IHRD Implementation Plan

Programme Initiation Document

PROGRAMME INITIATION DOCUMENT

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IHRD Implementation Plan
PROGRAMME BRIEF/ PROGRAMME INITIATION DOCUMENT

Contents

1. Purpose of document

1.1 Scope

This Programme Initiation Document sets out the scope of the programme as well as the structure and parameters within which it will operate. The Programme Initiation Document forms the 'contract' between the Senior Responsible Officer and the IHRD Programme Management Group and the work of the individual programme Workstreams. Any significant change to the material contained in the Programme Initiation Document will need to be referred to the SRO for agreement. The PID has two primary uses:

- To ensure that the SRO has a complete and sound basis on which to secure commitment to the implementation of recommendations of the Inquiry into Hyponatraemia Related Deaths
- To act as a base document against which the stakeholders can assess progress, review issues, and consider ongoing viability questions.

1.2 Definitions

The document defines the management, organisation and timescales within which the 120 activities / actions arising from the 96 IHRD Recommendations are to be performed. It is intended to be a single source for the following information:

- What outputs are to be delivered and by whom and when;
- How changes to the programme deliverables are to be controlled;
- How the programme delivery will be undertaken

1.3 Authority for the Programme

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

2. Context

2.1 Background

On 31 January 2018 the report of the Inquiry into Hyponatraemia Related Deaths (IHRD) was published following an extensive investigation into the deaths of five children in hospitals in Northern Ireland. After hearing evidence from a wide range of individuals and organisations it concluded that the five deaths had been avoidable and that the culture of the health service at the time, arrangements in place to ensure the quality of services and behaviour of individuals had contributed to those unnecessary deaths.

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

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

"We owe this to the families first and foremost, as well as to patients and other people who use our services across the province and the great many HSC staff who strive to do the right thing, often in very challenging circumstances…(and that)… a

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

critical element in the success of this work will be engagement with the public we serve, particularly those affected".

2.2 Summary of IHRD Recommendations

The Inquiry report made 96 recommendations (120 specific actions) across a number of themes reflecting the findings made during the investigation[3]. These are referenced in Appendix 1 and summarised below:

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

2.3 Principles

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

1 That healthcare services exist to serve the patient

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

3 That the particular needs of children must be addressed

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

5 That progress should be subject to regular external review

[3] IHRD Report Vol 3 Chapter 9 Pages 84-97

[4] IHRD Report January 2018: Vol 3 Chapter 9 Section 9.1

3 Programme Definition

3.1 Overview

This programme brief sets out the arrangements for the implementation of the 96 recommendations to improve the system and practice in Northern Ireland. It acknowledges that in effecting change, in so large and complex a system, changes in the culture that operates around Health and Social Care and into the wider system is needed for the quality of services to be assured and public confidence restored. With that must come greater transparency and accountability both in the planning and delivery of services and in the implementation of the 96 recommendations from the IHRD report.

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

To achieve that will require us to:

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

In effect how the implementation of the IHRD recommendations is undertaken, through the programme workstreams, is almost as important as the implementation of the recommendations themselves.

3.2 Terms of reference:

The Programme for implementation of the IHRD Report recommendations is expected to work within the following terms of reference. These may be amended as issues emerge.

1. To work within the principles set out in the recommendations from the IHRD report[5]

2. To be responsible for the implementation of 120 specific actions (as set out in Appendix 1) arising from 96 recommendations from the IHRD report

3. To work with key stakeholders, in setting out detailed plans for the implementation of the recommendations of the IHRD report, including the development of Involvement, Communications and Training Plans as well as an Assurance Framework, identifying and managing risks that arise.

4. Ensuring representation and involvement of relevant interests in the detailed work taken forward as part of the implementation programme;

5. Ensure that key linkages are maintained with related work external to the main programme workstreams and between the various workstream groups and sub-groups.

6. Providing clear direction and leadership on the delivery of the recommendations in the HSC system;

7. Providing challenge and rigour in the decision making process;

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

8. Monitoring progress against plans and ensuring that action is taken where required to address slippage in resolving implementation issues and managing risks;

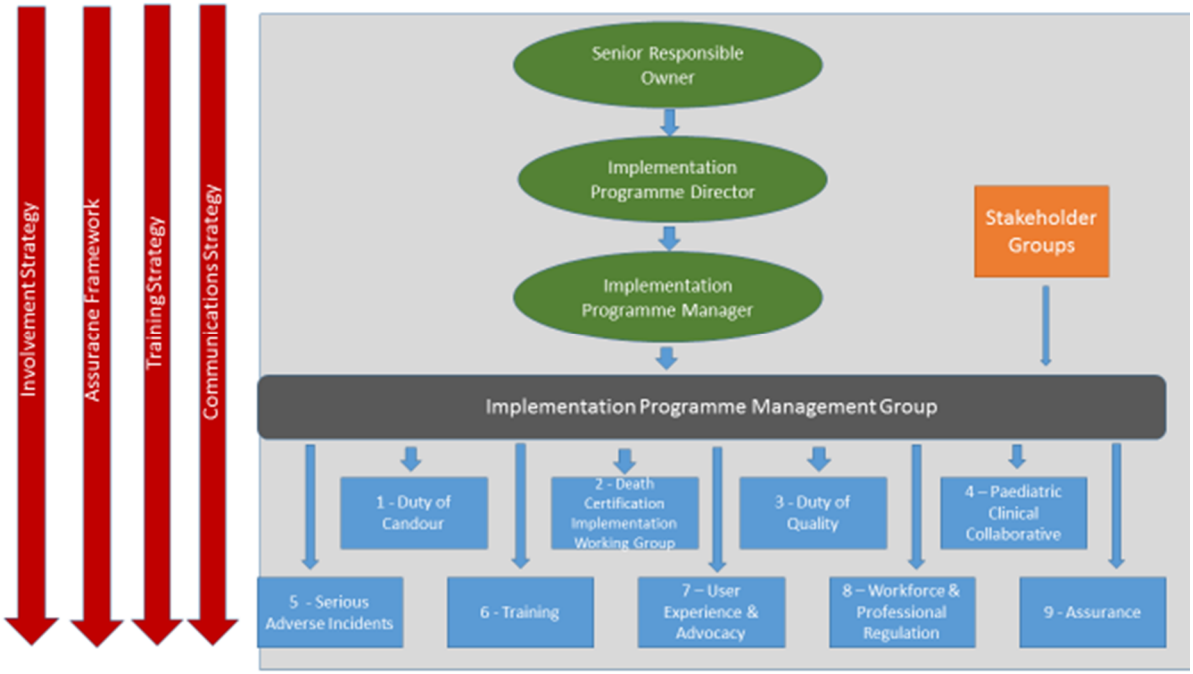
9. Commissioning the establishment of Workstream Groups to take forward specific actions for implementation, based on the principles of engagement with key stakeholders.

The terms of reference, membership and administrative arrangements for the individual Programme Workstreams briefs are set out in separate Programme Workstream Briefs.

4 Programme Structure

The IHRD Programme will ensure the effective implementation of the 120 actions arising from the 96 recommendations of the Inquiry Report. The programme structure is set out in Diagram 1.

Diagram 1: IHRD Implementation Programme Structure



4.1 Senior Responsible Officer (SRO)

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

4.2 The Implementation Programme Director (IPD)

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

4.3 The Implementation Programme Manager (IPM)

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

4.4 The Implementation Programme Management Group (IPMG)

Chaired by the Programme Manager the IPMG will comprise the individual Workstream Chairs and Subgroup Chairs.

The IPMG is responsible for the development and implementation of an involvement strategy in support of all workstreams and sub-groups. The IPMG is also responsible for ensuring that issues such as evolving and developing training needs are identified through the work undertaken and allocated to the appropriate workstream.

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

- Involvement strategy

- Communication strategy
- Training strategy
- Assurance Framework

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

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

4.6 Workstreams

The 120 individual actions arising from the 96 recommendations have been delegated to 9 workstreams (Appendix 2) that report to the Implementation Programme Management Group. These are:

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

Inevitably there will be cross over in individual workstreams and with existing work, where possible this has been identified in the Action Plan Matrix (Appendix 1) for each workstream and arrangements put in place to link to or subsume such work into the workstream.

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

4.7 Department of Health

As well as providing strategic leadership for the programme the Department is responsible for implementing specific recommendations[6]:

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

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

5 Programme Plan

5.1 Strategic objectives.

Following the publication of the Report from the Inquiry into Hyponatraemia Related Deaths Department of Health Permanent Secretary Richard Pengelly said: "everyone involved in Health and Social Care…will have cause to reflect on the findings…(and that it was)…essential that those of us with leadership responsibilities now take concerted and prompt action to address the issues raised in the Report, and reassert the primacy of patient safety and work diligently to rebuild public confidence in the care provided, whether in hospitals, the community or primary care".

To give a clear focus to the work, Mr Pengelly stated that he would be establishing a dedicated team, led by the Department and answerable to him, to develop a detailed action plan in response to the 96 recommendations in the Report

[6] Appendix 1: IHRD Action Plan Matrix

The purpose of the Programme is to provide the strategic leadership in the planning, delivery and long-term sustainability of the Implementation of the Inquiry Recommendations. That the composition of the different workstreams will reflect the clinical and managerial leadership needed for the achievement of these aims as well as the need to include representation from relevant stakeholder groups.

5.2 Deliverables and timescales

The initial list of deliverables are as follows:

	Deliverable	Description	Responsibility	Completion Date
1	Trust Audit	Trust self-audit against recommendations 10-30	DoH HSC Trusts	23/02/18
2	Draft Programme Plan	Define structure, responsibilities & recruit membership	DoH	March 18
3	Relatives engagement	Agree with relatives or representatives how wish to be engaged		March'18
4	Draft outline plan for implementation of IHRD recommendations	Development of plan for each recommendation	DoH	February 18
5	Programme Workstream Groups	Agree Workstream Chair, membership and ToR	DoH	March 2018
6	Business case development	Development of business case for resources to support programme		
7	Assurance Framework	Development of a Strategy and Framework to assure process of implementation	Workstream 9	
8	Communication & engagement	Throughout the process of planning and implementation to ensure good communication and engagement of		

Deliverable	Description	Responsibility	Completion Date
	stakeholders		

This initial list of deliverables may be added to over time. Each workstream and sub-group will develop its own work plan containing its own list of actions necessary to progress implementation.

5.3 Programme Controls

A range of control measures will underpin the implementation processes

5.3.1 Meeting control

The following meetings will be held as part of the Programme Implementation Plan:

Meeting Name	Description	Frequency	Attendees
Programme Directors' updates	Update to SRO	Quarterly	SRO, Programme Director, Programme Manager, Deputy Programme Manager and individual workstream Chairs as required. Members and attendees TBC
Programme Management Group	Main programme group to coordinate workstream progress	Monthly	Chair & subgroup chairs of Workstreams Chaired by PM
Workstream 1	Duty of Candour	Monthly	TBC
Workstream 2	Death Certification Implementation Working Group		TBC
Workstream 3	Duty of Quality		TBC
Workstream 4	Paediatric – Clinical – Collaborative		
Workstream 5	Serious Adverse Incidents		
Workstream 6	Training		

Workstream 7	User Experience and Advocacy
Workstream 8	Workforce and Professional Regulation
Workstream 9	Assurance

5.3.2 Reporting control

All Workstream Groups and Subgroups will be provided with reporting templates to be completed as a running record of actions planned and achieved. Each group will report at an agreed time frame, appropriate for the work being undertaken and the individual meeting cycles.

It is also expected that the groups will maintain an **Action Log** for identification of actions necessary to support implementation and an **Issues Log**. An agreed threshold for inclusion into the Programme Risk Register should be discussed with the Programme Manager.

5.3.2 Document Control

A set of Programme and workstream document templates will be developed and maintained. These will include issues log, risk register, work plan and actions log.

All core Programme documents will be version controlled with a Trim reference, version number, author, approval, circulation and date. These will be overseen by the Programme Manager.

A set of document templates will be developed and maintained for use by all Groups, Workstreams and Sub-Groups. These will include workstream action logs, exceptions log, meeting logs, work plans etc.). All documents will be dated and remain in draft form until agreed.

The administrative support staff will be responsible for the version control and updating of documents with individual workstream and subgroup chairs responsible for the accuracy of the content.

5 Governance

5.1 Responsibility

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

Department senior officers are responsible (as set out in section 4) for ensuring the reporting and monitoring of the implementation plan with progress on the programme of work reported to the SRO through the Programme Director.

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

5.2 Resources

A business case will be developed for resources to support the IHRD Programme Plan, evaluating the options for implementation

The Programme Manager will lead a team drawn from the Department, HSC Trusts, Public Health Agency, RQIA and other agencies as necessary. Initial resources will include:

- Department of Health - 3 Grade 7 officers, 5 Deputy Principals; 3 staff officers and an administration team to support work across the Programme
- HSC staff will be drawn from Trusts with experience in involvement, governance, workforce and complaints/ SAIs etc.
- Resources of the Programme team will be supplemented by expert policy advice from other Departmental policy staff, such as workforce, finance, primary and secondary care.
- Support and advice will also be provided from the Chief Nursing Officers group, Chief Medical Officers group, Chief Social Services Officer and other Chief Professional disciplines

- In addition, where required, the workstreams will be supported by staff with particular expertise, which may necessitate drafting in such capability from outside NI public services and at times outside the region. This will all be reflected in the business case.

Resource implications from the Training Plan, developed as part of the programme implementation, are likely to have an impact across Trusts, BSO, NIPEC, NIMDTA, RQIA, PCC etc. as well as undergraduate professional training. This will be taken account of in final proposals

5.3 Risk

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

The Programme Manager will oversee the development and maintenance of a programme **Risk Register** for the programme. The Programme Director will alert the SRO of substantive risks to the implementation of the recommendations.

An **Assurance Framework** will be developed for the programme implementation plan through Workstream 9, chaired by the RQIA Chief Executive. It will provide independent assurance to individual workstreams, the programme managers Group, the SRO *and* to families, the general public and the HSC that recommendations have been implemented on a sustainable basis.

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Appendices:

1 IHRD Action Plan Matrix

2 Recommendations delegated to Workstreams

3 Workstream sub-groups

Appendix 1

IHRD: RECOMMENDATIONS

Action Plan Matrix

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

	Ref	RECOMMENDATION	Report Reference	Workstream
		(iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).	Vol 1, Chapter 3: Section 3.178 Page 181 Section 3.242-244 Page 203-204 Section 3.245-248 Page 204 – 206 Vol 2, Chapter 4: Section 4.86 -88 Page 29 Section 4.310 (ii) Page 92 Section 4.330 Page 98 Vol 2: Chapter 5 Section 5.253-5.254 Page 181	**1-Duty of Candour** *Linked to:* *6-Training* *7-User experience* *8 Workforce and professional regulation*
		(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.	Vol 1, Chapter 3: Section 3.179 -180 Pages 181-182 Section 3.195-196 Page 186	**1-Duty of Candour** *Linked to:* *6-Training* *8-Workforce and professional regulation*
		(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	Vol 1, Chapter 3: Section 3.200 Page 188 Section 3.202 Page 188	**1-Duty of Candour** *Linked to:* *6-Training*

	Ref	RECOMMENDATION	Report Reference	Workstream
		(vi) Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.	Vol 1, Chapter 3: Section 3.178 Page Vol 2: Chapter 5: Section 5.253 Page 81	**1-Duty of Candour** *Linked to:* *5-SAI*
		(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.	Vol 2, Chapter 4: Section 4.47-53 page 17-19 Section 4.54-55 Page 19-20 Section 4.130 Page 41 Section 4.145 Page 46 Section 4.217 Page 66 Section 4.241 Page 72-73 Section 4.301 Page 89 Section 4.306 Page 98	**1-Duty of Candour** *Linked to:* *5-SAI* *8-Workforce and professional regulation*
	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.	Vol 3, Chapter 8: Section 8.103 Page 73 Section 8.106 Page 74	**1-Duty of Candour** *Linked to:* *8-Workforce and professional regulation*
	3	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty	Vol 3, Chapter 8: Section 8.104 page 74	**1-Duty of Candour** *Linked to:* *6-Training*
	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of		**1-Duty of Candour** *Linked to:*

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

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

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

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

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

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

	Ref	RECOMMENDATION	Report Reference	Workstream
				Linked to: *3-Duty of Quality*
	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.	Vol 3, Chapter 8: Section 8.108 Page 75	**4-Paediatric/Clinical Collaborative** *Linked to:* *1-Duty of Candour*
SAI - REPORTING	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').	Vol 2, Chapter 6 Section 6.67-69 Page 242-243 Vol 3: Chapter 8; Section 8.41-42 Page 54 Section 8.46-47 Page 55-56	**5-SAIs** *Linked to:* *1-Duty of Candour* *6-Training*
	32	Failure to report an SAI should be a disciplinary offence.	Vol 2, Chapter 4: Section 4.232 Page 78 Vol 3, Chapter 8: Section 8.65 - 8.66 Page 61	**8-Workforce & Professional Regulation** *Linked to:* *5-SAI*
SAI - INVESTIGATIO	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.	Vol 3, Chapter 8: Section 8.48 – 8.49 Page 56	**9-Assurance** Linked to: 3-Duty of Quality 5-SAI
			Vol 1 Chapter 3: Section 3.266 (iii – iv) Page 214	**1-Duty of Quality**

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

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

	Ref	RECOMMENDATION	Report Reference	Workstream
				7-User experience
		(ix) Families should be formally advised of the lessons learned and the changes effected		**5-SAI** *Linked to:* *3-Duty of Quality* *7-User experience*
		(x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation	Vol 2, Chapter 4: Section 4.179 Page 55	**5-SAI**
SAI - INVESTIGATION	38	Investigations should be subject to multi-disciplinary peer review.	Vol 3, Chapter 8: Section 8.73 page 64	**5-SAI** *Linked to:* *3-Duty of Quality* *6-Training*
	39	Investigation teams should reconvene after an agreed period to assess both investigation and response.		**5-SAI** *Linked to:*
	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit	Vol 3, Chapter 8: Section 8.49 -50 Page	**3-Duty of Quality** Linked to: 5-SAI
	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.		**3-Duty of Quality**
	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.	Vol 2, Chapter 4 Section 4.173-176 Page 54 Vol 3, Chapter 8:	**5-SAI** *Linked to:*

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

	Ref	RECOMMENDATION	Report Reference	Workstream
		(i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them. (ii) Work in liaison with the clinicians involved. (iii) Provide preliminary and final reports with expedition. (iv) Sign the post-mortem report. (v) Forward a copy of the post-mortem report to the family GP	Section 3.212 Page 191 Section 3.229-230 Page 197-198 Section 3.235-238 page 200-201 Vol 2, Chapter 4: Section 4.291 Page 86 Vol 1, Chapter 3: Section 3.232 Page 98	**Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*
	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.	Vol 3, Chapter 8: Section 8.61 Page 59-60	**2-Death Certification Implementation Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*
	49	Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.		**2-Death Certification Implementation Working group** *Linked to:* *1-Duty of Candour* *3-Duty of Quality* *6-Training*
	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved	Vol 2, Chapter 4: Section 5.282-291 Page 189-192 Vol 3, Chapter 7:	**2-Death Certification Implementation Working group**

	Ref	RECOMMENDATION	Report Reference	Workstream
			Section 7.57 Pages 21- 22	*Linked to:* *3-Duty of Quality*
	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.	Vol 1, Chapter 2: Section 2.148 Page 85 Section 2.199 Page 101 Vol 1, Chapter 3: Section 3.267 -273 Page 214-217	**2-Death Certification Implementation Working group**
	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.	Vol 1, Chapter 3: Section 3.279-280 Page 218-219	**2-Death Certification Implementation Working group**
	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.	Vol 3, Chapter 8: Section 8.129 Page 81	**2-Death Certification Implementation Working group**
	54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.	Vol 3, Chapter 8: Section 8.57 Page 58-59	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training* *7-User experience*
TRAINING &	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.		**3-Duty of Quality** *Linked to:* *5-SAI*

	Ref	RECOMMENDATION	Report Reference	Workstream
				6-Training
	56	All Trust Board Members should receive induction training in their statutory duties.		**3-Duty of Quality** *Linked to:* *6-Training*
	57	Specific clinical training should always accompany the implementation of important clinical guidelines.		**6-Training**
	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and Hyponatraemia.	Vol 3, Chapter 8: Section 8. 17-24Pages 46-48	**6-Training**
	59	There should be training in the completion of the post-mortem examination request form.		**2-Death Certification Implementation Working group** *Linked to:* *6-Training*
	60	There should be training in the communication of appropriate information and documentation to the Coroner's office.	Vol 2, Chapter 4: Section 4.258 Page 77 Section 4.270 Page 80	**2-Death Certification Implementation Working group** *Linked to:* *6-Training*
	61	Clinicians caring for children should be trained in effective communication with both parents and children.	Vol 3, Chapter 8: Section 8.86 Page 67	**6-Training**

	Ref	RECOMMENDATION	Report Reference	Workstream
				Linked to: *1-Duty of Candour* *4-Paediatric/Clinical* *7-User experience*
	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.	Vol 3, Chapter 8: Section 8.87-88 Page 68	**6-Training** *Linked to:* *1-Duty of Candour* *2-Death certification* *4-Paediatric/Clinical* *5-SAI* *7-User experience*
	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.	Vol 3, Chapter 8: Section 8.74-75 Page 64-65	**6-Training** *Linked to:* *1-Duty of Candour*
	64	Parents should be involved in the preparation and provision of any such training programme.		**6-Training** *Linked to:* *7-User experience*
	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.	Vol 2, Chapter 4: Section 4.112-113 Page 36-37 Vol 2, Chapter 5: Section 5.215 -217 Page 167-170	**6-Training** *Linked to:* *5-SAI*
	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	Vol 3, Chapter 8: Section 8.81 Page 66	**6-Training**

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

	Ref	RECOMMENDATION	Report Reference	Workstream
	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.	Vol 2, Chapter 5: Section 5.226 Page 173	**3-Duty of Quality**
	71	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.	Vol 1, Chapter 3: Section 3.292 Page 223 Vol 3, Chapter 8: Section 8.56 Page 58 Section 8.58- 8.59 Page 59	**3-Duty of Quality** *Linked to:* *4-Paediatric/Clinical*
	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.	Vol 2, Chapter 5: Section 5340-344 Page 209-209 Vol 3, Chapter 8: Section 8.83 Page 67 Section 8.107 Page 74	**3-Duty of Quality** *Linked to:* *1-Duty of Candour*
	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.	Vol 3, Chapter 8: Section 8.105 Page 74	**8-Workforce & professional regulation**
	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.		**8-Workforce & professional regulation**
	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies	Vol 1, Chapter 3: Section 3.299-301 Page 225-226 Vol 3, Chapter 8: Section 8.109 Page 75 Section 8.110 Page 76	**8-Workforce & professional regulation** *Linked to:* *1-Duty of Candour*

	Ref	RECOMMENDATION	Report Reference	Workstream
	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.		**3-Duty of Quality** *Linked to:* *9-Assurance*
	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.		**3-Duty of Quality**
	78	Implementation of clinical guidelines should be documented and routinely audited		
	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.		**3-Duty of Quality** *Linked to:* *4-Paediatric/ Clinical*
	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.	Vol 3, Chapter 8: Section 8.109 Page 75	**3-Duty of Quality**
	81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.	Vol 2, Chapter 4: Section 4.187-189 Page 57-58	**3-Duty of Quality** *Linked to:* *5-SAI*
	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.	Vol 2, Chapter 4: Section 4.93 Page 30 Vol 3, Chapter 8: Section 8.59 Page 59	**5-SAI** *Linked to:* *3-Duty of Quality*
	83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.		**5-SAI** *Linked to:*

	Ref	RECOMMENDATION	Report Reference	Workstream
				3-Duty of Quality
	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.		**3-Duty of Quality**
DEPARTMENT	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.		**Department** *Linked to:* *4-Paediatric/ Clinical* *8-Workforce & professional regulation*
	86	The Department should expand both the remit and resources of the RQIA in order that it might (i) Maintain oversight of the SAI process	Vol 3, Chapter 8: Section 8. Page 54-55 Section 8.71 Page 63 Section 8.107 Page 74	**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*
		(ii) Be strengthened in its capacity to investigate and review individual cases or groups of cases, and		**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*
		(iii) Scrutinise adherence to duty of candour.		**1-Duty of Quality** *Linked to:* *3-Duty of Candour* *5-SAI* *9-Assurance*

	Ref	RECOMMENDATION	Report Reference	Workstream
	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.	Vol 3, Chapter 8: Section 8.124 Page 80	**2-Death Certification Implementation Working group** *Linked to:* *3-Duty of Quality* *6-Training* *7-User experience*
	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel.	Vol 3, Chapter 8: Section 8.82 Page 66 Section 8.118 Page 78 Section 8.119 Page 78 Section 8.127 Page 81	**Department**
	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.	Vol 3, Chapter 8: Section 8.90 Page 69 Sections 8.95-8.97 Pages71	**7-User experience & Advocacy**
	90	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability.	Vol 3, Chapter 8: Section 8. Pages 52 -53	**3-Duty of Quality** *Linked to:* *8-Workforce & professional regulation*
		(ii) The identification of specific training requirements necessary for effective implementation.		**3-Duty of Quality** *Linked to:* *6-Training*
	91	The Department, HBSC, PHA, RQIA and HSC Trusts should	Vol 3, Chapter 8: Section 8.62- 8.64 Pages 60	**5-SAI**

	Ref	RECOMMENDATION	Report Reference	Workstream
		synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.		*Linked to:* *3-Duty of Quality*
	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.	Vol 3: Chapter 8:	**3-Duty of Quality**
	93	The Department should review Trust responses to the findings and recommendations of this Report.		**9-Assurance** *Linked to:* *All other workstreams*
CULTURE & LITIGATION	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.	Vol 2, Chapter 5: Section 5.355-362 Page 213-215 Vol 3, Chapter 7: Section 7.35 Pages 13-14	*Linked to:* *1-Duty of Candour*
	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.	Vol 2, Chapter 5: Section 5.316-320 Page 201-202 Vol 3, Chapter 8: Section 8.129 Page 81	**2-Death Certification Implementation Working group**
	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.	Vol 3, Chapter 8: Section 8.130 Page 82	**2-Death Certification Implementation Working group**

APPENDIX 2 IHRD Workstreams and Delegated tasks from IHRD Report Recommendations

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

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

APPENDIX 3 WORKSTREAM SUB-GROUPS

Workstream Sub-group	Workstream Linkages	Actions	Recommendations for implementation
Being Open	1 Duty of Candour	2 actions from 2 recommendations	Candour: 3, 4,
RQIA Remit	1 Duty of Quality	5 actions from 3 recommendations	Candour, 8 SAI Investigations: 34 Department: 86 (i), 86 (ii), 86 (ii)
Preparation for Inquests	2 Death Certification & Bereavement	7 actions from 7 recommendations	SAI Investigation: 36, SAI Death: 50,51,52,53, Culture and Litigation: 95,96
Independent Medical Examiner Sub-Group	1 Death Certification & Bereavement	1 actions from 1 recommendations	Department: 87
HSC Bereavement Network and Pathology Network	2 Death Certification & Bereavement	11 actions from 7 recommendations	SAI Death: 44, 45, 46, 47 (i), 47 (ii), 47 (ii), 47 (iii), 47 (iv), 47 (v), 54, Training: 59,60
ALB Board Effectiveness	3 Duty of Quality	9 actions from 7 recommendations	Leadership: 9, Training: 55, 56, Trust Governance: 69 (i), 69 (ii), 69 (iii), 70, 72, 84,
Clinical & Social Care Governance	2 Duty of Quality 5 SAI	13 actions from 12 recommendations	SAI Investigation: 40, 41, Training: 67, 68, Trust Governance: 71, 76, 77, 78, 79, 80, 81 Department: 90 (i), 90 (ii),