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| **Request for Specialist Support for Reviews**  **Forum of Postgraduate Training Bodies** |

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| **Section 1: Request Details** | |
| **Date of Request :** |  |
| **Requesting agency:** | Specify name of the requesting Hospital Group/ CHO |
| **Request to:** | Name of training body or bodies from who support is being requested. |
| **Request for:** | Consultant specialty |
| **Confirmation that specialist input requested cannot be provided from within or across Hospital Groups** | Outline the steps taken to secure the required input from within or across hospital groups/ CHOs |
| **Commissioner of Investigation** | Name of Commissioner |
| **Chairperson of investigation** | Name of chairperson. |

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| **Section 2: Type of Investigation** | |
| **Systems Analysis Investigation of a single incident** | Yes/No |
| **Look-back Review**  *Also indicate how many cases will be under review* | Yes/No |
| **Has any investigation/ look back review commenced prior to this request?** | Yes/No |
| **Has the investigation/review been completed?** | Yes/No |
| **Section 3: Type of Assistance Required** | |
| **Support Type 1:** To answer a specific clinical or technical question that has arisen for that investigation team. | Specify |
| **Support Type 2:** To validate that the draft report prepared by the investigation team is clinically/technically accurate and addresses the clinical/technical issues highlighted appropriately  Note: If the request is for validation of the draft report of a systems analysis investigation please confirm that the factual accuracy check has been carried out on the draft report | Specify |
| **Support Type 3:** To participate as member of the investigation/review team\*  **\*Based on the limited availability of clinical/technical experts to participate as members of Investigation/Review Teams; requests for input should be as far as reasonably practical be limited to (1) and (2) above** | Specify |

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| **Section 4: Details of Investigation/Look Back Review Team** | |
| **List the members of the Investigation/Look Back Review Team and their areas of responsibility:** | |
| **Name** | **Responsibility** |
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| **Section 5: Case Background and Goals** | |
| Outline general background and brief chronology of the case |  |
| Purpose of investigation/look back review | As per terms of reference (TOR) |
| Are the terms of reference attached for the investigation/look back review? | Yes/No |

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| **Section 6: Review Approach (Methodology)** | |
| **A System Analysis Investigation** | Yes/No |
| **A Review of multiple cases**  If multiple cases, indicate the number of cases under review | Yes/No |
| **Other (please specify)** |  |

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| **Section 7: Availability of Records and Information** | |
| Outline the range of material to be made available to the clinician(s) providing the specialist support during the investigation: |  |
| Outline how the nominated specialist clinician will be able access this information | Review files on site, files to be couriered to clinical expert etc |

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| **Section 8: Timescale for External Input** | |
| **Expected start date** |  |
| **Expected end date** |  |
| **Expected time commitment required** |  |

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| **Section 9: Communication Strategy** | |
| Is the clinician(s) expected to meet with either the complainant/family or other parties | Yes/No |
| *If yes outline the nature of this interaction* |  |
| Is the clinician(s) expected to meet with other health care professionals and staff as part of the review? | Yes/No |
| *If yes outline the nature of this interaction* |  |
| Is the clinician(s) expected to participate in the communication process during the investigation/review or in reporting its outcomes to either members of the public, to officials at the requesting agency? | Yes/No |
| *If yes outline the nature of this interaction* |  |

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| **Section 10: Indemnity/Remuneration** | |
| Indemnity will be provided by the requesting agency to the nominated specialist and the training body | Yes/No  Expert will not proceed until indemnity has been provided. |
| The requesting agency agrees to comply with the Forum of Irish Postgraduate Medical Training Bodies Policy on Remuneration | Yes/No |
| Name and contact details of whom the clinician(s) providing the specialist support to submit invoice: | Name:  Address:  Email address: |
| Administrative support will be provided to the clinician(s) providing the specialist support | Yes/No |
| Details of the administrative support to be available to the clinician(s) providing the specialist support | Contact Name:  Contact Details: |

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| **Application approved and signed by Hospital Group CEO/ CHO Chief Officer** |  |
| **Organisation name:** |  |
| **Date:** |  |

*Completed forms together with the TOR are to be submitted by the Commissioner of review / investigation to* [*Fiona.Culkin@hse.ie*](mailto:Fiona.Culkin@hse.ie) *(Quality Risk & Safety)* ***and copy the relevant Divisional Lead for Quality and Patient Safety.***