Belfast Health and Social Care Trust
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TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Trust Board - Public**	**Ref No. 5.5**
DIRECTOR	**Responsible for Neurology**	**Date 2 Sept 2021**
Neurology - Update		
Purpose	This paper provides an update of the following; • The review of patients in Cohort 3 recall is complete. • The outcome of the reviews have been validated and passed to HSCB/PHA for compilation into an Outcomes report • Royal College of Physicians (RCP) have provided their Quality Assurance Report and clinical record review. • The report indicates a high level of concordance between the judgements reached by the Review team on the 22 cases and the judgements reached by the Belfast reviewer. • The trust will write to the patients, whose case was reviewed by the RCP, to provide them with the specific review of their case.	
Corporate Objective	• Safety & Quality	
Key areas for consideration	.	
Recommendations	• For Information	

Briefing to Trust Board
2 September 2021
Neurology

Patient Recall – Cohort 3

On 20th April 2021, Belfast Trust announced a further recall of former patients of Dr Michael Watt. Patients to be recalled were patients of Dr Watt who had been discharged from his care during the timeframe 1996 to 31 March 2012. Only those patients on specific medications were identified. The Belfast Trust validated patient records to identify the patient population to be recalled. the review is now complete. The information of the outcome of the reviews has been validated and passed to HSCB/PHA for compilation into an Outcomes Report.

Stratified groups

Group 1 – **209** patients recalled for a review appointment by a consultant neurologist

Group 2 – **495** patients GP receive a letter, and asked to ascertain, if the current prescribing of any of these medications, is appropriate for their patient's **current** clinical indication. **436 of these letters were Belfast Trust patients,** 51 were on behalf of the Ulster Independent Clinic (UIC) and 8 for the Hillsborough Private Clinic (HPC)

Summary of key activity as at 22 August 21

Group 1 - Total Number of people in cohort 3 recall	**209**
Number of people reviewed	**190**
Number of people who have declined/no longer require an appointment/ DNA	**19**
Outcomes	
Patients discharge confirmed	**144**
Patients requiring ongoing review	**65**

Group 2 - Total Number of patient letters to GPs	436
Number of GP responses – recall required	**175**
Number of GP responses – recall NOT required	**136**
Total No of Patients actually recalled	**300**
Number of people who have declined/no longer require an appointment/ DNA/ deceased	**53**
Number of people reviewed at 22 August 21	**247**
Outcomes	
Patients discharge confirmed	**291**
Patients requiring ongoing review	**9**

RCP Blood Patch Review

The College has provided the Trust with the final report of their Quality Assurance Report and Clinical Record Review (4-5 February 2021)

The Trust will write to the patients, whose case was reviewed by the RCP, to provide them with the outcome of the specific review of their case.

The report indicates there was a high level of concordance between the judgements reached by the Review Team on the 22 cases and the judgements reached by the Belfast reviewer. Across the 22 cases, there was full concordance between the review teams overall rating on the quality of care and the rating reached by the Belfast reviewer in 73% of cases. Where the rating decided upon the Belfast reviewer differed from that reached by the review team, generally the Belfast reviewer had graded cases more critically than the review team.

The overriding conclusion from the review is that the desktop review of cases undertaken within the Trust was robust and effective. The report states 'the Trust can be assured that its process of structured judgement review stands up to external scrutiny'.

The report makes 12 recommendations to the Trust. These relate to sharing the report's findings and informing patients of the review outcome. Some of the recommendations have the potential to identify the individual. Other recommendations focus upon the future provision of EBP for SIH. The review team recommended that the Trust should continue to use the structured judgement form to review other cases, as necessary.

Recommendations

The Trust should share this report with the Trust Board, other relevant external stakeholders and the wider clinical team, and ensure that an appropriate action plan is developed to address the recommendations that follow.

The Trust should review the arrangements for obtaining and recording informed consent when undertaking an EBP procedure.

The Trust should have a clear protocol for referral for blood patching (if it does not already have one – if it does then the application of this should be fully audited). The protocol should incorporate an element of scrutiny of other clinicians at the Trust who are involved in providing this procedure, through MDT discussion of patients suspected to have low-pressure headache.

The protocol referred to above should set out the expertise required of any clinician who performs EBP for SIH within the Trust.

In cases where multiple clinicians are involved in the care of a patient, bringing together the documentation of a multidisciplinary assessment would be beneficial in this patient population in Northern Ireland. This could be a role for a specialty nurse.

The Trust should ask a radiologist to review the brain MRIs conducted for the 44 patients, who were not considered by this review, to understand how many of those listed for EBP had brain radiological features suggestive of SIH and whether they went on to have a spine MRI. This would be a useful audit to conduct periodically.

A review, by a radiologist, was undertaken and we are awaiting the report.

The Trust should continue to use the structured judgement form to review other cases, as necessary.

Bernie Owens
Director
27 August 21