next Update

The next update will be published in May 2020.

Appendix 1

Workstreams

The 120 individual actions arising from the 96 recommendations have been delegated to 9 workstreams that report to the Implementation Programme Management Group.

Workstream	Workstream name	Number of 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	Education and Training	6
7	User Experience and Advocacy	3
8	Workforce and Professional Regulation	7
9	Assurance	1

Sub-Groups

There are seven standing sub-groups tasked with taking forward a subset of recommendations within their workstream.

Linkages

There are linkages between the recommendations being looked at by different workstreams and sub-groups.

Appendix 2

Group Chairs

Name:	Group
Quintin Oliver (Independent)	Duty of Candour workstream
Peter McBride (Independent)	Being Open sub-group
David Best (DoH)	Death Certification Implementation Working Group (DCIWG) workstream
Vivien McConvey (Patient Client Council, PCC)	Preparation for Inquests [and Litigation] sub-group
Paul Finnegan (Cruse Bereavement Care)	Independent Medical Examiner sub-group
Sharon Wright (DoH)	HSC Bereavement and Pathology Network sub-group
Eddie Rooney (Former HSC)	Duty of Quality workstream
Jim Moore (Translink)	ALB Board Effectiveness sub-group
Lynn Charlton (Northern Ireland Ambulance Service, NIAS)	Clinical and Social Care Governance sub-group
Donna Ruddy (DoH)	RQIA Remit sub-group
John Simpson (Former HSC)	Paediatric-Clinical Collaborative workstream
Conrad Kirkwood (DoH)	Serious Adverse Incidents workstream
Keith Gardiner (Northern Ireland Medical and Dental Training Agency, NIMDTA)	Education and Training workstream
Rodney Morton (DoH)	User Experience and Advocacy workstream
Andrew Dawson (DoH)	Workforce and Professional Regulation workstream
Olive MacLeod (Regulation and Quality Improvement Authority, RQIA)	Assurance workstream

Appendix 3 – Allocation of recommendations to Workstreams

Table 1: IHRD Recommendation delegated to the Duty of Candour Workstream

IHRD Number	Workstream Action	Recommendation
1 (i)	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
1 (ii)	2	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
1 (iii)	3	iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).
1 (iv)	4	(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.
1 (v)	5	(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.
1 (vi)	6	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.
1 (vii)	7	(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	8	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	9	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	10	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.
6	11	Support and protection should be given to those who properly fulfil their duty of candour.

Table 2 : IHRD Recommendation delegated to the Death Certification Implementation Working Group Workstream

IHRD Number	Workstream Action	Recommendation
36	1	Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.
43	2	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.
44	3	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
45	4	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem
46	5	Where possible, treating clinicians should attend for clinico-pathological discussions at the time of post-mortem examination and thereafter upon request.
47 (i)	6	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.
47 (ii)	7	(ii) Work in liaison with the clinicians involved.
47 (iii)	8	(iii) Provide preliminary and final reports with expedition.
47 (iv)	9	(iv) Sign the post-mortem report.
47 (v)	10	(v) Forward a copy of the post-mortem report to the family GP
48	11	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.
49	12	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.
50	13	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
51	14	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.
52	15	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.
53	16	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.
54	17	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.
59	18	There should be training in the completion of the post-mortem examination request form.
60	19	There should be training in the communication of appropriate information and documentation to the Coroner's office.

Table 2 : IHRD Recommendation delegated to the Death Certification Implementation Working Group Workstream *(continued)*

IHRD Number	Workstream Action	Recommendation
87	20	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.
95	21	Given that the public is entitled to expect appropriate transparency from a publicly funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.
96	22	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.

Table 3: IHRD Recommendation delegated to the Duty of Quality Workstream

IHRD Number	Workstream Action	Recommendation
8[26]	1	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance (with the Duty of Candour) and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.
9	2	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.
34[6]	3	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses
40	4	Learning and trends identified in SAI investigations should inform programmes of clinical audit
41	5	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.
55	6	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.
56	7	All Trust Board Members should receive induction training in their statutory duties.
67	8	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed
68	9	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.
69 (i)	10	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour
69 (ii)	11	(ii) Child Healthcare.
69 (iii)	12	(iii) Learning from SAI related patient deaths.
70	13	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.
71	14	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.
72	15	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director
76	16	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.
77	17	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.
78	18	Implementation of clinical guidelines should be documented and routinely audited
79	19	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.

26
Delegated to workstream sub-group: RQIA Remit

Table 3: IHRD Recommendation delegated to the Duty of Quality Workstream

(continued)

IHRD Number	Workstream Action	Recommendation
80	20	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.
81	21	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.
84	22	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.
86 (i) [6]	23	The Department should expand both the remit and resources of the RQIA in order that it might (i) Maintain oversight of the SAI process
86 (ii) [6]	24	(ii) Be strengthened in its capacity to investigate and review individual cases or groups of cases, and
86 (iii) [6]	25	(iii) Scrutinise adherence to duty of candour.
90 (i)	26	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability.
90 (ii)	27	(ii) The identification of specific training requirements necessary for effective implementation.
92	28	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.

Table 4: IHRD Recommendation delegated to the Paediatric-Clinical Collaborative Workstream

IHRD Number	Workstream Action	Recommendation
10	1	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
11	2	There should be a protocol to specify the information accompanying a patient transfer from one hospital to another
12	3	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.
13	4	Foundation doctors should not be employed in children's wards.
14	5	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.
15	6	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.
16	7	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.
17	8	Any change in clinical accountability should be recorded in the notes.
18	9	The names of all on-call consultants should be prominently displayed in children's wards.
19	10	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.
20	11	Children's ward rounds should be led by a consultant and occur every morning and evening
21	12	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.
22	13	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.
23	14	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.
24	15	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.
25	16	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.
26	17	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.

Table 4: IHRD Recommendation delegated to the Paediatric-Clinical Collaborative Workstream *(continued)*

IHRD Number	Workstream Action	Recommendation
27	18	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.
28	19	Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent.
29	20	Record keeping should be subject to rigorous, routine and regular audit.
30	21	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.

Table 5: IHRD Recommendation delegated to the SAI Workstream

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
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.

Table 6: IHRD Recommendation delegated to the Education and Training Workstream

IHRD Number	Workstream Action	Recommendation
57	1	Specific clinical training should always accompany the implementation of important clinical guidelines.
58	2	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and Hyponatraemia.
61	3	Clinicians caring for children should be trained in effective communication with both parents and children.
62	4	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.
64	5	Parents should be involved in the preparation and provision of any such training programme.
65	6	Training in SAI investigation methods and procedures should be provided to those employed to investigate.

Table 7: IHRD Recommendation delegated to the User Experience and Advocacy Workstream

IHRD Number	Workstream Action	Recommendation
37 (iv)	1	(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.
63	2	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.
89	3	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.

Table 8: IHRD Recommendation delegated to the Workforce and Professional Regulation Workstream

IHRD Number	Workstream Action	Recommendation
5	1	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.
7	2	Trusts should monitor compliance and take disciplinary action against breach (of Duty of Candour) .
32	3	Failure to report an SAI should be a disciplinary offence.
35	4	Failure to co-operate with investigation should be a disciplinary offence.
73	5	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.
74	6	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.
75	7	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

Table 9: IHRD Recommendation delegated to the Assurance Workstream

IHRD Number	Workstream Action	Recommendation
93	1	The Department should review Trust responses to the findings and recommendations of this Report.