IHRD Phase 1 Recommendations – ACTIONED

Workstream/ Sub-Group	Number	Recommendation
Duty of Quality Workstream	9	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members
Paediatric Clinical Workstream	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings
Paediatric Clinical Workstream	11	There should be a protocol to specify the information accompanying a patient transfer from one hospital to another
Paediatric Clinical Workstream	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients **Revised Definition - "Paediatricians hold responsibility when children are admitted to paediatric medical wards. However, it recognised that this arrangement would not be in the best interests of the safest clinical care for the child where consultants from other specialties are responsible for the direct delivery of care and treatment to the child. In such cases adequate arrangements need to be put in place to ensure that senior paediatric advice is available, particularly in prescribing fluids for children and in managing the deteriorating patient"**
Paediatric Clinical Workstream	13	Foundation doctors should not be employed in children's wards **Revised Definition - "No Foundation Year 1 (F1) doctors (previously known as Junior House Officers JHO) are employed in Paediatric Wards. Foundation Year 2 (F2) doctors (previously known as Senior House Officers SHO) rotate through Paediatric units and sufficient supervision must be put in place to ensure safe practice in the care and treatment of children"**
Paediatric Clinical Workstream	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment
Paediatric Clinical Workstream	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership
Paediatric Clinical Workstream	16	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
Paediatric Clinical Workstream	17	Any change in clinical accountability should be recorded in the notes
Paediatric Clinical Workstream	18	The names of all on-call consultants should be prominently displayed in children's wards
Paediatric Clinical Workstream	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels
Paediatric Clinical Workstream	20	Children's ward rounds should be led by a consultant and occur every morning and evening
Paediatric Clinical Workstream	21	The 'accountable' nurse should, insofar as is possible, attend at every interaction between a doctor and child patient
Paediatric Clinical Workstream	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans
Paediatric Clinical Workstream	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded
Paediatric Clinical Workstream	24	All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart

Paediatric Clinical Workstream	25	All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician
Paediatric Clinical Workstream	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care
Paediatric Clinical Workstream	27	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care
Paediatric Clinical Workstream	28	Consideration should be given to recording and/or emailing information and advice provided for the purpose of obtaining informed consent
Paediatric Clinical Workstream	29	Record keeping should be subject to rigorous, routine and regular audit
Paediatric Clinical Workstream	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed
Clinical and Social Care Governance Sub-Grou p	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit
Clinical and Social Care Governance Sub-Group	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality
HSC Bereavement and Pathology Network Sub-Group	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
HSC Bereavement and Pathology Network Sub-Group	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem
HSC Bereavement and Pathology Network Sub-Group	46	Where possible, treating clinicians should attend for clinico-pathological discussions at the time of post-mortem examination and thereafter upon request
HSC Bereavement and Pathology Network Sub-Group	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
HSC Bereavement and Pathology Network Sub-Group	47(ii)	In providing post-mortem reports pathologists should be under a duty to: Work in liaison with the clinicians involved
HSC Bereavement and Pathology Network Sub-Group	47(iii)	In providing post-mortem reports pathologists should be under a duty to: Provide preliminary and final reports with expedition
HSC Bereavement and Pathology Network Sub-Group	47(iv)	In providing post-mortem reports pathologists should be under a duty to: Sign the post-mortem report
HSC Bereavement and Pathology Network Sub-Group	47(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
HSC Bereavement and Pathology	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

Network Sub-Group		
ALB Board Effectiveness Sub-Group	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.
ALB Board Effectiveness Sub-Group	56	All Trust Board Members should receive induction training in their statutory duties
Education and Training Workstream	57	Specific clinical training should always accompany the implementation of important clinical guidelines
Education and Training Workstream	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and Hyponatraemia
HSC Bereavement and Pathology Network Sub-Group	59	There should be training in the completion of the post-mortem examination request form
HSC Bereavement and Pathology Network Sub-Group	60	There should be training in the communication of appropriate information and documentation to the Coroner's office
Education and Training Workstream	61	Clinicians caring for children should be trained in effective communication with both parents and children
Education and Training Workstream	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death
User Experience and Advocacy Workstream	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement
Education and Training Workstream	64	Parents should be involved in the preparation and provision of any such training programme
Education and Training Workstream	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate
Clinical and Social Care Governance Sub-Group	67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed
Clinical and Social Care Governance Sub-Group	68	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining
ALB Board Effectiveness Sub-Group	69(ii)	Trusts should appoint and train Executive Directors with specific responsibility for: Child Healthcare
ALB Board Effectiveness Sub-Group	69(iii)	Trusts should appoint and train Executive Directors with specific responsibility for: Learning from SAI related patient deaths
ALB Board Effectiveness Sub-Group	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved
Clinical and Social Care Governance Sub-Group	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
Clinical and Social Care Governance Sub-Group	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit
Clinical and Social Care Governance Sub-Group	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction

Clinical and Social Care Governance Sub-Group	78	Implementation of clinical guidelines should be documented and routinely audited
Clinical and Social Care Governance Sub-Group	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition
Clinical and Social Care Governance Sub-Group	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
ALB Board Effectiveness Sub-Group	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure
Departmental	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare
Departmental	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel
User Experience and Advocacy Workstream	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department
Clinical and Social Care Governance Sub-Group	90(i)	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability
Clinical and Social Care Governance Sub-Group	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
Clinical and Social Care Governance Sub-Group	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary
Assurance Workstream	93	The Department should review Trust responses to the findings and recommendations of this Report

TOTAL 63 actions

IHRD Phase 2A Recommendations

Workstream/ Sub-Group	No	Recommendation
Workforce and Professional Regulation Workstream	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
Workforce and Professional Regulation Workstream	7	Trusts should monitor compliance and take disciplinary action against breach
Workforce and Professional Regulation Workstream	32	Failure to report an SAI should be a disciplinary offence
Workforce and Professional Regulation Workstream	35	Failure to co-operate with investigation should be a disciplinary offence
Preparation for Inquests Sub-Group	36	Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation
User Experience and Advocacy Workstream	37(iv)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular 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
Death Certification Implementation Workstream	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement
Death Certification Implementation Workstream	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures
Death Certification Implementation Workstream	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
Preparation for Inquests Sub-Group	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved
Preparation for Inquests Sub-Group	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office
Preparation for Inquests Sub-Group	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests
Preparation for Inquests Sub-Group	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed
Workforce and Professional Regulation Workstream	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.
Workforce and Professional Regulation Workstream	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment
Workforce and Professional Regulation Workstream	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies
Clinical and Social Care	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.

Governance Sub-Group		
Departmental	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended
Preparation for Inquests Sub-Group	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts
Preparation for Inquests Sub-Group	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited

TOTAL 20 actions

IHRD Phase 2B Recommendations

Workstream/ Sub-Group	No	Recommendation
Duty of Candour Workstream	1(i)	A statutory duty of candour should now be enacted in Northern Ireland so that: Every healthcare organisation and everyone working for them must be open and honest in all their dealings with patients and the public
Duty of Candour Workstream	1(ii)	A statutory duty of candour should now be enacted in Northern Ireland so that: 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.
Duty of Candour Workstream	1(iii)	A statutory duty of candour should now be enacted in Northern Ireland so that: Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative)
Duty of Candour Workstream	1(iv)	A statutory duty of candour should now be enacted in Northern Ireland so that: Any statement made to a regulator or other individual pursuant to statutory duty must be truthful and not misleading by omission
Duty of Candour Workstream	1(v)	A statutory duty of candour should now be enacted in Northern Ireland so that: Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission
Duty of Candour Workstream	1(vi)	A statutory duty of candour should now be enacted in Northern Ireland so that: 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
Duty of Candour Workstream	1(vii)	A statutory duty of candour should now be enacted in Northern Ireland so that: 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
Duty of Candour Workstream	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty
Being Open Sub-Group	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
Being Open Sub-Group	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare
Being Open Sub-Group	6	Support and protection should be given to those who properly fulfil their duty of candour
RQIA Remit Sub-Group	8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception
Serious Adverse Incident Workstream	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs')
Serious Adverse Incident Workstream	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive
RQIA Remit Sub-Group	34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses
Serious Adverse Incident Workstream	37(i)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints
Serious Adverse Incident Workstream	37(ii)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular families should be given the opportunity to become involved in setting the terms of reference for an investigation
Serious Adverse Incident Workstream	37(iii)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular families should, if they so wish, engage with the investigation and receive feedback on progress
Serious Adverse Incident Workstream	37 (v)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular 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
Serious Adverse Incident Workstream	37(vi)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular all written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive

Serious Adverse Incident Workstream	37(vii)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing
Serious Adverse Incident Workstream	37(viii)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular family GPs should, with family consent, receive copies of feedback provided
Serious Adverse Incident Workstream	37(ix)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular families should be formally advised of the lessons learned and the changes effected
Serious Adverse Incident Workstream	37(x)	Trusts should seek to maximise the involvement of families in SAI investigations and in particular Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation
Serious Adverse Incident Workstream	38	Investigations should be subject to multi-disciplinary peer review
Serious Adverse Incident Workstream	39	Investigation teams should reconvene after an agreed period to assess both investigation and response
Serious Adverse Incident Workstream	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families
Serious Adverse Incident Workstream	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours
Duty of Candour Workstream	69(i)	Trusts should appoint and train Executive Directors with specific responsibility for: Issues of Candour.
ALB Board Effectiveness Sub-Group	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated Non-Executive Director
Serious Adverse Incident Workstream	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths
Serious Adverse Incident Workstream	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
RQIA Remit Sub-Group	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
RQIA Remit Sub-Group	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.
RQIA Remit Sub-Group	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.
Independent Medical Examiner Sub-Group	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner
Serious Adverse Incident Workstream	91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information

TOTAL 37 actions