

[REDACTED]

From: Horisk, Damian
Sent: 31 January 2022 14:07
To: Metcalfe, Alan
Subject: FW: SEA Report Template
Attachments: SEA Report Template.docx

Alan

For info.

Regards

Damian

From [REDACTED]
Sent: 31 January 2022 14:05
To: Horisk, Damian [REDACTED]
Cc: Henry, Robert [REDACTED]
Subject: SEA Report Template

Hi Damian

As requested, please find attached SEA Report Template for completion.

Thanks

[REDACTED]

[REDACTED]

Key Points to consider when conducting a SIGNIFICANT EVENT AUDIT (SEA) within BHSC

Introduction

The Belfast Trust is committed to being an open, transparent and supportive organisation. This is one of the key elements of the Trust's Quality Improvement Strategy 2017-2020.

Improving the quality and safety of patient care is a key clinical governance priority in healthcare. The SEA process has an important role to play in contributing to this aim.

A SEA can be defined as 'a process in which individual episodes (when there has been a significant occurrence either beneficial or deleterious) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate changes that might lead to future improvements'

SEA is an investigative method that can be used as a tool to review different situations including incidents and complaints. It is therefore not just for use within the Serious Adverse Incidents (SAIs) Process.

Please note if an incident meets SAI reporting criteria* it is important that this is reported as per HSCB SAI guidance (**This can be accessed via the Hub at the link below*).

http://intranet.belfasttrust.local/directorates/medical/riskgovernance/BHSC%20Shared%20Learning%20Letters/HSCB%20SAI%20Procedure_Procedure%20for%20the%20Reporting%20and%20Follow%20up%20of%20SAIs_Version%201.1_November%202016.pdf

SAIs will be reviewed as either a Level 1, 2 or 3.

A SEA may also be completed following a Hot debrief**

(*** Separate guidance available for BHSC Hot debrief can be accessed via the Hub at the link below*)

http://intranet.belfasttrust.local/directorates/medical/riskgovernance/BHSC%20Shared%20Learning%20Letters/Hot%20Debrief_Final%203.0_14032018.pdf

Purpose of a SEA

Effective SEA's allow teams to highlight and learn from both strengths and weaknesses in our systems /processes and ultimately in the care we provide.

Taking part in SEAs offers teams a chance to reflect on individual events that are identified as being 'significant' or when improvements in our services are required. Importantly, the opportunity for reflection, discussion and analysis helps teams and individual healthcare professionals identify learning and share good practices. Another major advantage of doing a SEA well is that it can enhance team-working and morale, and improve communication between team members and others. A well undertaken SEA also focuses on system improvement rather than individuals and therefore helps to embed a no blame and just culture.

Stages of a SEA

NPSA guidance outlines 7 key stages within the SEA process. These are

1 – Awareness and prioritisation of a significant event

2 – Information gathering

3 – The facilitated team-based meeting

4 – Analysis of the significant event

5 – Agree, implement and monitor change

6 – Write it up

7 – Report, share and review

Full guidance on completion of a SEA can be obtained from www.npsa.nhs.uk/nrls/gp

Key Points to be aware of

- If a SEA is being conducted for an incident that has not been reported as a SAI, this information should be shared with the relevant Governance Manager for Service Directorates (or relevant Senior Manager for other Directorates) at the earliest possible opportunity and the fact that an SEA is being undertaken should be added to the Datix record.
- The team undertaking the SEA should provide a brief overview as to who is facilitating the SEA and approximate timeframes for completion.
- Staff should be aware that all SEA reports whether they are being carried out for an incident that has been reported as a SAI or outside of the SAI process may potentially be shared with the Coroner, Litigation Department, HSENI, HSCB, family members etc.
- On completion, the SEA should be approved in accordance with Divisional processes and the final version uploaded onto Datix. Any recommendations identified by the SEA team must be transferred into an Action plan. Completion of the Action plan is the responsibility of the senior manager in the area in which the investigation was undertaken. The Action plan should also be attached to the Datix record upon completion.
- Any SEA completed must be discussed at the relevant service team meeting and any identified learning appropriately shared.

Further Information

Please contact either Corporate Governance or your Governance Manager for further advice

[REDACTED]

From: Horisk, Damian
Sent: 31 January 2022 13:45
To: Metcalfe, Alan
Subject: FW: SEA Guidance - key points (BHSCT 28 Jan 2020).pdf
Attachments: SEA Guidance - key points (BHSCT 28 Jan 2020).pdf; NPSAquickSEAguide.pdf

Alan

For discussion.

Damian

From: Henry, Robert [REDACTED]
Sent: 31 January 2022 13:24
To: Horisk, Damian [REDACTED]
Subject: FW: SEA Guidance - key points (BHSCT 28 Jan 2020).pdf

From: Henry, Robert
Sent: 28 January 2020 17:00
To: Vincent, Nicky [REDACTED]; Murton, Carolanne
[REDACTED]; [REDACTED]; Farrelly, Owen
[REDACTED]; McCollam, Ursula [REDACTED]; [REDACTED]
[REDACTED]; Welsh, Jolene [REDACTED]; [REDACTED]
[REDACTED]; [REDACTED]; [REDACTED]
[REDACTED]
Cc: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]
[REDACTED]; Hagan, Chris [REDACTED]; Cairns, Claire
[REDACTED]
Subject: FW: SEA Guidance - key points (BHSCT 28 Jan 2020).pdf

Dear All,

This had been discussed and agreed before Christmas as part of the Governance Forum discussions, so apologies in only getting this out now.

Please can you kindly share with your teams

Many thanks,

Robert Henry
Risk & Governance
6th Floor McKinney House
Musgrave Park Hospital
[REDACTED]

Significant Event Audit

NHS
National Patient
Safety Agency
National Reporting
and Learning Service

A quick guide to conducting a Significant Event Audit

Conducting an effective Significant Event Audit (SEA) allows you and your team to highlight and learn from both strengths and weaknesses in the care you provide.

Improving the quality and safety of patient care is a key clinical governance priority in primary healthcare and SEA has an important role in contributing to this aim.

This quick guide to conducting an effective SEA will help you and your team improve care for all your patients.

The seven stages of Significant Event Audits

Stage 1 – Awareness and prioritisation of a significant event

Staff should be confident in their ability to identify and prioritise a significant event when it happens. The practice should be fully committed to the routine and regular audit of significant events.

Stage 2 – Information gathering

Collect and collate as much factual information on the event as possible from personal testimonies, written records and other healthcare documentation. For more complex events, an in-depth analysis will be required to fully understand causal factors.

Stage 3 – The facilitated team-based meeting

The team should appoint a facilitator who will structure the meeting, maintain basic ground rules and help with the analysis of each event. The team should meet regularly to discuss, investigate and analyse events. These meetings are often the key function in co-ordinating the SEA process and they should be held in a fair, open, honest and non-threatening atmosphere.

Agree any ground rules before the meeting starts to reinforce the educational spirit of the SEA and ensure opinions are respected and individuals are not 'blamed'.

Minutes of the meeting should be taken and action points noted. These should be sent to all staff, including those unable to attend the meeting.

An effective SEA should involve detailed discussion of each event, demonstration of insightful analysis, the identification of learning needs and agreement on any action to be taken.

Significant Event Audit

Stage 4 – Analysis of the significant event

The analysis of a significant event can be guided by answering four questions:

1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned?

The possible outcomes may include:

- no action required;
- a celebration of excellent care;
- identification of a learning need;
- a conventional audit is required;
- immediate action is required;
- a further investigation is needed;
- sharing the learning.

Stage 5 – Agree, implement and monitor change

Any agreed action should be implemented by staff designated to co-ordinate and monitor change in the same way the practice would act on the results of 'traditional' audits.

Progress with the implementation of necessary change should always be monitored by placing it on the agenda for future team or significant event meetings.

Where appropriate, the effective implementation and review of change is vital to the SEA process. To test how well the SEA process has gone, practices should ask themselves 'What is the chance of this event happening again?'

Stage 6 – Write it up

It is important to keep a comprehensive, anonymised, written record of every SEA, as external bodies will require evidence that the SEA was undertaken to a satisfactory standard. The SEA report is a written record of how effectively the significant event was analysed.

Stage 7 – Report, share and review

Reporting when things go wrong is essential in general practice. The practice should formally report (either to the National Reporting and Learning Service, or via the primary care trust/healthcare organisation) those events where patient safety has, or could have been, compromised.

Where a mechanism exists, practices should share knowledge of important significant events with local clinical governance leaders so that others may learn from these.

To download the full guidance on SEA go to www.npsa.nhs.uk/nrls/gp

Reference: 0789 October 2008

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[REDACTED]

From: Horisk, Damian
Sent: 31 January 2022 13:11
To: Metcalfe, Alan
Subject: FW: Plaque Incident - Datix ref: W322874

For info

Damian

From: Taylor, Kevin [REDACTED]
Sent: 31 January 2022 13:00
To: Horisk, Damian [REDACTED]
Subject: Plaque Incident - Datix ref: W322874

Hi Damian,

A Datix Incident has now been logged - W322874

Regards,

Kevin Taylor

Divisional Operations Manager
Estate Services Department
Belfast Health & Social Care Trust
Belfast City Hospital
51 Lisburn Road
Belfast BT9 7AB

[REDACTED]

From: Horisk, Damian
Sent: 31 January 2022 11:45
To: Metcalfe, Alan
Subject: RE: SEA

Alan

A few thoughts and some guidance for discussion:

Need to think of membership in context of possible future actions.

Incident Report completed? (Datix)

SAI Notification Form?

8 weeks to completion

Guidance

Review Team Membership:

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes. (P21)

Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation' arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

- serious incidents of public interest or concern relating to:
 - any of the criteria above
 - theft, fraud, information breaches or data losses
 - a member of HSC staff or independent practitioner

Learning

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole.

From: Metcalfe, Alan [REDACTED]
Sent: 31 January 2022 11:07
To: Horisk, Damian [REDACTED]
Subject: SEA

Thought dump – thinking we should bring back to ESMT for agreement and denote them as the “Review Team” ???

Regards,

Alan

Alan Metcalfe
Co-Director Estates Services

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[REDACTED]

From: Horisk, Damian
Sent: 27 January 2022 14:57
To: Metcalfe, Alan
Subject: RE: Significant Event Audit

Happy with that Alan

Damian

From: Metcalfe, Alan [REDACTED]
Sent: 27 January 2022 13:02
To: Horisk, Damian [REDACTED]
Subject: Significant Event Audit

Damian,

A few initial notes below for reflection / consideration / discussion:

PURPOSE

The purpose of the Audit is to determine the facts in respect of the removal of a Plaque from the Belfast City Hospital and to identify any learning arising from this event.

INITIAL INTERVIEWEES

[REDACTED]

DRAFT INTERVIEW QUESTIONS

- Are you aware of any instruction to remove the plaque?
- Can you tell us what you know about the removal of the plaque?
- Are you aware of anyone else who may be able to assist us in gathering the facts and learning in relation to the actual removal of the plaque or the decision to do so?

ADDITIONAL INFORMATION GATHERED

- Initial request for information received by the BHSCT Corporate Communications Team
- Enquiry received by Complaints Team regarding Plaque (and distribution thereof)

Regards,

Alan

Alan Metcalfe
Co-Director Estates Services

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[REDACTED]

From: Metcalfe, Alan
Sent: 27 January 2022 12:37
To: [REDACTED]
Cc: Horisk, Damian
Subject: Significant Event Audit

Importance: High

Hi [REDACTED]

Can you set up meeting with the following next Wednesday if possible (need to be completed by 3pm as I have an unavoidable appointment – any other meeting can be changed/missed):

[REDACTED]

30 minute consecutive slots (Kevin will arrange for the Generator House meeting room if you link in with him).

In advance of that can you send each an email as follows:

(you may need to direct the communication to Joseph through Kevin to ensure it is received by [REDACTED])

Dear..

Re Significant Event Audit

As you will be aware, a plaque was recently removed from the Belfast City Hospital.

I have been asked to undertake a Significant Event Audit in respect of the removal of the plaque.

The purpose of the Audit is to determine the facts in respect of the event and to identify any learning arising from it.

I have asked [REDACTED] to set up a meeting to discuss this with you. Accompanying me at the meeting will be Damian Horisk.

Should you wish to bring a Staff Side Representative or colleague to this meeting you are welcome to do so.

Regards,

Alan

Alan Metcalfe
Co-Director Estates Services

[REDACTED]

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[REDACTED]

From: Horisk, Damian
Sent: 26 January 2022 10:59
To: Metcalfe, Alan
Subject: RE: Prince Andrew Plaque

Alan

No, [REDACTED] only shared this email with me.

Regards

Damian

From: Metcalfe, Alan [REDACTED]
Sent: 25 January 2022 17:17
To: Horisk, Damian [REDACTED]
Subject: FW: Prince Andrew Plaque

Damian,

Can you check if [REDACTED] shared it.

Thanks,

Alan

From: [REDACTED]
Sent: 25 January 2022 17:16
To: Metcalfe, Alan [REDACTED]; [REDACTED]
Cc: Horisk, Damian [REDACTED]
Subject: RE: Prince Andrew Plaque

I had only shared with yourself [REDACTED].

Caller was anonymous.

[REDACTED]

From: Metcalfe, Alan [REDACTED]
Sent: 25 January 2022 17:15
To: [REDACTED]
[REDACTED]
Cc: Horisk, Damian [REDACTED]
Subject: FW: Prince Andrew Plaque

[REDACTED]

I have been asked to look into the circumstances around the removal of this plaque.

Can you advise if this email / request was shared with others?

Thanks,

Alan

From: Horisk, Damian [redacted]
Sent: 24 January 2022 14:51
To: Metcalfe, Alan [redacted]
Subject: FW: Prince Andrew Plaque

Alan

A little background below [redacted] hadn't responded until he spoke to me. I've asked him to leave it.

Damian

From: [redacted]
Sent: 24 January 2022 14:41
To: Horisk, Damian [redacted]
Subject: FW: Prince Andrew Plaque

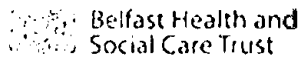
From: [redacted]
Sent: 21 January 2022 16:24
To: [redacted]
Cc: [redacted]
Subject: Prince Andrew Plaque

[redacted]

Please see request below from a member of the public.

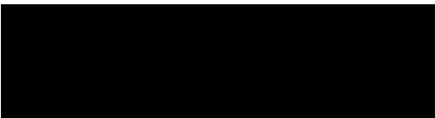
I am unsure who this needs to go to?

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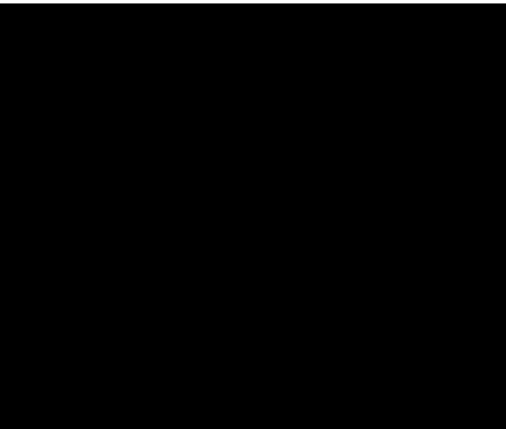
From: [redacted]
Sent: 20 January 2022 12:05
To: complaints-SM <complaints@belfasttrust.hscni.net>
Subject: Prince Andrew Plaque

There is a plaque in BCH OPC opposite the chat coffee which is causing offence in the current circumstances as it references Prince Andrew – can this be removed. Caller wanted to remain anonymous.





From: [REDACTED]
Sent: 25 January 2022 14:35
To: Metcalfe, Alan
Subject: FW: [REDACTED]

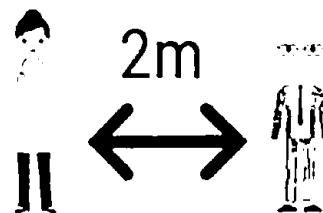


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Wash your
hands
regularly



Keep
your
distance



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From: [REDACTED]
Sent: 24 January 2022 10:16
To: DL-MediaServices <DL-MediaServices@belfasttrust.hscni.net>
Subject: [REDACTED]

Hi,

It's [REDACTED]. I was wondering if Belfast Trust could clarify this?

A plaque in Belfast City Hospital marking the official opening of its tower block by Prince Andrew has been removed.

The plaque (which was located near the front entrance) was unveiled by the Duke and Duchess of York in 1986. I understand it has been removed in recent days.

- May I ask when the plaque was removed, and why?

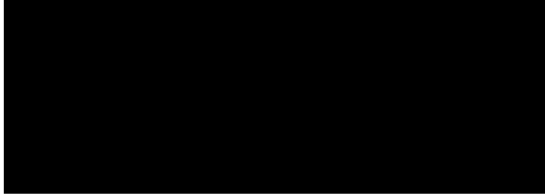
- Have any other displays linked to Prince Andrew been removed, and if so which ones?

Please let me know if you receive this. It would be great to get details before 3pm.

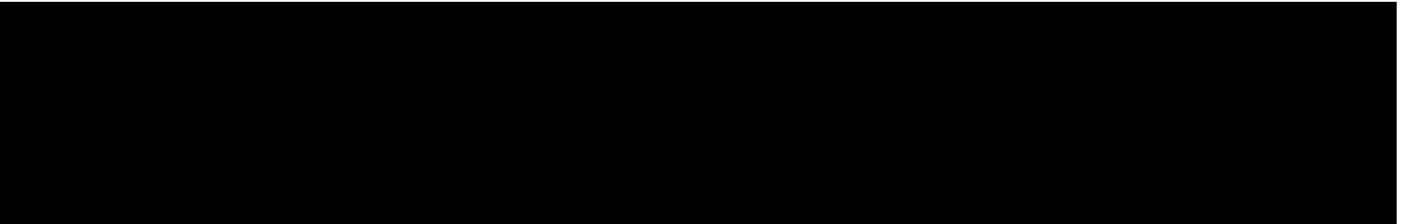
Thanks again,



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From:
Sent:
To:
Cc:
Subject:

25 January 2022 14:32
Metcalfe, Alan
Horisk, Damian
Re: Plaque Removal



BELFAST CITY HOSPITAL TOWER
opened by
H.R.H. The PRINCE ANDREW
25th. June, 1986

From: Metcalfe, Alan [REDACTED]
Sent: Tuesday, January 25, 2022 2:28:51 PM
To: [REDACTED]
Cc: Horisk, Damian [REDACTED]
Subject: Plaque Removal

Hi [REDACTED]

I've been asked to investigate the circumstances around the removal of the plaque from BCH (as discussed yesterday).

Can you give me a little background i.e. how it was brought to your attention and when (and anything else you might think relevant).

Much appreciated,

Alan

Alan Metcalfe
Co-Director Estates Services

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Asking together



Caring



Improving



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HSC Values



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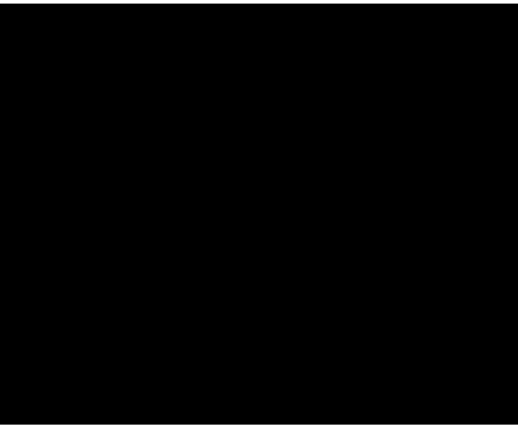
[Redacted]

From: [Redacted]
Sent: 25 January 2022 14:31
To: Metcalfe, Alan
Cc: Horisk, Damian
Subject: RE: Plaque Removal

Alan

The Comms Dept got an mail from [Redacted] asking about it. Was the first and only time I had heard. We responded with very little info. I must say that I saw the story on [Redacted] today and was quite puzzled by the pic they have. It is on my phone and I will send on a separate email.

[Redacted]

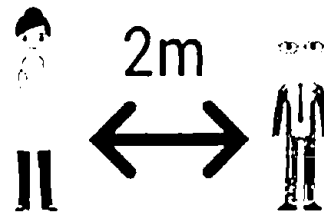


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[uTube.com/BelfastTrust](https://YouTube.com/BelfastTrust)

Wash your
hands
regularly



Keep
your
distance



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From: Metcalfe, Alan [Redacted]
Sent: 25 January 2022 14:29
To: [Redacted]
Cc: Horisk, Damian [Redacted]
Subject: Plaque Removal

Hi [Redacted]

I've been asked to investigate the circumstances around the removal of the plaque from BCH (as discussed yesterday).

Can you give me a little background i.e. how it was brought to your attention and when (and anything else you might think relevant).

Much appreciated,

Alan

Alan Metcalfe
Co-Director Estates Services

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